

**INDEPENDENT REGULATORY  
REVIEW COMMISSION**

**Regulatory Analysis Form**

(Completed by Promulgating Agency)

(All Comments submitted on this regulation will appear on IRRC's website)

(1) Agency

Department of Human Services

(2) Agency Number: 14-540

Identification Number:

IRRC Number: 3160

2016 OCT 25 AM 10:16

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(3) PA Code Cite: 55 Pa.Code Chapters 51, 2380, 2390, 6100, 6200, 6400 and 6500

(4) Short Title: Home and Community-Based Supports and Licensing

(5) Agency Contacts (List Telephone Number and Email Address):

Primary Contact: Julie Mochon, Human Service Program Specialist Supervisor, Office of Developmental Programs, 783-5771, [jmochon@pa.gov](mailto:jmochon@pa.gov)

Secondary Contact: Karen E. Kroh, Regulatory Management Consultant, Office of Developmental Programs, 265-7746, [c-karkroh@pa.gov](mailto:c-karkroh@pa.gov)

(6) Type of Rulemaking (check applicable box):

Proposed Regulation

Final Regulation

Final Omitted Regulation

Emergency Certification Regulation;

Certification by the Governor

Certification by the Attorney General

(7) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

This regulation supports Pennsylvanians with an intellectual disability or autism to live in and participate fully in the life of their community, to achieve greater independence and to have the full range of opportunities enjoyed by all citizens. The proposed rulemaking strengthens community supports to promote person-centered approaches, community integration, personal choice, quality in support delivery, equity, accountability in the utilization of resources and innovation in service design.

The regulation governs the program, operational and fiscal aspects of: (a) home and community-based supports (HCBS) provided through the adult autism, consolidated and person/family directed support 1915(c) waiver programs; (b) Medicaid state plan HCBS for individuals with an intellectual disability or autism, such as targeted support management; and (c) services funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B of the Human Services Code.

(8) State the statutory authority for the regulation. Include specific statutory citation.

Sections 201(2), 403(b), 403.1 (a) and (b), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021) and section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)).

(9) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

Yes, the HCBS provisions are mandated by 42 CFR Part 441-Services: Requirements and Limits Applicable to Specific Services.

No, there are no relevant court decisions.

(10) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The regulation is needed to continue the Commonwealth's eligibility for Federal financial participation in the HCBS waiver programs. The regulation protects the health, safety and well-being of the individuals receiving supports in individual directed, family-based, community residential and day programs funded through the HCBS waivers, the Commonwealth's Title XIX state plan and state-funds-only allocations. The regulation reduces duplication and conflict with licensing regulations, thus streamlining regulatory compliance efforts.

The regulation eliminates unnecessary language, streamlines processes and reduces the volume of regulation. The regulation incorporates consistent and best practice terms, language and principles throughout the regulations.

The proposed Chapter 6100 regulation applies to a broad scope of programs receiving Commonwealth and Federal funds. The regulation applies to approximately 944 HCBS and base funded providers providing support to more than 50,000 individuals with an intellectual disability or autism.

The proposed Chapters 2380, 2390, 6400, and 6500 regulation applies to approximately 4,900 community homes serving 15,000 individuals, 1,700 family living homes serving 2,200 individuals, 370 adult training facilities serving 13,900 individuals and 170 vocational facilities serving 11,400 individuals.

Benefits for self-advocates, families and advocates include strengthened individual rights, assistance to locate and sustain employment, strict discharge conditions and procedures, minimum notice required for transition to a new provider, prohibition of restraints except for an emergency protective physical hold, a rights team to review potential rights violations and medication administration by trained, non-medically licensed persons.

Benefits for providers include the reduced administrative burden by coordinating multiple chapters of Departmental regulations, reduction in the overall length and complexity of the regulations, the ability to submit innovation projects, a flexible staff training plan designed by the provider, reduction in the conflict of interest reporting requirements, clarification of the documentation required to support a claim, flexible payment options to support potential changes to the payment methodologies, more frequent updates of the market-based data for fee-based rates and the reduction of the donation reporting requirements.

Benefits for county intellectual disability programs include clarity of roles for the support coordinators and targeted support managers, deletion of conflicting PSP time frames, acknowledgement of county human rights committees and the regulation of services funded exclusively by grants to counties. These amendments provide consistent program requirements on a statewide basis to support the ease of county-to-county transitions, as well as transitions from services and supports funded through state-funds-only allocations to HCBS Federal funding.

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

(11) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

The regulation incorporates and clarifies the Federal requirements such as community integration, employment and person-centered planning. The regulation will also be folded into the Department's waiver applications/revisions and submitted to the CMS for review and approval.

The state licensing regulations, however, are not governed by Federal law. Several areas of the licensing such as medication administration, abuse and incident reporting, staff training, positive interventions, the prohibition of restraints and a rights team are not regulated by Federal law.

Chapter 6100 addresses additional areas that are not comprehensively regulated by the federal standards such as regulatory waiver procedures, innovation projects, transition procedures, fee-based rates, cost-based rates, room and board rates and special programs such as autism and vendor good and services.

(12) How does this regulation compare with those of the other states? How will this affect Pennsylvania's ability to compete with other states?

Other states have only begun to revise their regulations to meet the new Federal requirements. Pennsylvania is in the forefront of adapting its community intellectual disability and autism system to meet the new Federal requirements.

The Department studied the HCBS programs of the states of New York, Maryland, New Jersey, Ohio, Illinois, Massachusetts and Wisconsin. Since no two states have the same administrative, program or funding structures, nor do they share the same historical development, a strict data comparison is not possible; however, in a comparison of the HCBS standards in other states across staff training, PSPs, positive interventions and incident management, the proposed Pennsylvania regulation is compatible with the standards, policies, practices and procedures of other states.

This regulation does not affect Pennsylvania's ability to compete with other states.

(13) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No, this regulation will not affect other regulations of the Department or another state agency.

(14) Describe the communications with and solicitation of input from the public, any advisory council/group, small businesses and groups representing small businesses in the development and drafting of the regulation. List the specific persons and/or groups who were involved. ("Small business" is defined in Section 3 of the Regulatory Review Act, Act 76 of 2012.)

The Department supports and is committed to managing an active and open community participating process throughout the development of the regulation. The public process to date has included the following:

(a) From February 2015 through August 2015, the Department held 9 days of external stakeholder regulation work group meetings with a diverse group of stakeholders. A total of 43 persons were selected to represent the broad range of interests, experiences and ideas to include self-advocates, advocates, county programs, providers, universities and provider organizations. The purpose of the work group was for the Department to listen to the concerns and suggestions from interested parties and to cultivate constructive dialogue and promote an understanding of the views of others.

Each of the major sections of the regulations were reviewed and discussed by the Work Group on three occasions—first, a review of any requested changes to Chapter 51; second, a review and comment on the Department's draft regulatory language and third, a comprehensive review of each section. Work group notes and a revised draft regulation were shared with the work group members immediately following each meeting. Work group members were encouraged to comment at the meetings and by submitting written comments following each meeting. Non-work group members were encouraged to attend the regulation meetings as observers and submit written comments. Many work group members shared the draft regulation with other interested parties outside the work group. More than 80 written public comments were received and carefully reviewed and considered in drafting the proposed regulation. Numerous edits were made to the draft regulation over the period from February through September 2015 in response to public comment.

The Department commends and greatly appreciates the expertise, time and attention contributed by the

work group members, as well as the productive and forward-thinking comments provided by the work group and the public at large.

(b) Twenty-two meetings with statewide and regional advocacy, provider and county organizations and representatives were held to discuss specific areas of the proposed regulation. These discussions focused on the constituent issues that are important to particular affected parties. The Department appreciates the constructive and helpful advice and suggestions provided during these meetings.

(c) At the request of the work group, the Secretary of the Department of Human Services convened a fiscal sub-work group to review and consider the future payment system direction of Pennsylvania's HCBS program. In December 2015, the sub-work group presented its report to the Secretary of Human Services. While the formal recommendations of the sub-work group required no regulatory amendments, several regulation edits were made in response to comments of the sub-work group.

(d) The Department will reconvene the external stakeholder regulation work group following publication of proposed rulemaking to review and consider edits to the proposed regulation, based on the analysis of the formal public comments received.

(15) Identify the types and number of persons, businesses, small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012) and organizations which will be affected by the regulation. How are they affected?

The regulation affects individuals with an intellectual disability or autism who receive funded supports through the Office of Developmental Programs ("ODP"), families of individuals, providers of state and Federally-funded intellectual disability and autism supports, the Department's licensed facilities and county mental health and intellectual disability programs.

The proposed Chapter 6100 regulation applies to a broad scope of programs receiving Commonwealth and Federal funds through the ODP. The regulation applies to approximately 944 HCBS and base-funded providers providing support to more than 50,000 individuals with an intellectual disability or autism.

Of the 944 providers that deliver state or federally-funded services and supports through the Office of Developmental Programs, approximately 800 providers are small businesses with annual revenue of less than \$15 million.

The proposed Chapters 2380, 2390, 6400, and 6500 regulation applies to approximately 4,900 community homes serving 15,000 individuals, 1,700 family living homes serving 2,200 individuals, 370 adult training facilities serving 13,900 individuals and 170 vocational facilities serving 11,400 individuals.

(16) List the persons, groups or entities, including small businesses that will be required to comply with the regulation. Approximate the number that will be required to comply.

Providers of an HCBS or a block-grant or based-funded support, as well as licensed providers of day and residential supports, will be required to comply with this regulation. The regulation applies to 944 HCBS and block-grant/base-funded providers. The regulation applies to 4,900 community homes, 1700 family living homes, 370 adult training facilities and 170 vocational facilities.

Of the 944 providers that deliver state or federally-funded services and supports through the Office of Developmental Programs, approximately 800 providers are small businesses with annual revenue of less than \$15 million.

(17) Identify the financial, economic and social impact of the regulation on individuals, small businesses, businesses and labor communities and other public and private organizations. Evaluate the benefits expected as a result of the regulation.

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

Some new costs may be associated with the proposed regulation relating to background checks and staff training since a wider net has been cast as to who must submit a background check and receive training in areas such as rights, abuse and incidents. The Department and many self-advocates and advocates, believe that all persons who provide reimbursed supports should submit a background check to identify any history of abuse, assault, theft or other crimes that may impact the well-being of an individual. In addition, it is critical that persons who provide reimbursed supports have the minimum training necessary to identify and know what to do if they observe abuse, an incident or a rights violation. This includes a volunteer, a student and a consultant who provides reimbursed supports and will be alone with an individual. This does not include the individual's friends or family who do not provide reimbursed support.

The fee for the completion of a Pennsylvania State Police background check is \$8.00. The fee for the completion of a child abuse history certification is \$8.00. The cost for the completion of a background check and a child abuse history certification may be absorbed by the job applicant or by the employer. The overall cost impact relating to background checks and training will vary as some providers already require background checks on all persons and some provide training for a broader scope than is currently required by regulation, thus negating or minimizing a cost impact.

The Department convened a fiscal sub-work group of the external stakeholder regulation work group to study alternatives to the current fee-based and cost-based payment systems. This sub-group met for multiple months through 2015, and continues to meet, to research and recommend long-term payment system initiatives and solutions. The proposed rulemaking provides an array of payment mechanisms to include fee-based, cost-based, managed care and other rate-setting methodologies, so that payment

alternatives may be further examined. This full array of payment options is proposed to allow the Department, in consultation with stakeholders, to continue to research, design and implement payment mechanisms to address the evolving needs of Pennsylvanians with intellectual disabilities and autism over the coming decade. The fiscal impact of a change to the Department's payment system cannot be estimated until new payment options are determined, an effective date is established and updated budget figures are available.

(18) Explain how the benefits of the regulation outweigh any cost and adverse effects.

Benefits for self-advocates, families and advocates include strengthened individual rights, assistance to locate and sustain employment, strict discharge conditions and procedures, minimum notice required for transition to a new provider, prohibition of restraints except for an emergency protective physical hold, a rights team to review potential rights violations, improved protections for individuals with autism and medication administration by trained, non-medically licensed persons.

Benefits for providers include the reduced administrative burden by coordinating multiple chapters of Departmental regulations, reduction in the overall length and complexity of the regulations, the ability to submit innovation projects, a flexible staff training plan designed by the provider, reduction in the conflict of interest reporting requirements, clarification of the documentation required to support a claim, flexible payment options to support potential changes to the payment methodologies, more frequent updates of the market-based data for fee-based rates and the reduction of the donation reporting requirements.

Benefits for county intellectual disability programs include clarity of roles for the support coordinators and targeted support managers, deletion of conflicting PSP time frames, acknowledgement of county human rights committees and the regulation of base-funding and block-grant funding to provide consistent program requirements on a statewide basis to support the ease of county-to-county transitions, as well as transitions from base and block grant state-only funding to HCBS Federal funding. No increase in costs for county programs will result; some efficiency in existing practices and administrative oversight of the providers should be realized through the improved coordination of HCBS and licensing programs.

Benefits for the Commonwealth include compliance with the Federal requirements to support continued Federal HCBS funding, the reduced volume of regulations with improved coordination efforts across six chapters of regulations providing an opportunity for streamlined compliance monitoring; consistent program requirements for the individuals across multiple funding sources; aligning intellectual disability and autism standards to the benefit of both programs and establishing a baseline of core values across multiple programs. The benefit of this regulation to achieve and maintain full compliance with the Federal requirements is monumental; any administrative cost associated with compliance with the Federal requirements is outweighed by the potential loss of \$1.3 billion in Federal funds for the HCBS program.

(19) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

Costs to providers will be lessened with the reduced administrative burden by coordinating multiple chapters of Departmental regulations, reduction in the overall length and complexity of the regulations, the ability to submit innovation projects, a flexible staff training plan designed by the provider, clarification of the documentation required to support a claim, the reduction of the conflict of interest and donation reporting requirements, flexible payment options to support potential changes to the payment methodologies and more frequent updates of the market-based data for fee-based rates.

Costs to provider may increase due to staff training, criminal background checks and child abuse checks for those providers who do not currently implement a rigorous education and screening process for all employees and volunteers. The fee for the completion of a Pennsylvania State Police background check is \$8.00. The fee for the completion of a child abuse history certification is \$8.00. The cost for the completion of a background check and a child abuse history certification may be absorbed by the job applicant or by the employer.

See the Department's response to Question 17 for added detail.

(20) Provide a specific estimate of the costs and/or savings to the **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

There is no cost for local government; county mental health and intellectual disability programs should experience increased efficiency in existing practices and administrative oversight of the providers through the improved coordination between HCBS and licensing programs.

(21) Provide a specific estimate of the costs and/or savings to the **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

There is negligible cost to state government to administer the regulation. There is the opportunity for reduced paperwork and the associated administrative workload with the improved coordination between the Department's licensing and HCBS functions.

(22) For each of the groups and entities identified in items (19)-(21) above, submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

Increased paperwork will result from the expansion of the scope of the persons for which background checks and training is required.

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

Decreased provider paperwork will result from the elimination of duplicate and conflicting incident reporting requirements for licensing and waiver compliance. Also eliminated is the provider paperwork required by licensing regulation to maintain a record of incidences that are not reportable, such as minor illnesses. While many providers will choose to retain this documentation as best-practice, the Department will no longer review this documentation for regulatory compliance.

The PSP is simplified and the process is streamlined, thus reducing paperwork. One comprehensive and coordinated PSP is required across all programs and funding streams. This will reduce the paperwork for the provider, the county program and the Department.

Decreased provider paperwork will result from the reduction in the conflict of interest and donation reporting requirements.

*David J. Hall 4-5-16*

(23) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
<b>SAVINGS:</b>	\$	\$	\$	\$	\$	\$
Regulated Community	\$0	\$0	\$0	\$0	\$0	\$0
Local Government	\$0	\$0	\$0	\$0	\$0	\$0
State Government	\$0	\$0	\$0	\$0	\$0	\$0
Total Savings	\$0	\$0	\$0	\$0	\$0	\$0
<b>COSTS:</b>						
Regulated Community	\$0	\$0	\$0	\$0	\$0	\$0
Local Government	\$0	\$0	\$0	\$0	\$0	\$0
State Government	\$0	\$0	\$0	\$0	\$0	\$0
Total Costs	\$0	\$0	\$0	\$0	\$0	\$0
<b>REVENUE LOSSES:</b>						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(23a) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY
Community Services - Waiver *	\$931,885,000	\$1,026,790,000	\$1,074,887,000	\$1,202,683,000
Community Base Program	\$151,223,000	\$150,918,000	\$149,681,000	\$148,229,000
Autism Intervention and Services	\$13,000,000	\$16,487,000	\$19,169,000	\$21,501,000
Intellectual Disabilities - Lansdowne Residential Services	\$340,000	\$340,000	\$340,000	\$340,000

(24) For any regulation that may have an adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), provide an economic impact statement that includes the following:

- (a) An identification and estimate of the number of small businesses subject to the regulation.
- (b) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed regulation, including the type of professional skills necessary for preparation of the report or record.
- (c) A statement of probable effect on impacted small businesses.
- (d) A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

There is no adverse impact on small businesses.

(a) Of the 944 providers that deliver state or federally-funded services and supports through the Office of Developmental Programs, approximately 800 providers are small businesses with annual revenue of less than \$15 million.

(b) No additional reporting, recordkeeping or compliance is required by this regulation. Recordkeeping is reduced by coordinating multiple chapters of regulations thus reducing compliance documentation, simplification of the PSP process, clarification of the documentation required to support a claim, a reduction in donation reporting and a reduction in the conflict of interest requirements.

(c) Small businesses will experience a decrease in reporting, recordkeeping and compliance efforts as described in (b).

(d) Since the proposed regulation significantly reduces paperwork requirements and coordinates regulatory provisions, no methods were identified.

(25) List any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, the elderly, small businesses, and farmers.

This regulation affects individuals with disabilities and provides greater access and opportunities for integration into the community.

(26) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

The Department chose provisions that protect the health and safety of individuals, while at the same time reduce paperwork requirements and streamline regulatory provisions.

Applicable Federal and state laws require the promulgation of regulations relating to licensing and compliance with the Federal requirements.

Alternatives for each section of the regulation have been reviewed and considered as part of the Department's rigorous and inclusive public development process. The recommendations of the self-advocates, advocates, families, providers and county governments weight heavily to inform the Department in its proposed rulemaking. See the Response to Question #14 for a description of the public involvement opportunities in the regulation development process.

(27) In conducting a regulatory flexibility analysis, explain whether regulatory methods were considered that will minimize any adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), including:

- a) The establishment of less stringent compliance or reporting requirements for small businesses;
- b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;
- c) The consolidation or simplification of compliance or reporting requirements for small businesses;
- d) The establishment of performing standards for small businesses to replace design or operational standards required in the regulation; and
- e) The exemption of small businesses from all or any part of the requirements contained in the regulation.

This regulation has no negative impact on small businesses.

- a) Federal regulation requires consistent compliance and reporting requirements for all HCBS waiver providers. The regulation is drafted to meet the Federal requirements; therefore, the regulation has consistent standards for all providers. While different standards for small versus large businesses are not allowable, the regulation reduces administrative, compliance and reporting responsibilities for all providers, the vast majority of which are small businesses.
- b) Federal regulation requires consistent schedules and deadlines for all HCBS waiver providers; however, the regulation reduces administrative, compliance and reporting responsibilities for all providers.
- c) Federal regulation requires consistent compliance and reporting requirements for all HCBS waiver providers; however, the regulation consolidates multiple chapters of regulations and simplifies the regulatory compliance requirements for all providers.

- d) Federal regulation requires consistent performance standards for all HCBS providers. Performance/outcome measures were considered, but were deemed not to meet the Federal requirements or the licensing measurement and enforcement requirements.
- e) The regulation includes exemptions from certain requirements for unique programs such as the adult autism waiver, agency with choice, organized health care delivery system, state-only funding and vendor goods and services, many of which are provided by small businesses.

(28) If data is the basis for this regulation, please provide a description of the data, explain in detail how the data was obtained, and how it meets the acceptability standard for empirical, replicable and testable data that is supported by documentation, statistics, reports, studies or research. Please submit data or supporting materials with the regulatory package. If the material exceeds 50 pages, please provide it in a searchable electronic format or provide a list of citations and internet links that, where possible, can be accessed in a searchable format in lieu of the actual material. If other data was considered but not used, please explain why that data was determined not to be acceptable.

The Department studied the HCBS regulations of the states of New York, Maryland, New Jersey, Ohio, Illinois, Massachusetts and Wisconsin. Since no two states have the same administrative, program or funding structures, nor do they share the same historical development, a strict data comparison is not possible; however, in a comparison of the HCBS standards in other states across staff training, PSPs, positive interventions and incident management, the proposed Pennsylvania regulation is reasonably consistent with the standards, policies, practices and procedures of other states.

(29) Include a schedule for review of the regulation including:

A. The date by which the agency must receive public comments: 45 days following proposed rulemaking

B. The date or dates on which public meetings or hearings will be held: An external regulation workgroup meeting, with an observation opportunity that is open to the public, will be held within 120 days after the publication of proposed rulemaking.

C. The expected date of promulgation of the proposed regulation as a final-form regulation: 12 months following proposed rulemaking.

D. The expected effective date of the final-form regulation: Upon promulgation as final-form rulemaking.

E. The date by which compliance with the final-form regulation will be required: Upon promulgation as final-form rulemaking. The Department, however, will consider establishing varied effective dates for certain sections of the regulations to coincide with a Commonwealth fiscal-year.

F. The date by which required permits, licenses or other approvals must be obtained: Licensing inspections will follow their normal sequencing; while regulatory compliance is mandated upon the rule's final effective date, licensing inspections will occur throughout a 12-month period, on a staggered basis.

(30) Describe the plan developed for evaluating the continuing effectiveness of the regulation after its implementation.

The Department will continue to evaluate the effectiveness and efficiency of the new regulation through its numerous public participation venues, by conducting research particularly relating to the payment options and methodologies and through its compliance monitoring and licensing inspection efforts.

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**FACE SHEET  
FOR FILING DOCUMENTS  
WITH THE LEGISLATIVE REFERENCE BUREAU**

**(Pursuant to Commonwealth Documents Law)**

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality.

Attorney General  
*Amy N. Elliott*

By: \_\_\_\_\_  
(Deputy Attorney General)

OCT 21 2016

Date of Approval

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

DEPARTMENT OF HUMAN SERVICES

(Agency)

LEGAL COUNSEL: *[Signature]*

DOCUMENT/FISCAL NOTE NO. 14-540

DATE OF ADOPTION: \_\_\_\_\_

BY: *[Signature]*

TITLE: SECRETARY OF HUMAN SERVICES  
(Executive Officer, Chairman or Secretary)

Copy below is hereby approved as to Form and legality. Executive or Independent Agencies.

BY: *[Signature]*

8/19/16

Date of Approval

(Deputy General Counsel)  
(Chief Counsel, Independent Agency)  
(Strike inapplicable title)

Check if applicable. No Attorney General approval or objection within 30 days after submission.

Check if applicable  
Copy not approved.  
Objections attached.

**NOTICE OF PROPOSED RULEMAKING**

**DEPARTMENT OF HUMAN SERVICES**

**OFFICE OF DEVELOPMENTAL PROGRAMS  
OFFICE OF ADMINISTRATION**

Home and Community-Based Supports and Licensing

[55 Pa.Code Chapter 51. Office of Developmental Programs Home and Community-Based Services]

[55 Pa.Code Chapter 2380. Adult Training Facilities]

[55 Pa.Code Chapter 2390. Vocational Facilities.]

[55 Pa.Code Chapter 6100. Support for Individuals with an Intellectual Disability]

[55 Pa.Code Chapter 6200. Room and Board Charges]

[55 Pa.Code Chapter 6400. Community Homes for Individuals with an Intellectual Disability]

[55 Pa.Code Chapter 6500. Family Living Homes]

### *Statutory Authority*

Notice is hereby given that the Department of Human Services (Department) under the authority of §§ 201(2), 403(b), 403.1 (a) and (b), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021) and section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)) intends to adopt the regulation set forth in Annex A and repeal 55 Pa.Code Chapters 51 (relating to Office of Developmental Programs home and community-based services) and 6200 (relating to room and board charges).

### *Purpose of Rulemaking*

The purpose of this proposed rulemaking is to support Pennsylvanians with an intellectual disability or autism to live in and participate fully in the life of their community, to achieve greater independence and to have the full range of opportunities enjoyed by all citizens. The proposed rulemaking strengthens community supports to promote person-centered approaches, community integration, personal choice, quality in support delivery, equity, accountability in the utilization of resources and innovation in service design.

The proposed rulemaking governs the program, operational and fiscal aspects of the following: (a) home and community-based supports (HCBS) provided through the adult autism, consolidated and person/family directed support 1915(c) waiver programs; (b) Medicaid state plan HCBS for individuals with an intellectual disability or autism, such as targeted support management; and (c) services funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B

of the Human Services Code. The proposed rulemaking amends four chapters of licensing regulations to eliminate duplication and conflict in the areas of training, rights, person-centered support plans (PSP), incident management, positive intervention and medication administration. These licensing chapters are Chapters 2380, 2390, 6400 and 6500. The proposed rulemaking also repeals and replaces 55 Pa.Code Chapters 51 (relating to Office of Developmental Programs home and community-based services) and 6200 (relating to room and board charges).

The rulemaking is needed to continue the Commonwealth's eligibility for Federal financial participation in the HCBS waiver programs (see 42 CFR Part 441-Services: Requirements and Limits Applicable to Specific Services). The rulemaking protects the health, safety and well-being of the individuals receiving supports in individual-directed, family-based, community residential and day programs funded through the HCBS waivers, the Commonwealth's Title XIX state plan and state-funds-only allocations.

The rulemaking eliminates unnecessary language, streamlines processes and reduces the volume of regulation. The rulemaking incorporates consistent and best practice terms, language and principles throughout the regulations.

### *Background*

Chapter 51 was promulgated on June 9, 2012 under the authority of Act 22 of 2011 (Act) that permitted the Department of Public Welfare<sup>1</sup> to promulgate certain assistance and eligibility regulations as final rulemaking through an abbreviated regulatory process. In response to numerous concerns about Chapter 51 from individuals who receive

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<sup>1</sup> The Department of Public Welfare was renamed the Department of Human Services under Act 2014-132.

support, families, advocates, providers and county programs, in January 2015, the Department initiated a comprehensive revision of Chapter 51, applying a widely representative and interactive community participation process that encourages and values external stakeholder participation throughout the regulatory development, proposed rulemaking and final promulgation regulatory processes.

### *Requirements*

The proposed Chapter 6100 encompasses the program, operational and fiscal aspects of the following: three Office of Developmental Programs (ODP) HCBS Federally-funded waiver programs including the consolidated waiver, the adult autism waiver and the person/family directed support waiver; Medicaid state plan HCBS for individuals with an intellectual disability or autism, such as targeted support management; and services funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B of the Human Services Code.

The proposed rulemaking encompasses health, safety and well-being protections for individuals with a disability or autism who receive support in a licensed adult training facility, vocational facility, community home for individuals with an intellectual disability or family living home.

A summary of the major revisions, additions and deletions from the current regulation to the proposed rulemaking follows:

## Chapter 6100 – Support for Individuals with an Intellectual Disability or Autism:

1. Inclusion of base-funding. Chapter 6100 of the proposed rulemaking replaces Chapter 51. Chapter 6100 enlarges the scope of the chapter to incorporate program and operational provisions for services funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B of the Human Services Code. The inclusion of these services in the scope of this rulemaking is intended to provide protection and support for individuals who are not served in a HCBS waiver program, but who receive similar supports and services through state-funds-only allocations. Only certain program and operational sections of the rulemaking apply to these services. Specifically, the fiscal operations of the programs continue to be regulated under Chapter 4300 (relating to county mental health and mental retardation fiscal manual).
2. Provisions for individuals with autism. The proposed rulemaking incorporates provisions for the regulation of HCBS adult autism supports. Under Chapter 51, many regulatory exemptions were specified for the adult autism waiver, thereby, creating a system of inconsistent opportunities for individuals with an intellectual disability versus individuals with autism. In response to concerns from individuals with autism and disability advocates, the Department proposes to thoroughly incorporate the adult autism waiver program into the proposed rulemaking. In some cases, best practice program concepts from the adult autism waiver are proposed for inclusion across the intellectual disability program; in other cases, similar health, safety and well-being protections afforded to individuals with an intellectual disability are proposed to apply to the

adult autism program. The goal of the more comprehensive inclusion of the adult autism waiver in Chapter 6100 is to provide similar safeguards and opportunities for both individuals with autism and individuals with an intellectual disability.

The proposed rulemaking expands the scope of Chapters 6400 (relating to community homes for individuals with an intellectual disability) and 6500 (relating to family living homes) including individuals with autism. This proposed amendment codifies existing practice whereby community homes and family living homes that support individuals with autism are inspected and licensed under the same licensing regulations that govern homes serving individuals with intellectual disabilities. Chapters 2380 (relating to adult training facilities) and 2390 (relating to vocational facilities) currently include individuals with autism.

3. Improved flow and format. To aid in overall readability, rather than disperse regulatory exemptions and special program requirements throughout the chapter, the special program provisions and exemptions are listed at the end of the chapter. The special program sections include the adult autism waiver, agency with choice, support coordination and targeted support management services, organized health care delivery and vendor goods and services. This revised format improves the flow and readability for the mainstream of programs affected by the rulemaking and it shortens the overall length of the regulations.
4. Plain English and definitions. The proposed rulemaking uses plain English and consistent terminology. In addition, acronyms are kept to a minimum to aid in

readability. Further, unnecessary language is removed from the regulatory provisions making the regulation shorter and easier to read.

5. Ch. 6200 rescission. Chapter 6200 (relating to room and board charges) is proposed to be rescinded with the promulgation of the final-form rulemaking. Chapter 6200 applies for non-HCBS supports, while Chapter 51 applies for HCBS supports; however, the provisions of the two chapters are unnecessarily different, and require duplicative administrative systems. The proposed rulemaking includes the same updated room and board provisions for both HCBS and state-funds only programs, providing application across the community system. The elimination of a chapter of regulations reduces the administrative burden for providers, the county programs and the Department.
6. Federal compliance. The Commonwealth must demonstrate full compliance with the Federal requirements at 42 CFR Part 441 by March 17, 2019. This proposed rulemaking addresses the key components of this Federal regulation.
7. Reduction of licensing duplication. Four existing chapters of licensing regulations govern many of the same facilities that are also funded through the HCBS waivers, the Commonwealth's Title XIX state plan and state-funds-only allocations. To provide consistency between the HCBS provisions and the four licensing chapters, the proposed rulemaking includes revisions to the four licensing chapters to promulgate the same requirements for six major program and operational areas including staff training, rights, incident management, person-centered support plans, positive interventions and medication administration. See the section titled "Chapters 2380, 2390, 6400 and 6500

Licensing Regulations” that describes these proposed licensing revisions in detail.

8. Background check clarity. Changes are proposed to cast a wider net on the categories of persons who must complete background checks. Household members, volunteers, life sharers and interns who provide a support and staff persons will require a criminal history check.
9. Staff training overhaul. Traditionally, the licensing regulations have dictated the specific training courses that each staff person must complete upon initial hire and on an annual basis. The proposed rulemaking takes a new approach whereby only four core courses are required, with much of the training program designed by the provider based on the needs of the individuals.

As suggested by the external stakeholder regulation work group, latitude is provided for the provider to design its own training plan to meet its administrative needs for each staff position, while encompassing specifications of the individuals’ person-centered support plans (PSP). Four core courses are required for all persons who provide HCBS: person-centeredness; rights; abuse prevention and reporting; and incident prevention and reporting. In sync with the community home licensing regulations, training in positive interventions is required if an individual served may have a dangerous behavior. Also consistent with licensing regulations, training in medications administration is required if the person will administer medications. The licensing regulations continue to require

facility-based courses, such as fire safety, cardiopulmonary resuscitation and first aid.

The proposed number of 24 annual training hours matches the number of hours currently required in Chapters 2380, 2390, 6400 and 6500. Only 12 training hours are required annually for management and other non-direct support staff persons, 8 of which are required in the four key areas (person-centeredness, rights, abuse, and incidents), as these are core value and protection areas that everyone who works for the provider, including maintenance and office workers, must understand and embrace.

To provide truly integrated, person-centered and value-based supports, all members of the organization must understand the core values and protection areas. This includes a maintenance worker, office worker or volunteer who may greet and interact with an individual, observe a reportable incident or have knowledge of an allegation of abuse.

10. Expansion of individual rights. The proposed rulemaking encompasses a broad array of individual rights. Several of the rights are Federal requirements. Most of the rights are already enumerated under Chapter 6400, which are applicable for community homes. These rights must be protected equally for an individual who receives support in the individual's own home, a family home, through non-facility based supports, as well as in facility-based programs.

11. Modification of the person-centered support plan. The individual support plan provisions have been streamlined to address the Federal requirements. The term “individual support plan (ISP)” has been updated to “PSP” to align with the Federal language of “person-centered plan”. As requested by the external stakeholder regulation work group, clarification of the required documentation of support delivery for purposes of eligibility for Federal financial participation was also added.
12. Use of positive interventions. The proposed rulemaking proposes to propel Pennsylvania forward as a leader of humane treatment of individuals with disabilities, by prohibiting the use of chemical restraints, mechanical restraints, exclusion and many manual restraints. The use of a physical protective restraint is permitted by trained staff, in an emergency situation, to protect the life safety of the individual or others. A rights team must review the use of a restraint and all rights violations. Several organizations, such as the Disability Rights Pennsylvania and The Arc, have encouraged and applauded the elimination of restraints.
13. Facility characteristics. A new section is proposed to address the Federal requirements for facility size and community location to promote integration into the community. See 42 CFR Part 441. The proposed rulemaking sets a maximum program capacity size of 4 individuals for residential facilities and 15 individuals at any one time for day facilities, with the caveat that with the Department’s approval, existing residential facilities may be able to retain their current size limit of 8.

In addition to the size restriction, facilities may not be located adjacent to or in close proximity to another day or residential human service facility, with an exception for existing programs, subject to the Department's approval.

14. Array of payment options. The proposed rulemaking allows an array of payment options including fee-based, cost-based, managed care and other methodologies. This array of payment options is intended to allow the continued research, design and implementation of payment mechanisms to address the evolving needs of Pennsylvanians with intellectual disabilities and autism over the coming decade. The Department and some providers agree that the current system of cost-based reimbursement for residential habilitation is costly and inefficient. The Department agrees that providers, advocates and self-advocates should be included in discussions to transition from the cost-based system to a more viable payment system.

15. Refresh of the data used to establish fee schedule rates. The proposed rulemaking requires the refresh of data every 3 years. In addition, the Department will request public comment on the market-based factors prior to establishing new fee schedule rates.

16. Fee-schedule criteria expanded. The factors considered to establish fees through the market-based approach have been expanded including individual needs, a review of the HCBS service definitions as provided in the Federally-approved waivers and waiver amendments and the associated costs, as well as the fiscal impact of compliance with Federal and Commonwealth laws and regulations and local ordinances. The Department may also consider other

criteria that impact costs, such as the cost of living in a particular geographic area, if the criteria significantly affects staffing costs.

17. Reduced requirement for reporting donations. In response to concerns from the external stakeholder regulation work group, and in particular non-profit providers, the proposed rulemaking proposes to eliminate the reporting of an unrestricted donation that is not used for an allowable HCBS cost, a restricted donation used for a purpose other than a HCBS and for a noncash donation of \$1,000 or less.

#### Chapters 2380, 2390, 6400 and 6500 – Licensing Regulations:

The Department proposes to revise its licensing regulations at Chapters 2380, 2390, 6400 and 6500 to mirror the proposed Chapter 6100 regulation in the areas of training, rights, person-centered support planning, incident reporting, positive intervention and medication administration. The proposed rulemaking significantly reduces duplication and conflict across the proposed Chapter 6100 and the four chapters of licensing regulations. This proposal to reduce regulatory duplication by amending five chapters of regulations at the same time is precedent setting, requiring the cooperation and coordination of multiple Departmental program offices and functions. The Department supports the reduction of recordkeeping for providers, county programs and the Department. These reductions include the following: reduced compliance paperwork; reduced time spent on compliance monitoring by the designated managing entities and the Department; lessened compliance management functions required at the provider level; and the opportunity for reduced oversight, without reduced protections for the individuals.

## Chapter 2380 – Adult Training Facilities:

1. Staff training. Chapter 2380 requires 24 hours of annual training for the chief executive officer (CEO), full-time program specialists and direct support staff persons in the areas of human services, fire safety, first aid, Heimlich and cardiopulmonary resuscitation. The proposed rulemaking requires 24 hours of training for both full-time and part-time direct support staff, but only 12 hours of training for management and other non-direct support staff, including the CEO. The proposed rulemaking reduces the number of annual training hours from 24 hours to 12 hours for the CEO. The proposed training sections are consistent with the Chapter 6100 proposed rulemaking, making it administratively less complex to manage a comprehensive staff development program and easier to transfer staff persons from one program to another within a large, multi-function provider agency.
2. Rights. The proposed adult training facilities regulation includes a more robust section on individual rights based on more current lists of rights in other licensing regulations. The proposed sections on individual rights are consistent with the Chapter 6100 proposed rulemaking, making it easier to approach training on rights from a systemic perspective, manage regulatory compliance across a multi-service agency and assure the continuity of supports for the individual.
3. PSP. The proposed rulemaking simplifies the PSP process, addresses the Federal requirements and most importantly matches the PSP requirements across the entire support system for the individual. Without the proposed amendments, the multiple chapters of regulations could: a) require two support

plans with two sets of procedures and content areas; b) cause confusion as to which plan applies; c) result in the poor coordination of supports for the individual; or d) create management oversight challenges for the provider.

4. Incident reporting. The current requirements in Chapter 2380 to file a separate death report, create incident policies and maintain incident records for seizures, non-inpatient hospitalization or emergency room visits are eliminated. Reporting timelines, however, remain unchanged. The types of incidents to be reported and the timelines for reporting are streamlined and in sync across the intellectual disability and autism programs. Further, the incident investigation procedure and reporting requirements codify current incident management practices.
5. Positive intervention. The proposed rulemaking creates a system-wide approach to behavior management to avoid the conflict of applying differing methods of behavior management across varied service locations, treats individuals with dignity and respect and uses positive interventions as a means to affect behavior.

The broad definition of a “restrictive procedure”, the requirement to create restrictive procedure policies and the design of a detailed and free-standing restrictive procedure plan are reduced. Certain types of restraints such as chemical restraints, mechanical restraints, exclusion and many manual restraints are no longer permitted. The proposed rulemaking creates a seamless and uniform system of positive interventions, restraint prohibitions and emergency protective restraint procedures. The proposed rulemaking incorporates positive

intervention planning into the PSP process as opposed to developing a separate behavior plan.

6. Medication administration. The section on medications clarifies the special training required for the administration of epinephrine for allergies, as well as for the administration of insulin injections.

#### Chapter 2390 – Vocational Facilities:

1. Staff training. Chapter 2390 requires 24 hours of annual training for the CEO, the program specialist, the production manager and floor supervisors (direct support workers) in the areas of human services, vocational services, fire safety, first aid, Heimlich and cardiopulmonary resuscitation. The proposed rulemaking requires 24 hours of training for direct support staff including program specialist, the production manager and the floor supervisors, but only 12 hours of annual training for management and other non-direct support staff. The proposed rulemaking reduces the number of annual training hours from 24 to 12 hours for the CEO. The proposed sections on training are consistent with the Chapter 6100 proposed rulemaking, making it administratively less complex to manage a comprehensive staff development program and easier to transfer staff from one program to another within a large, multi-function provider agency.
2. Rights. Proposed changes to the vocational facilities regulation include the addition of a more robust section on individual rights. The proposed sections on individual rights are consistent with the Chapter 6100 proposed rulemaking, making it easier to manage regulatory compliance across a multi-service agency and to assure continuity of supports for the individual.

3. PSP. The proposed rulemaking simplifies the PSP process, addresses the Federal requirements and most importantly matches the PSP requirement across the entire support system for the individual. Without the proposed amendments, the multiple chapters of regulations could: a) require two support plans with two sets of procedures and content areas, b) cause confusion as to which plan applies, c) result in poor coordination of supports for the individual; or d) create management oversight challenges for the provider.
4. Incident reporting. The proposed rulemaking clarifies the types of reportable incidents to coincide with the requirements in other licensing regulations, such as Chapters 2380 and 6400. Reporting timelines, however, remain unchanged. The types of incidents to be reported and the timelines for reporting are streamlined and in sync across the intellectual disability and autism programs. Further, the incident investigation procedures and reporting requirements codify current incident management practices.
5. Positive intervention. Neither positive intervention nor the prohibition of restraints, are currently addressed in Chapter 2390. The proposed rulemaking creates a system-wide approach to behavior management that avoids conflict of applying differing methods of behavior management across varied service locations, treats individuals with dignity and respect and uses positive interventions as a means to affect behavior. The proposed rulemaking aligns the positive intervention requirements uniformly across all intellectual disability and autism programs. The proposed rulemaking creates a seamless and uniform

system of positive intervention, restraint prohibitions and emergency protective hold procedures.

6. Medications administration. A new section on medication administration is added to permit trained, non-medically licensed staff persons to administer prescription medications, epinephrine injections for allergies and insulin injections.

#### Chapter 6400 – Community Homes:

1. Scope. The proposed rulemaking expands the scope of Chapter 6400 to include individuals with autism. This proposed amendment codifies existing practice whereby community homes that support individuals with autism are inspected and licensed under the same licensing regulations that govern homes serving individuals with intellectual disabilities.
2. Staff training. Chapter 6400 requires 24 hours of annual training for the CEO, full-time program specialists and direct support staff persons, in the areas of human services, fire safety, first aid, Heimlich and cardiopulmonary resuscitation. The proposed rulemaking requires 24 hours of training for both full-time and part-time direct support staff, but only 12 hours of training for management and other non-direct support staff, including the CEO. The proposed rulemaking reduces the number of mandated training hours from 24 to 12 hours annually, for the CEO. The proposed sections on training are consistent with the Chapter 6100 proposed rulemaking, making it administratively less complex to manage the staff development program and easier to transfer staff from one program to another within a large, multi-function provider agency.

3. Rights. Chapter 6400 addresses specific residential care rights such as privacy, communication, participation in planning and abuse protection. The proposed sections on individual rights are clarified and consistent with the Chapter 6100 proposed rulemaking, making it easier to manage regulatory compliance across a multi-service agency and to assure continuity of supports for the individual.
4. PSP. The proposed rulemaking simplifies the PSP process, addresses the Federal requirements and most importantly matches the PSP requirement across the entire support system for the individual. Without the proposed regulation amendment, the multiple chapters of regulations could: a) require two support plans with two sets of procedures and content areas, b) cause confusion as to which plan applies, c) result in the poor coordination of supports for the individual; or d) create management oversight challenges for the provider.
5. Incident reporting. The requirements in Chapter 6400 to file a separate death report, create incident policies and maintain incident records for seizures, non-inpatient hospitalization or emergency room visits are eliminated. Reporting timelines, however, remain unchanged. The types of incidents to be reported and the timelines for reporting are streamlined and consistent across the intellectual disability and autism program. The incident investigation procedures and reporting requirements codify current incident management practices.
6. Positive intervention. The proposed rulemaking creates a system-wide approach to behavior management that avoids conflict of applying differing methods of behavior management across varied service locations, treats individuals with dignity and respect and uses positive interventions as a means to affect

behavior. The broad definition of a “restrictive procedure”, the requirement to create written restrictive procedure policies and the design of a detailed and free-standing restrictive procedure plan are reduced. Certain types of restraints such as chemical restraints, mechanical restraints, exclusion and many manual restraints are no longer permitted. The proposed rulemaking creates a seamless and uniform system of positive interventions, restraint prohibitions and emergency protective hold procedures. The proposed rulemaking incorporates positive intervention planning into the PSP process as opposed to developing a separate behavior plan.

7. Medication administration. The section on medications clarifies the special training required for the administration of epinephrine for allergies.

#### Chapter 6500 - Family Living Homes:

1. Scope. The proposed rulemaking expands the scope of Chapter 6500 including individuals with autism. This proposed amendment codifies existing practice whereby family living homes that support individuals with autism are inspected and licensed under the same licensing regulations that govern homes serving individuals with intellectual disabilities.
2. Terminology. The terms “family living” have been changed to “life sharing” to reflect the current terms used to describe the living arrangement.
3. Staff training. Chapter 6500 requires 24 hours of annual training for the primary caregiver and full-time life sharing specialists in the areas of human services, fire safety, first aid, Heimlich and cardiopulmonary resuscitation. The proposed rulemaking requires 24 hours of training for the primary caregiver and life sharing

specialists, with 8 of those hours in the areas of person-centeredness, abuse prevention and reporting, incident reporting and positive interventions if the individual served has a dangerous behavior. Training in fire safety and first aid, Heimlich and cardiopulmonary resuscitation continue to be required as part of the 24 hours. The proposed sections on training are consistent with the Chapter 6100 proposed rulemaking, making it administratively less complex to manage a comprehensive staff development program and easier to transfer staff from one program to another within a large, multi-function provider agency.

4. Rights. Chapter 6500 addresses civil rights, as well as specific residential care rights such as privacy, communication, participation in planning and abuse protection. The proposed sections on individual rights are clarified and consistent with Chapter 6100 proposed rulemaking, making it easier to manage regulatory compliance across a multi-service agency and to assure continuity of supports for the individual.
5. PSP. The proposed rulemaking simplifies the PSP process, addresses the Federal requirements and most importantly matches the PSP requirement across the entire support system for the individual. Without the proposed amendments, the multiple chapters of regulations could: a) require two support plans with two sets of procedures and content areas, b) cause confusion as to which plan applied under what circumstances, c) result in the poor coordination of supports for the individual; or d) create unmanageable management oversight challenges for the provider.

6. Incident reporting. The requirements in Chapter 6500 to file a separate death report and maintain incident records for seizures, non-inpatient hospitalization or emergency room visits are eliminated. Reporting timelines, however, remain unchanged. The types of incidents to be reported and the timelines for reporting are streamlined and consistent across the intellectual disability service system. The incident investigation procedures and reporting requirements codify current incident management practices.
7. Positive intervention. The proposed rulemaking creates a system-wide approach to behavior management that avoids conflict of applying differing methods of dangerous behavior management across varied service locations, treats individuals with dignity and respect and uses positive interventions as a means to affect behavior. The broad definition of a “restrictive procedure”, the requirement to create written restrictive procedure policies and the design of a detailed and free-standing restrictive procedure plan are eliminated. Certain types of restraints such as chemical restraints, mechanical restraints, exclusion and many manual restraints are no longer permitted. The proposed rulemaking creates a seamless and uniform system of positive interventions, restraint prohibitions and emergency protective hold procedures. The proposed rulemaking incorporates positive intervention planning into the PSP process as opposed to developing a separate behavior plan.
8. Medications administration. The section on medications clarifies the special training required for the administration of epinephrine for allergies. Life sharing caregivers who administer medications would be required to take and pass the

Department's medication administration training course, as opposed to receiving training from the individual's health care practitioner. The Department's medication administration training course is well-developed and has been refined continually since its inception in 1982, making it effective, meaningful and accessible for life sharing caregivers.

### *Affected Individuals and Organizations*

The Chapter 6100 proposed rulemaking applies to a broad scope of programs receiving Commonwealth and Federal funds. The rulemaking applies to approximately 944 HCBS and base-funded providers providing support to more than 50,000 individuals with an intellectual disability or autism.

The proposed Chapters 2380, 2390, 6400, and 6500 rulemaking applies to approximately 4,900 community homes serving 15,000 individuals, 1,700 family living homes serving 2,200 individuals, 370 adult training facilities serving 13,900 individuals and 170 vocational facilities serving 11,400 individuals.

The Department supports and is committed to managing an active and open community participating process throughout the development of the rulemaking. The public process has included the following:

- a. From February 2015 through August 2015, the Department held 9 days of external stakeholder regulation work group meetings with a diverse group of stakeholders. A total of 43 persons were selected to represent the broad range of interests, experiences and ideas including self-advocates, advocates, county programs, providers, universities and provider

organizations. The purpose of the work group was for the Department to listen to the concerns and suggestions from interested parties and to cultivate constructive dialogue and promote an understanding of the views of others.

Each of the major sections of the draft rulemaking were reviewed and discussed by the Work Group on three occasions—first, a review of any requested changes to Chapter 51; second, a review and comment on the Department’s draft regulatory language and third, a comprehensive review of each section of the draft rulemaking. Work group notes and a revised draft rulemaking were shared with the work group members immediately following each meeting. Work group members were encouraged to comment at the meetings and by submitting written comments following each meeting. Many work group members shared the draft proposed rulemaking with other interested parties outside the work group. Non-work group members were encouraged to attend the regulation meetings as observers and submit written comments. More than 80 written public comments were received and carefully reviewed and considered in drafting the proposed rulemaking. Numerous edits were made to the draft rulemaking over the period from February through September 2015, in response to public comment.

The Department commends and greatly appreciates the expertise, time and attention contributed by the work group members, as well as the productive

and forward-thinking comments provided by the work group and others who contributed written comments.

- b. In addition to the regulation work group meetings, 22 meetings with statewide and regional advocacy, provider and county organizations and representatives were held to discuss specific areas of the proposed rulemaking. These discussions focused on the constituent issues that are important to particular affected parties. The Department appreciates the constructive and helpful advice and suggestions provided during these meetings.
- c. At the request of the work group, the Secretary of the Department of Human Services convened a fiscal sub-work group to review and consider the future payment system direction of Pennsylvania's HCBS program. In December 2015, the sub-work group presented its report to the Secretary of Human Services. While the formal recommendations of the sub-work group required no regulatory amendments, several regulation edits were made in response to comments from the sub-work group.
- d. The Department will reconvene the external stakeholder regulation work group following publication of the proposed rulemaking to review and consider edits to the proposed rulemaking, based on the analysis of the formal public comments received.

## *Accomplishments and Benefits*

The proposed rulemaking supports Pennsylvanians with an intellectual disability or autism to achieve greater independence, choice and opportunity in their lives. The proposed rulemaking strengthens community supports by promoting equity, innovation, person-centered approaches and community participation.

Benefits for self-advocates, families and advocates include strengthened individual rights, assistance to locate and sustain employment, strict discharge conditions and procedures, minimum notice required for transition to a new provider, prohibition of restraints except for an emergency protective physical hold, a rights team to review potential rights violations, improved protections for individuals with autism and medication administration by trained, non-medically licensed persons.

Benefits for providers include the reduced administrative burden by coordinating multiple chapters of Departmental regulations, the inclusion of autism programs in the core standards to alleviate the administrative burden of managing dual processes, the ability to submit innovation projects, a flexible staff training plan designed by the provider, the reduction in the conflict of interest requirements, clarification of the documentation required to support a claim, flexible payment options to support potential changes to the payment methodologies, more frequent updates of the market-based data for fee-based rates and the reduction of the donation reporting requirements.

Benefits for county intellectual disability programs include clarity of roles for the support coordinators and targeted support managers, deletion of conflicting PSP time frames between the Federal waivers and the multiple chapters of regulations,

acknowledgement of county human rights committees and the regulation of services funded exclusively by grants to counties. These amendments provide consistent program requirements on a statewide basis to support the ease of county-to-county transitions, as well as transitions from services and supports funded through state-funds-only allocations to HCBS Federal funding.

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

#### *Fiscal Impact*

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

Some new costs may be associated with the proposed rulemaking relating to background checks and staff training since a wider net has been cast as to who must

submit a background check and receive training in areas such as rights, abuse and incidents. Under the proposed rulemaking, all persons who provide supports should submit a background check to identify any history of abuse, assault, theft or other crimes that may impact the well-being of an individual. This provision is supported by many self-advocates and advocates. In addition, it is critical that persons who provide reimbursed supports have the minimum training necessary to identify and know what to do if they observe abuse, an incident or a violation of rights. This includes a volunteer, a student and a consultant who provides supports and will be alone with an individual. This does not include the individual's friends or family who do not provide a reimbursed support.

The fee for the completion of a Pennsylvania State Police background check is \$8.00. The fee for the completion of a child abuse history certification is \$8.00. The cost for the completion of a background check and a child abuse history certification may be absorbed by the job applicant or by the employer. The overall cost impact relating to background checks and training will vary, as some providers already require background checks on all persons and some provide training for a broader scope than is currently required by regulation, thus negating or minimizing a cost impact.

The Department convened a fiscal sub-work group of the external stakeholder regulation work group to study alternatives to the current fee-based and cost-based payment systems. This sub-group met for multiple months through 2015, and continues to meet, to research and recommend long-term payment system initiatives and solutions. The proposed rulemaking provides an array of payment mechanisms including fee-based, cost-based, managed care and other rate-setting methodologies,

so that payment alternatives may be further examined. This full array of payment options is proposed to allow the Department, in consultation with stakeholders, to continue to research, design and implement payment mechanisms to address the evolving needs of Pennsylvanians with intellectual disabilities and autism over the coming decade. The fiscal impact of a change to the Department's payment system cannot be estimated until new payment options are determined, an effective date is established and updated budget figures are available.

### *Paperwork Requirements*

Increased paperwork will result from the expansion of the scope of the persons for which background checks and training is required.

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

Decreased provider paperwork will result from the elimination of duplicate and conflicting incident reporting requirements for licensing and waiver compliance. Also eliminated is the provider paperwork required by licensing regulations to maintain a record of incidences that are not reportable, such as minor illnesses. While many

providers will choose to retain this documentation as best-practice, the Department will no longer review this documentation for regulatory compliance.

The PSP is simplified and the process is streamlined, thus reducing paperwork. One comprehensive and coordinated PSP is required across all programs and funding streams. This will reduce the paperwork for the provider, the county program and the Department.

Decreased provider paperwork will result from the reduction in the conflict of interest and the donation reporting requirements.

#### *Effective Date*

The rulemaking will be effective upon final publication in the *Pennsylvania Bulletin*. The Department, however, will consider establishing varied effective dates for certain sections of the regulations to coincide with a Commonwealth fiscal year.

#### *Public Comment*

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed rulemaking to the Department at the following address: Julie Mochon, Human Service Program Specialist Supervisor, Office of Developmental Programs, Room 502 Health and Welfare Building, 625 Forster Street, Harrisburg, Pennsylvania 17120 or through email at [jmochon@pa.gov](mailto:jmochon@pa.gov), within 45 calendar days after the date of publication of this proposed rulemaking in the *Pennsylvania Bulletin*.

Reference Regulation No. ~~14-540~~ when submitting comments.

Persons with a disability who require an auxiliary aid or service may submit comments by using the AT&T Relay Service at 1-800-654-5984 (TDD users) or 1-800-654-5988 (voice users).

### *Regulatory Review Act*

Under § 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on **OCT 25 2016** the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Human Services and the Senate Committee on Public Health and Welfare. In addition to submitting the proposed rulemaking, the Department has provided the IRRC and the Committees with a copy of a Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

Under § 5(g) of the Regulatory Review Act, if the IRRC has any comments, recommendations or objections to any portion of the proposed rulemaking, it may notify the Department and the Committees within 30 days after the close of the public comment period. Such notification shall specify the regulatory review criteria that have not been met. The Regulatory Review Act specifies detailed procedures for review by the Department, the General Assembly and the Governor, of any comments, recommendations or objections raised, prior to final publication of the rulemaking.

**ANNEX A**

**TITLE 55. PUBLIC WELFARE**

**PART I. DEPARTMENT OF HUMAN SERVICES**

**SUBPART E. HOME AND COMMUNITY-BASED SERVICES**

**[CHAPTER 51. OFFICE OF DEVELOPMENTAL PROGRAMS HOME AND  
COMMUNITY-BASED SERVICES] (RESERVED).**

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**PART IV. ADULT SERVICES MANUAL**

**SUBPART D. NONRESIDENTIAL AGENCIES/FACILITIES/SERVICES**

**CHAPTER 2380. ADULT TRAINING FACILITIES**

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**§ 2380.3. Definitions.**

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

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*[Content discrepancy—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]*

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*[Documentation—Written statements that accurately record details, substantiate a claim or provide evidence of an event.]*

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*[ISP—Individual Support Plan—The comprehensive document that identifies services and expected outcomes for an individual.]*

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*[Outcomes—Goals the individual and individual's plan team choose for the individual to acquire, maintain or improve.*

*Plan lead—The program specialist or family living specialist, as applicable, when the individual is not receiving services through an SCO.*

*Plan team—The group that develops the ISP. ]*

PSP – Person-centered support plan.

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Restraint - A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the PSP or used on an emergency basis.

## GENERAL REQUIREMENTS

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### **§ 2380.17. [Reporting of unusual incidents.**

(a) An unusual incident is:

- (1) Abuse or suspected abuse of an individual.
- (2) Injury, trauma or illness requiring inpatient hospitalization, that occurs while the individual is at the facility or under the supervision of the facility.
- (3) A suicide attempt by an individual.
- (4) A violation or alleged violation of an individual's rights.
- (5) An individual whose absence is unaccounted for, and is therefore presumed to be at risk.
- (6) The misuse or alleged misuse of an individual's funds or property.
- (7) An outbreak of a serious communicable disease, as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions) to the extent that confidentiality laws permit reporting.
- (8) An incident requiring the services of a fire department or law enforcement agency.

(9) A condition, except for snow or ice conditions, that results in closure of the facility for more than 1 scheduled day of operation.

(b) Written policies and procedures on the prevention, reporting, investigation and management of unusual incidents shall be developed and kept at the facility.

(c) The facility shall orally notify, within 24 hours after abuse or suspected abuse of an individual or an incident requiring the services of a fire department or law enforcement agency occurs:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual involved in the unusual incident has mental illness or an intellectual disability.

(2) The funding agency.

(3) The appropriate regional office of the Department.

(d) The facility shall initiate an investigation of the unusual incident and complete and send copies of an unusual incident report on a form specified by the Department, within 72 hours after an unusual incident occurs, to:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual involved in the unusual incident has mental illness or an intellectual disability.

(2) The funding agency.

(3) The appropriate regional office of the Department.

(e) At the conclusion of the investigation the facility shall send a copy of the final unusual incident report to:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual involved in the unusual incident has mental illness or an intellectual disability.

(2) The funding agency.

(3) The appropriate regional office of the Department.

(f) A copy of unusual incident reports relating to an individual shall be kept in the individual's record.

(g) A copy of unusual incident reports relating to the facility itself, such as those requiring the services of a fire department, shall be kept.

(h) The individual's family, if appropriate, and the residential services provider, if applicable, shall be immediately notified in the event of an unusual incident relating to the individual.

**§ 2380.18. Reporting of deaths.**

(a) The facility shall complete and send copies of a death report on a form specified by the Department, within 24 hours after a death of an individual that occurs at the facility or while under the supervision of the facility to:

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(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual had mental illness or an intellectual disability.

(2) The funding agency.

(3) The regional office of the Department.

(b) The facility shall investigate and orally notify, within 24 hours after an unusual or unexpected death occurs:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual had mental illness or an intellectual disability.

(2) The funding agency.

(3) The regional office of the Department.

(c) A copy of death reports shall be kept in the individual's record.

(d) The individual's family, and the residential service provider, if applicable, shall be immediately notified in the event of a death of an individual.

**§ 2380.19. Record of incidents.**

The facility shall maintain a record of an individual's illnesses, traumas and injuries requiring medical treatment but not inpatient hospitalization, and seizures that occur at the facility or while under the supervision of the facility.]

**Incident report and investigation.**

(a) The facility shall report the following incidents, alleged incidents and suspected incidents in the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) Suicide attempt.

(3) Inpatient admission to a hospital.

(4) Visit to an emergency room.

(5) Abuse.

(6) Neglect.

(7) Exploitation.

(8) An individual who is missing for more than 24 hours or who could be in jeopardy if missing at all.

(9) Law enforcement activity.

(10) Injury requiring treatment beyond first aid.

(11) Fire requiring the services of the fire department.

(12) Emergency closure.

(13) Use of a restraint.

(14) Theft or misuse of individual funds.

(15) A violation of individual rights.

(b) The individual and the persons designated by the individual shall be notified immediately upon discovery of an incident relating to the individual.

(c) The facility shall keep documentation of the notification in subsection (b).

- (d) The incident report, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual and persons designated by the individual, upon request.
- (e) The facility shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or notice of an incident, alleged incident and suspected incident.
- (f) The facility shall initiate an investigation of an incident within 24 hours of discovery by a staff person.
- (g) A Department-certified incident investigator shall conduct an incident investigation of the incident listed under subsection (a).
- (h) The facility shall finalize the incident report in the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person.
- (i) The facility shall provide the following information to the Department as part of the final incident report:
- (1) Additional detail about the incident.
  - (2) The results of the incident investigation.
  - (3) A description of the corrective action taken in response to an incident.
  - (4) Action taken to protect the health, safety and well-being of the individual.
  - (5) The person responsible for implementing the corrective action.
  - (6) The date the corrective action was implemented or is to be implemented.

**§ 2380.18. Incident procedures to protect the individual.**

(a) In investigating an incident, the facility shall review and consider the following needs of the affected individual:

- (1) Potential risks.
- (2) Health care information.
- (3) Medication history and current medication.
- (4) Behavioral health history.
- (5) Incident history.
- (6) Social needs.
- (7) Environmental needs.
- (8) Personal safety.

(b) The facility shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The facility shall work cooperatively with the PSP team to revise the PSP if indicated by the incident investigation.

**§ 2380.19. Incident analysis.**

(a) The facility shall complete the following for each confirmed incident:

- (1) Analysis to determine the root cause of the incident.
- (2) Corrective action.
- (3) A strategy to address the potential risks to the affected individual.

(b) The facility shall review and analyze incidents and conduct a trend analysis at least every 3 months.

(c) The facility shall identify and implement preventive measures to reduce:

- (1) The number of incidents.
- (2) The severity of the risks associated with the incident.
- (3) The likelihood of an incident recurring.

(d) The facility shall educate staff persons and the individual based on the circumstances of the incident.

(e) The facility shall analyze incident data continuously and take actions to mitigate and manage risks.

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**§ 2380.21. [Civil] Individual rights.**

[(a) An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

(b) The facility shall develop and implement civil rights policies and procedures. Civil rights policies and procedures shall include the following:

(1) Nondiscrimination in the provision of services, admissions, placements, facility usage, referrals and communications with individuals who are nonverbal or non-English speaking.

(2) Physical accessibility and accommodation for individuals with physical disabilities.

(3) The opportunity to lodge civil rights complaints.

(4) Informing individuals on their right to register civil rights complaints.]

(a) An individual may not be deprived of rights, as provided under subsections (b) –(s).

(b) An individual shall be continually supported to exercise the individual's rights.

(c) An individual shall be provided the support and accommodation necessary to be able to understand and actively exercise the individual's rights.

(d) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.

(e) A court's written order that restricts an individual's rights shall be followed.

(f) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual, in accordance with a court order.

(g) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in decision-making in accordance with the court order.

(h) An individual has the right to designate persons to assist in decision-making on behalf of the individual.

(i) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

(j) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely and practice the religion of his choice or to practice no religion.

(k) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

- (l) An individual shall be treated with dignity and respect.
- (m) An individual has the right to make choices and accept risks.
- (n) An individual has the right to refuse to participate in activities and supports.
- (o) An individual has the right to privacy of person and possessions.
- (p) An individual has the right of access to and the security of the individual's possessions.
- (q) An individual has the right to voice concerns about the supports the individual receives.
- (r) An individual has the right to participate in the development and implementation of the PSP.
- (s) An individual's rights shall be exercised so that another individual's rights are not violated.
- (t) Choices shall be negotiated by the affected individuals in accordance with the facility's procedures for the individuals to resolve differences and make choices.
- (u) The facility shall inform and explain individual rights to the individual and persons designated by the individual upon admission to the facility and annually thereafter.
- (v) The facility shall keep a copy of the statement signed by the individual or the individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

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**§ 2380.23. Applicable laws and regulations.**

The facility shall comply with applicable Federal, State and local laws, regulations and ordinances.

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**STAFFING**

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**§ 2380.33. Program specialist.**

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(b) The program specialist shall be responsible for the following:

(1) [Coordinating and completing assessments.

(2) Providing the assessment as required under § 2380.181(f) (relating to assessment).

(3) Participating in the development of the ISP, including annual updates and revisions of the ISP.

(4) Attending the[ISP meetings.

(5) Fulfilling the role of plan lead, as applicable, under §§ 2380.182 and 2380.186(f)

and (g) (relating to relating to development, annual update and revision of the ISP; and ISP review and revision.

- (6) Reviewing the ISP, annual updates and revisions under § 2380.186 for content accuracy.
- (7) Reporting content discrepancy to the SC or plan lead, as applicable, and plan team members.
- (8) Implementing the ISP as written.
- (9) Supervising, monitoring and evaluating services provided to the individual.
- (10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.
- (11) Reporting a change related to the individual's needs to the SC or plan lead, as applicable, and plan team members.
- (12) Reviewing the ISP with the individual as required under § 2380.186.
- (13) Documenting the review of the ISP as required under § 2380.186.
- (14) Providing the documentation of the ISP review to the SC, as applicable, and team members as required under § 2380.186(d).
- (15) Informing plan team members of the option to decline the ISP Review documentation as required under § 2380.186(e).
- (16) Recommending a revision to a service or outcome in the ISP as provided under § 2380.186(c)(4).

- (17) Coordinating the services provided to an individual.
- (18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each individual.
- (19) Developing and implementing provider services as required under § 2380.188 (relating to provider services).]

Coordinating the completion of assessments.

(2) Participating in the PSP process, PSP development, PSP team reviews and the implementation of the PSP in accordance with this chapter.

(3) Providing and supervising activities for the individuals in accordance with the PSPs.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and involvement with families and friends.

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**§ 2380.35. Staffing.**

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(d) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the individual's [ISP] PSP, as an outcome which requires the achievement of a higher level of independence.

(e) The staff qualifications and staff ratio as specified in the [ISP] PSP shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

**§ 2380.36. [Staff ] Emergency training.**

(a) [The facility shall provide orientation for staff persons relevant to their responsibilities, the daily operation of the facility and policies and procedures of the facility before working with individuals or in their appointed positions.

(b) The chief executive officer shall have at least 24 hours of training relevant to human services or administration annually.

(c) Program specialists and direct service workers who are employed for more than 40 hours per month shall have at least 24 hours of training relevant to human services annually.

(d) Program specialists and direct service workers shall have training in the areas of services for people with disabilities and program planning and implementation, within 30 calendar days after the day of initial employment or within 12 months prior to initial employment.

(e) Program specialists and direct service workers shall be trained before working with individuals in general firesafety, evacuation procedures, responsibilities during fire drills, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures if individuals or staff persons smoke at the facility, the use of fire extinguishers, smoke detectors and fire alarms, and notification of the local fire department as soon as possible after a fire is discovered.

[(f)] (b) Program specialists and direct service workers shall be trained annually by a firesafety expert in the training areas specified in subsection [(f)] (a).

[(g)] (c) There shall be at least one staff person for every 18 individuals, with a minimum of two staff persons present at the facility at all times who have been trained by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid, Heimlich techniques and cardio-pulmonary resuscitation within the past year. If a staff person

has formal certification from a hospital or other recognized health care organization that is valid for more than 1 year, the training is acceptable for the length of time on the certification.

[(h) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and staff persons attending, shall be kept.]

**§ 2380.37. Annual training plan.**

(a) The facility shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, other data and analysis indicating staff person training needs and as required under § 2380.39 (relating to annual training).

(b) The annual training plan shall include the orientation program as specified at § 2380.38 (relating to orientation program).

(c) The annual training plan shall include training aimed at improving the knowledge, skills and core competencies of the staff persons to be trained.

(d) The annual training plan shall include the following:

(1) The title of the position to be trained.

(2) The required training courses, including training course hours, for each position.

**§ 2380.38. Orientation program.**

(a) Prior to working alone with individuals, and within 30 days after hire, the following shall complete an orientation program as described in subsection (b):

- (1) Management, program, administrative and fiscal staff persons.
- (2) Dietary, housekeeping, maintenance and ancillary staff persons.
- (3) Direct service workers, including full and part time staff persons.
- (4) Volunteers who will work alone with individuals.
- (5) Paid and unpaid interns who will work alone with individuals.
- (6) Consultants who will work alone with individuals.

(b) The orientation program shall encompass the following areas:

- (1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.
- (2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. §§ 10225.701 - 10225.708 (relating to older adult protective services), 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101 – 10210.704 (relating to adult protective services) and applicable protective services regulations.
- (3) Individual rights.
- (4) Recognizing and reporting incidents.
- (5) Job-related knowledge and skills.

**§ 2380.39. Annual training.**

- (a) The following staff persons shall complete 24 hours of training each year.
  - (1) Direct service workers, including full and part time staff persons.
  - (2) Direct supervisors of direct service workers.

(3) Positions required by this chapter.

(b) The following staff persons shall complete 12 hours of training each year.

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons.

(3) Consultants who work alone with individuals.

(4) Volunteers who work alone with individuals.

(5) Paid and unpaid interns who work alone with individuals.

(c) A minimum of 8 of the annual training hours specified in subsections (a) and (b) shall encompass the following areas:

(1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. §§ 10225.701 – 10225.708 (relating to older adult protective services), 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101 – 10210.704 (relating to adult protective services) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of positive interventions, if the staff person will provide a support to an individual with a dangerous behavior.

(d) The balance of the annual training hours shall be in areas identified by the facility in the facility's annual training plan as required under § 2380.37 (relating to annual training plan).

(e) All training, including those training courses identified in subsections (c) and (d), shall be included in the provider's annual training plan.

(f) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.

(g) A training record for each person trained shall be kept.

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## **MEDICATIONS**

### **§ 2380.121. [Storage of medications.]**

(a) Prescription and nonprescription medications shall be kept in their original containers, except for medications of individuals who self-administer medications and keep their medications in personal daily or weekly dispensing containers.

(b) Prescription and nonprescription medications shall be kept in an area or container that is locked.

(c) Prescription medications stored in a refrigerator shall be kept in a separate locked container.

(d) Prescription and nonprescription medications shall be stored under proper conditions of sanitation, temperature, moisture and light.

(e) Discontinued prescription medications shall be returned to the individual's family or residential program for proper disposal.

**§ 2380.122. Labeling of medications.**

(a) The original container for prescription medications shall be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

(b) Nonprescription medications, except for medications of individuals who self-administer medications, shall be labeled with the original label.

**§ 2380.123. Use of prescription medications.**

(a) Prescription medications shall only be used by the individual for whom the medication was prescribed.

(b) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a written protocol as part of the ISP to address the social, emotional and environmental needs of the individual related to the symptoms of the psychiatric illness.

**§ 2380.124. Medication log.**

(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered, and the name of the person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer medication.

(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication.

(c) A list of prescription medications, the prescribed dosage, special instructions and the name of the prescribing physician shall be kept for each individual who self-administers medication.

**§ 2380.125. Medication errors.**

Documentation of medication errors and follow-up action taken shall be kept.

**§ 2380.126. Adverse reaction.**

If an individual has a suspected adverse reaction to a medication, the facility shall notify the prescribing physician and the family or residential program immediately.

Documentation of adverse reactions shall be kept.

**§ 2380.127. Administration of medications.**

(a) Prescription medications and injections of a substance not self-administered by individuals shall be administered by one of the following:

(1) A licensed physician, licensed dentist, certified physician's assistant, registered nurse or licensed practical nurse.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the facility.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the facility.

(4) A staff person who meets the criteria in § 2380.128 (relating to medication administration training), for the administration of oral, topical and eye and ear drop prescription medications and insulin injections.

(b) Prescription medications and injections shall be administered according to the directions specified on the prescription.

**§ 2380.128. Medication administration training.**

(a) A staff person who has completed and passed the Department's Medications Administration Course is permitted to administer oral, topical and eye and ear drop prescription medications.

(b) A staff person who has completed and passed the Department's Medications Administration Course and who has completed and passed a diabetes patient education program within the past 12 months that meets the National Standards for Diabetes Patient Education Programs of the National Diabetes Advisory Board, 7550 Wisconsin

Avenue, Bethesda, Maryland 20205, is permitted to administer insulin injections to an individual who is under the care of a licensed physician who is monitoring the diabetes.

(c) Medications administration training of staff persons shall be conducted by an instructor who has completed and passed the Medications Administration Course for trainers and is certified by the Department to train staff persons.

(d) A staff person who administers prescription medications or insulin injections to individuals shall complete the Medications Administration Course Practicum annually.

(e) Documentation of the dates and locations of medications administration training for trainers and staff persons and the annual practicum for staff persons shall be kept.

**§ 2380.129. Self-administration of medications.**

(a) To be considered capable of self-administration of medications, an individual shall:

(1) Be able to recognize and distinguish the individual's own medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken.

(b) Insulin that is self-administered by an individual shall be measured by the individual or by licensed or certified medical personnel.]

**Self-administration.**

(a) The facility shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

(c) The facility shall provide or arrange for assistive technology to support the individual's self-administration of medications.

(d) The PSP shall identify if the individual is unable to self-administer medications.

(e) To be considered able to self-administer medications, an individual shall do all of the following:

(1) Recognize and distinguish the individual's medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken. This knowledge may include reminders of the schedule and offering the medication at the prescribed times, as specified in subsection (b).

(4) Take or apply the individual's own medication with or without the use of assistive technology.

**§ 2380.122. Medication administration.**

(a) A facility whose staff persons are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer his prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A person who has completed the medication administration training as specified in § 2380.129 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

(3) Crush or split the medication as ordered by the prescriber.

- (4) Place the medication in a medication cup or other appropriate container or into the individual's hand, mouth or other route as ordered by the prescriber.
- (5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.
- (6) Injection of insulin or epinephrine in accordance with this chapter.

**§ 2380.123. Storage and disposal of medications.**

- (a) Prescription and nonprescription medications shall be kept in their original labeled containers.
- (b) A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.
- (c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.
- (d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.
- (e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.
- (f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to the Department of Environmental Protection and applicable Federal and State regulations.

(i) Subsections (a), (b), (c), (d) and (f) do not apply for an individual who self-administers medication and stores the medication on his person or in the individual's private property, such as a purse or backpack.

**§ 2380.124. Labeling of medications.**

The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- (1) The individual's name.
- (2) The name of the medication.
- (3) The date the prescription was issued.
- (4) The prescribed dosage and instructions for administration.
- (5) The name and title of the prescriber.

**§ 2380.125. Prescription medications.**

- (a) A prescription medication shall be prescribed in writing by an authorized prescriber.
- (b) A prescription order shall be kept current.
- (c) A prescription medication shall be administered as prescribed.
- (d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a registered nurse in accordance with regulations of the Department of State. The individual's medication record shall be updated as soon as a written notice of the change is received.

**§ 2380.126. Medication record.**

(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:

- (1) Individual's name.
- (2) Name and title of the prescriber.
- (3) Drug allergies.
- (4) Name of medication.
- (5) Strength of medication.
- (6) Dosage form.
- (7) Dose of medication.
- (8) Route of administration.
- (9) Frequency of administration.
- (10) Administration times.
- (11) Diagnosis or purpose for the medication, including pro re nata .
- (12) Date and time of medication administration.
- (13) Name and initials of the person administering the medication.
- (14) Duration of treatment, if applicable.
- (15) Special precautions, if applicable.

(16) Side effects of the medication, if applicable.

(b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

(d) The directions of the prescriber shall be followed.

**§ 2380.127. Medication errors.**

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong amount of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(b) Documentation of medication errors, follow-up action taken and the prescriber's response shall be kept in the individual's record.

**§ 2380.128. Adverse reaction.**

(a) If an individual has a suspected adverse reaction to a medication, the facility shall immediately consult a health care practitioner or seek emergency medical treatment.

(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction, and the action taken shall be documented.

**§ 2380.129. Medication administration training.**

(a) A staff person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer the following:

(1) Oral medications.

(2) Topical medications.

(3) Eye, nose and ear drop medications.

(b) A staff person may administer insulin injections following:

(1) Successful completion of the course specified in subsection (a).

(2) Successful completion of a Department-approved diabetes patient education program within the past 12 months.

(c) A staff person may administer an epinephrine injection via an auto-injection device in response to anaphylaxis or another serious allergic reaction following:

(1) Successful completion of the course specified in subsection (a).

(2) Successful completion of training relating to the use of an auto-injection epinephrine injection device provided by a licensed, registered or certified health care professional within the past 12 months.

(d) A record of the training shall be kept including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

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## **[RESTRICTIVE PROCEDURES] POSITIVE INTERVENTION**

### **§ 2380.151. [Definition of restrictive procedures.**

A restrictive procedure is a practice that does one or more of the following:

- (1) Limits an individual's movement, activity or function.
- (2) Interferes with an individual's ability to acquire positive reinforcement.
- (3) Results in the loss of objects or activities that an individual values.
- (4) Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.

### **§ 2380.152. Written policy.**

A written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which restrictive procedures may be used, the persons who may authorize the use of restrictive procedures, a mechanism to monitor and control the use of restrictive procedures and a process for the individual and family to review the use of restrictive procedures shall be kept at the facility.

**§ 2380.153. Appropriate use of restrictive procedures.**

(a) A restrictive procedure may not be used as retribution, for the convenience of staff persons, as a substitute for a program or in a way that interferes with the individual's developmental program.

(b) For each incident requiring a restrictive procedure:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than a restrictive procedure.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

**§ 2380.154. Restrictive procedure review committee.**

(a) If a restrictive procedure is used, there shall be a restrictive procedure review committee.

(b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.

(c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.

(d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.

**§ 2380.155. Restrictive procedure plan.**

(a) For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written prior to the use of restrictive procedures.

(b) The restrictive procedure plan shall be developed and revised with the participation of the program specialist, the individual's direct care staff, the interdisciplinary team, as appropriate, and other professionals, as appropriate.

(c) The restrictive procedure plan shall be reviewed, and revised if necessary, according to the time frame established by the restrictive procedure review committee, not to exceed 6 months.

(d) The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the restrictive procedure review committee and the program specialist, prior to the use of a restrictive procedure, whenever the restrictive procedure plan is revised and at least every 6 months.

(e) The restrictive procedure plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.

(2) The single behavioral outcome desired, stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.

(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(5) A target date for achieving the outcome.

(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in this chapter.

(7) Physical problems that require special attention during the use of the restrictive procedure.

(8) The name of the staff person or staff position responsible for monitoring and documenting progress with the plan.

(f) The restrictive procedure plan shall be implemented as written.

(g) Copies of the restrictive procedure plan shall be kept in the individual's record.

**§ 2380.156. Staff training.**

(a) If a restrictive procedure is used, at least one staff person shall be available when the restrictive procedure is used who has completed training within the past 12 months in the use of and ethics of using restrictive procedures including the use of alternate positive approaches.

(b) A staff person responsible for developing, implementing or managing a restrictive procedure plan shall be trained in the use of the specific techniques or procedures that are used.

(c) If manual restraint or exclusion is used, the staff person responsible for developing, implementing or managing a restrictive procedure plan shall have experienced the use of the specific techniques or procedures directly on themselves.

(d) Documentation of the training program provided, including the staff persons trained, dates of the training, description of the training and the training source, shall be kept.

**§ 2380.157. Seclusion.**

Seclusion, defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

**§ 2380.158. Aversive conditioning.**

The use of aversive conditioning, defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli, is prohibited.

**§ 2380.159. Chemical restraints.**

(a) A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual.

(b) Administration of a chemical restraint is prohibited except for the administration of drugs ordered by a licensed physician on an emergency basis.

(c) If a chemical restraint is administered as specified in subsection (b), the following apply:

(1) Prior to each incidence of administering a drug on an emergency basis, a licensed physician shall examine the individual and give a written order to administer the drug.

(2) Prior to each readministration of a drug on an emergency basis, a licensed physician shall examine the individual and order readministration of the drug.

(3) The individual's vital signs shall be monitored at least once each hour.

(4) Physical needs of the individual shall be met promptly.

(d) A Pro Re Nata (PRN) order for controlling acute, episodic behavior is prohibited.

(e) A drug ordered by a licensed physician as part of an ongoing program of medication is not a chemical restraint.

(f) A drug ordered by a licensed physician for a specific, time-limited stressful event or situation to assist the individual to control behavior, is not a chemical restraint.

(g) A drug ordered by a licensed physician as pretreatment prior to a medical or dental examination or treatment is not a chemical restraint.

(h) A drug self-administered by an individual is not a chemical restraint.

(i) If a drug is administered in accordance with subsection (b), (f), (g) or (h) to treat a behavior that occurs at the facility, there shall be training for the individual aimed at eliminating or reducing the need for the drug in the future.

(j) Documentation of compliance with subsections (b)—(i) shall be kept.

**§ 2380.160. Mechanical restraints.**

(a) A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices.

(b) The use of a mechanical restraint is prohibited except for the use of helmets, mitts and muffs to prevent self-injury on an interim basis but only for the first 3 months after admission.

(c) If a mechanical restraint is used as specified in subsection (b), the following apply:

(1) The use of a mechanical restraint may not exceed 2 hours, unless a licensed physician examines the individual and gives written orders to continue the use of the restraint. Reexamination and new orders by a licensed physician are required for each 2-hour period the restraint is continued. If a restraint is removed for a purpose other than for movement and reused within 24 hours after the initial use of the restraint, it is considered continuation of the initial restraint.

(2) A licensed physician shall be notified immediately after a mechanical restraint is used.

(3) The restraint shall be checked for proper fit by staff at least every 15 minutes.

(4) Physical needs of the individual shall be met promptly.

(5) The restraint shall be removed completely for at least 10 minutes during every 2 hours the restraint is used.

(6) There shall be training for the individual aimed at eliminating or reducing the need for the restraint in the future.

(7) Documentation of compliance with subsection (b) and paragraphs (1)—(6) shall be kept.

(d) A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, is not considered a mechanical restraint.

**§ 2380.161. Manual restraints.**

(a) A manual restraint is a physical hands-on technique that lasts more than 30 seconds, used to control acute, episodic behavior that restricts the movement or function of an individual or a portion of an individual's body such as basket holds and prone or supine containment.

(b) A manual restraint shall be used only when necessary to protect the individual from injuring himself or others.

(c) A manual restraint shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from injuring himself or others.

(d) An individual shall be released from the manual restraint within the time specified in the restrictive procedure plan not to exceed 30 minutes within a 2-hour period.

**§ 2380.162. Exclusion.**

(a) Exclusion is removing an individual from his immediate environment and restricting him alone to a room or area. If a staff person remains with the individual, it is not exclusion.

(b) Exclusion shall be used only when necessary to protect the individual from self-injury or injury to others.

(c) Exclusion shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from self-injury or injury to others.

(d) An individual shall be permitted to return to routine activity within the time specified in the restrictive procedure plan not to exceed 60 minutes within a 2-hour period.

(e) Exclusion may not be used for an individual more than two times in the same day.

(f) An individual in exclusion shall be monitored continually by a staff person.

(g) A room or area used for exclusion shall have at least 40 square feet of indoor floor space, with a minimum ceiling height of 7 feet.

(h) A room or area used for exclusion shall have an open door or a window for staff observation of the individual.

(i) A room or area used for exclusion shall be well lighted and ventilated.

**§ 2380.163. Emergency use of exclusion and manual restraints.**

If exclusion or manual restraints are used on an unanticipated, emergency basis, §§ 2380.154 and 2380.155 (relating to restrictive procedure review committee; and restrictive procedure plan) do not apply until after the exclusion or manual restraint is used for the same individual twice in a 6-month period.

**§ 2380.164. Use of personal funds and property.**

(a) An individual's personal funds or property may not be used as a reward or punishment.

(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages.

**§ 2380.165. Restrictive procedure records.**

A record of each use of a restrictive procedure documenting the specific behavior addressed, methods of intervention used to address the behavior, the date and time the restrictive procedure was used, the specific procedures followed, the staff person who used the restrictive procedure, the duration of the restrictive procedure, the staff person who observed the individual if exclusion was used and the individual's condition following the removal of the restrictive procedure shall be kept in the individual's record.]

**Use of a positive intervention.**

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

"Dangerous behavior" is an action with a high likelihood of resulting in harm to the individual or others.

"Positive intervention" is an action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.

**§ 2380.152. PSP.**

If the individual has a dangerous behavior as identified in the PSP, the PSP shall include the following:

- (1) The specific dangerous behavior to be addressed.
- (2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.
- (3) The outcome desired.
- (4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.
- (5) A target date to achieve the outcome.
- (6) Health conditions that require special attention.

**§ 2380.153. Prohibition of restraints.**

The following procedures are prohibited:

- (1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.
- (2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.
- (3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.
- (4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical

restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.

(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a non-emergency basis, or, for a period of more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor.

**§ 2380.154. Permitted interventions.**

(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.

(b) A physical protective restraint may be used only in accordance with § 2380.153 (6) - (8).

(c) A physical protective restraint shall not be used until § 2380.39(c)(5) (relating to annual training) and § 2380.185(9) (relating to content of PSP) are met.

(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.

(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.

(f) A physical protective restraint may not be used for a period of more than 15 minutes within a 2-hour period.

(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 2380.39.

(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.

**§ 2380.155. Access to or use of an individual's personal property.**

(a) Access to or the use of an individual's personal funds or property shall not be used as a reward or punishment.

(b) An individual's personal funds or property shall not be used as payment for damages unless the individual consents to make restitution for the damages as follows:

(1) A separate written consent by the individual is required for each incidence of restitution.

(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.

(3) There shall be no coercion in obtaining the consent of an individual.

(4) The facility shall keep a copy of the individual's written consent.

**§ 2380.156. Rights team.**

(a) The facility shall have a rights team. The facility may use a county mental health and intellectual disability program rights team that meets the requirements of this section.

(b) The role of the rights team shall be to:

(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified at § 2380.21 (relating to individual rights).

(2) Review each incidence of the use of a restraint to:

(i) Analyze systemic concerns.

(ii) Design positive supports as an alternative to the use of a restraint.

(iii) Discover and resolve the reason for an individual's behavior.

(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for himself, the individual's support coordinator, a representative from the funding agency if applicable and a facility representative.

- (d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.
- (e) If a restraint was used, the individual's health care practitioner shall be consulted.
- (f) The rights team shall meet at least once every 3 months.
- (g) The rights team shall report its recommendations to the individual's PSP team.
- (h) The facility shall keep documentation of the rights team meetings and the decisions made at the meetings.

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## RECORDS

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### § 2380.173. Content of records.

Each individual's record must include the following information:

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(2) [Unusual incident] Incident reports related to the individual.

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(5) [A copy of the invitation to:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(6) A copy of the signature sheet for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(7) A copy of the current ISP.

(8) Documentation of ISP reviews and revisions under § 2380.186 (relating to ISP review and revision), including the following:

(i) ISP review signature sheets.

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(9) Content discrepancies in the ISP, the annual update or revision under § 2380.186.]

PSP documents as required by this chapter.

[(10) Restrictive procedure protocols and] (6) Positive intervention records related to the individual.

[(11)] (7) Copies of psychological evaluations, if applicable.

## PROGRAM

### § 2380.181. Assessment.

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(b) If the program specialist is making a recommendation to revise a service or outcome in the [ISP as provided under § 2380.186(c)(4) (relating to ISP review and revision)] PSP, the individual shall have an assessment completed as required under this section.

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(f) The program specialist shall provide the assessment to the SC [or plan lead], as applicable, and [plan] PSP team members at least 30 calendar days prior to [an ISP] a PSP meeting [for the development, annual update and revision of the ISP under § § 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP)].

### § 2380.182. [Development, annual update and revision of the ISP.

(a) An individual shall have one ISP.

(b) When an individual is not receiving services through an SCO and does not reside in a home licensed under Chapter 6400 or 6500 (relating to community homes for

individuals with mental retardation; and family living homes), the adult training facility program specialist shall be the plan lead when one of the following applies:

(1) The individual attends a facility licensed under this chapter.

(2) The individual attends a facility licensed under this chapter and a facility licensed under Chapter 2390 (relating to vocational facilities).

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the individual's current assessment as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the individual's admission date to the facility.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) and also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 2380.186 (relating to ISP review and revision), shall be provided as required under § 2380.187 (relating to copies).

**§ 2380.183. Content of the ISP.**

The ISP, including annual updates and revisions under § 2380.186 (relating to ISP review and revision), must include the following:

- (1) Services provided to the individual and expected outcomes chosen by the individual and individual's plan team.
- (2) Services provided to the individual to increase community involvement, including work opportunities as required under § 2380.188 (relating to provider services).
- (3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.
- (4) A protocol and schedule outlining specified periods of time for the individual to be without direct supervision, if the individual's current assessment states the individual may be without direct supervision and if the individual's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve the higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the individual, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.

(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

(iii) The method and timeline for eliminating the use of restrictive procedures.

(iv) A protocol for intervention or redirection without utilizing restrictive procedures.

(7) Assessment of the individual's potential to advance in the following:

(i) Vocational programming.

(ii) Community involvement.

(iii) Competitive community-integrated employment.

**§ 2380.184. Plan team participation.**

(a) The plan team shall participate in the development of the ISP, including the annual updates and revisions under § 2380.186 (relating to ISP review and revision).

(1) A plan team must include as its members the following:

(i) The individual.

(ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the individual.

(iii) A direct service worker who works with the individual from each provider delivering a service to the individual.

(iv) Any other person the individual chooses to invite.

(2) If the following have a role in the individual's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the individual from each provider delivering services to the individual.

(iii) The individual's parent, guardian or advocate.

(b) At least three plan team members, in addition to the individual, if the individual chooses to attend, shall be present for an ISP, annual update and ISP revision meeting.

(c) A plan team member who attends a meeting under subsection (b) shall sign and date the signature sheet.

**§ 2380.185. Implementation of the ISP.**

(a) The ISP shall be implemented by the ISP'S start date.

(b) The ISP shall be implemented as written.

**§ 2380.186. ISP review and revision.**

(a) The program specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the facility licensed under this chapter with the individual every 3 months or more frequently if the individual's needs change which impact the services as specified in the current ISP.

(b) The program specialist and individual shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of an individual's participation and progress during the prior 3 months toward ISP outcomes supported by services provided by the facility licensed under this chapter.

(2) A review of each section of the ISP specific to the facility licensed under this chapter.

(3) The program specialist shall document a change in the individual's needs, if applicable.

(4) The program specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the program specialist shall complete a revised assessment as required under § 2380.181(b) (relating to assessment).

(d) The program specialist shall provide the ISP review documentation, including recommendations, if applicable, to the SC or plan lead, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The program specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead as applicable, under § § 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.

**§ 2380.187. Copies.**

A copy of the ISP, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP annual update and ISP revision meetings.

**§ 2380.188. Provider services.**

(a) The facility shall provide services including assistance, training and support for the acquisition, maintenance or improvement of functional skills, personal needs, communication and personal adjustment.

(b) The facility shall provide opportunities and support to the individual for participation in community life, including work opportunities.

(c) The facility shall provide services to the individual as specified in the individual's ISP.

(d) The facility shall provide services that are age and functionally appropriate to the individual.]

**Development of the PSP.**

(a) An individual shall have one, approved and authorized PSP at a given time.

(b) An individual's service implementation plan shall be consistent with the PSP in subsection (a).

- (c) The support coordinator, targeted support manager or program specialist shall coordinate the development of the PSP, including revisions, in cooperation with the individual and the individual's PSP team.
- (d) The initial PSP shall be developed based on the individual assessment, within 60 days of the individual's date of admission to the facility.
- (e) The PSP shall be initially developed, revised annually and revised when an individual's needs change, based upon a current assessment.
- (f) The individual, and persons designated by the individual, shall be involved in and supported in the development and revisions of the PSP.
- (g) The PSP, including revisions, shall be documented on a form specified by the Department.

**§ 2380.183. The PSP team.**

- (a) The PSP shall be developed by an interdisciplinary team including the following:
  - (1) The individual.
  - (2) Persons designated by the individual.
  - (3) The individual's direct care staff persons.
  - (4) The program specialist.
  - (5) The program specialist for the individual's residential program, if applicable.
  - (6) Other specialists such as health care, behavior management, speech, occupational, physical therapy, as appropriate for the individual needs.
- (b) At least three members of the PSP team, in addition to the individual and persons designated by the individual, shall be present at a PSP meeting at which the PSP is developed or revised.

(c) Members of the PSP team who attend the meeting shall sign and date the PSP.

**§ 2380.184. The PSP process.**

The PSP process shall:

- (1) Provide necessary information and support to ensure that the individual directs the PSP process to the maximum extent possible.
- (2) Enable the individual to make informed choices and decisions.
- (3) Be conducted to reflect what is important to the individual to ensure that supports are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.
- (4) Be timely in relation to the needs of the individual and occur at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.
- (5) Be communicated in clear and understandable language.
- (6) Reflect cultural considerations of the individual.
- (7) Include guidelines for solving disagreements among the PSP team members.
- (8) Include a method for the individual to request updates to the PSP.

**§ 2380.185. Content of the PSP.**

The PSP, including revisions, shall include the following:

- (1) The individual's strengths and functional abilities.
- (2) The individual's individualized clinical and support needs.

- (3) The individual's goals and preferences related to relationships, community participation, employment, income and savings, health care, wellness and education.
- (4) Individually identified, person-centered desired outcomes.
- (5) Supports to assist the individual to achieve desired outcomes.
- (6) The type, amount, duration and frequency for the support, specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.
- (7) Communication mode, abilities and needs.
- (8) Opportunities for new or continued community participation.
- (9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.
- (10) Modification of individual rights as necessary to mitigate risks, if applicable.
- (11) Health care information, including a health care history.
- (12) Financial information including how the individual chooses to use personal funds.
- (13) The person responsible for monitoring the implementation of the PSP.

**§ 2380.186. Implementation of the PSP.**

The facility shall implement the PSP, including revisions.

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**CHAPTER 2390. VOCATIONAL FACILITIES**

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**§ 2390.5. Definitions.**

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

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*[Content discrepancy—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]*

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*[Documentation—Written statements that accurately record details, substantiate a claim or provide evidence of an event.]*

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*[ISP—Individual Support Plan—The comprehensive document that identifies services and expected outcomes for a client.*

*Interdisciplinary team—A group of persons representing one or more service areas relevant to identifying a client's needs, including at a minimum the county case manager if the client is funded through the county mental health and intellectual disability program, the client and the program specialist.*

*Outcomes—Goals the client and client's plan team choose for the client to acquire,*

maintain or improve.

*Plan lead*—The program specialist or family living specialist, as applicable, when the client is not receiving services through an SCO.

*Plan team*—The group that develops the ISP. ]

PSP – Person-centered plan.

Restraint - A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the PSP or used on an emergency basis.

*[Restrictive procedure*—A practice that limits a client's movement, activity or function; interferes with a client's ability to acquire positive reinforcement; results in the loss of objects or activities that a client values; or requires a client to engage in a behavior that the client would not engage in given freedom of choice.]

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## GENERAL REQUIREMENTS

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### § 2390.18. [Unusual incident report.

(a) An unusual incident report shall be completed by the facility on a form specified by the Department for a serious event, including death of a client, injury or illness of a client requiring inpatient hospitalization or a fire requiring the services of a fire department.

The facility shall send copies of the report to the Regional Office of Mental Retardation and the funding agency within 24 hours after the event occurs. A copy of unusual incident reports shall be kept on file by the facility.

(b) If an unusual incident occurs during a weekend, the Regional Office of Mental Retardation and the funding agency shall be notified within 24 hours after the event occurs and the unusual incident report shall be sent on the first business day following the event.

**§ 2390.19. Abuse.**

(a) Abusive acts against clients are prohibited.

(b) Staff or clients witnessing or having knowledge of an abusive act to a client shall report it to the chief executive officer or designee within 24 hours.

(c) The chief executive officer or designee shall investigate reports of abuse and prepare and send a report to the Regional Office of Mental Retardation and the funding agency within 24 hours of the initial report. If the initial report occurs during a weekend, the Regional Office of Mental Retardation and the funding agency shall be notified within 24 hours after the initial report and the abuse investigation report shall be sent on the first business day following the initial report. The report shall either support or deny the allegation and make recommendations for appropriate action. The chief executive officer or designee shall implement changes immediately to prevent abuse in the future.

(d) Incidents of criminal abuse shall be reported immediately to law enforcement authorities.]

**Incident report and investigation.**

(a) The facility shall report the following incidents, alleged incidents and suspected incidents in the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) Suicide attempt.

(3) Inpatient admission to a hospital.

(4) Visit to an emergency room.

(5) Abuse.

(6) Neglect.

(7) Exploitation.

(8) An individual who is missing for more than 24 hours or who could be in jeopardy if missing at all.

(9) Law enforcement activity.

(10) Injury requiring treatment beyond first aid.

(11) Fire requiring the services of the fire department.

(12) Emergency closure.

(13) Use of a restraint.

(14) Theft or misuse of individual funds.

(15) A violation of individual rights.

- (b) The individual, and the persons designated by the individual, shall be notified immediately upon discovery of an incident relating to the individual.
- (c) The facility shall keep documentation of the notification in subsection (b).
- (d) The incident report, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual and persons designated by the individual, upon request.
- (e) The facility shall take immediate action to protect the health, safety and well-being of the individual, following the initial knowledge or notice of an incident, alleged incident and suspected incident.
- (f) The facility shall initiate an investigation of an incident within 24 hours of discovery by a staff person.
- (g) A Department-certified incident investigator shall conduct the incident investigation of an incident listed under subsection (a).
- (h) The facility shall finalize the incident report in the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person.
- (i) The facility shall provide the following information to the Department as part of the final incident report:
- (1) Additional detail about the incident.
  - (2) The results of the incident investigation.
  - (3) A description of the corrective action taken in response to an incident.
  - (4) Action taken to protect the health, safety and well-being of the individual.
  - (5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

**§ 2390.19. Incident procedures to protect the individual.**

(a) In investigating an incident, the facility shall review and consider the following needs of the affected individual:

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The facility shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The facility shall work cooperatively with the PSP team to revise the PSP if indicated by the incident investigation.

(d) The facility shall complete the following for each confirmed incident:

(1) Analysis to determine the root cause of the incident.

(2) Corrective action.

(3) A strategy to address the potential risks to the affected individual.

(e) The facility shall review and analyze incidents and conduct a trend analysis at least every 3 months.

(f) The facility shall identify and implement preventive measures to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of an incident recurring.

(g) The facility shall educate staff persons and the individual based on the circumstances of the incident.

(h) The facility shall analyze incident data continuously and take actions to mitigate and manage risks.

**§ 2390.21. [Civil] Individual rights.**

[(a) A client may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex, nor be deprived of civil or legal rights.

(b) A facility shall develop and implement civil rights policies and procedures. Civil rights policies and procedures include the following:

(1) Nondiscrimination in the provision of services, admissions, placement, facility usage, referrals and communication with non-English speaking clients.

(2) Program accessibility and accommodation for disabled clients.

(3) The opportunity to lodge civil rights complaints.

(4) Orientation for clients on their rights to register civil rights complaints.]

(a) An individual may not be deprived of rights, as provided under subsections (b) – (s).

- (b) An individual shall be continually supported to exercise the individual's rights.
- (c) An individual shall be provided the support and accommodation necessary to be able to understand and actively exercise the individual's rights.
- (d) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.
- (e) A court's written order that restricts an individual's rights shall be followed.
- (f) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with a court order.
- (g) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in decision-making in accordance with the court order.
- (h) An individual has the right to designate persons to assist in decision-making on behalf of the individual.
- (i) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.
- (j) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely and practice the religion of his choice or to practice no religion.
- (k) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.
- (l) An individual shall be treated with dignity and respect.
- (m) An individual has the right to make choices and accept risks.

- (n) An individual has the right to refuse to participate in activities and supports.
- (o) An individual has the right to privacy of person and possessions.
- (p) An individual has the right of access to and security of the individual's possessions.
- (q) An individual has the right to voice concerns about the supports the individual receives.
- (r) An individual has the right to participate in the development and implementation of the PSP.
- (s) An individual's rights shall be exercised so that another individual's rights are not violated.
- (t) Choices shall be negotiated by the affected individuals in accordance with the facility's procedures for the individuals to resolve differences and make choices.
- (u) The facility shall inform and explain individual rights to the individual, and persons designated by the individual, upon admission to the facility and annually thereafter.
- (v) The facility shall keep a copy of the statement signed by the individual, or an individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

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**§ 2390.24. Applicable laws and regulations.**

The facility shall comply with applicable Federal, State and local laws, regulations and ordinances.

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## STAFFING

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### § 2390.33. Program specialist.

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(b) The program specialist shall be responsible for the following:

(1) [Coordinating and completing assessments.

(2) Providing the assessment as required under § 2390.151(f) (relating to assessment).

(3) Participating in the development of the ISP, including annual updates and revisions of the ISP.

(4) Attending the ISP meetings.

(5) Fulfilling the role of plan lead, as applicable, under §§ 2390.152 and 2390.156(f) and (g) (relating to development, annual update and revision to the ISP; and ISP review and revision).

(6) Reviewing the ISP, annual updates and revisions for content accuracy.

(7) Reporting content discrepancy to the SC or plan lead, as applicable, and plan team members.

(8) Implementing the ISP as written.

- (9) Supervising, monitoring and evaluating services provided to the client.
- (10) Reviewing, signing and dating the monthly documentation of a client's participation and progress toward outcomes.
- (11) Reporting a change related to the client's needs to the SC or plan lead, as applicable, and plan team members.
- (12) Reviewing the ISP with the client as required under § 2390.156.
- (13) Documenting the review of the ISP as required under § 2390.156.
- (14) Providing documentation of the ISP review to the SC or plan lead, as applicable, and plan team members as required under § 2390.156(d).
- (15) Informing plan team members of the option to decline the ISP review documentation as required under § 2390.156(e).
- (16) Recommending a revision to a service or outcome in the ISP as provided under § 2390.156(c)(4).
- (17) Coordinating the services provided to a client.
- (18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each client.
- (19) Developing and implementing provider services as required under § 2390.158 (relating to provider services). ]

Coordinating the completion of assessments.

(2) Participating in the PSP process, PSP development, PSP team reviews and the implementation of the PSP in accordance with this chapter.

(3) Providing and supervising activities for the individuals in accordance with the PSPs.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and involvement with families and friends.

(c) A program specialist shall meet one of the following groups of qualifications:

(1) Possess a master's degree or above from an accredited college or university in Special Education, Psychology, Public Health, Rehabilitation, Social Work, Speech Pathology, Audiology, Occupational Therapy, Therapeutic Recreation or other human services field.

(2) Possess a bachelor's degree from an accredited college or university in Special Education, Psychology, Public Health, Rehabilitation, Social Work, Speech Pathology, Audiology, Occupational Therapy, Therapeutic Recreation or other human services field; and 1 year experience working directly with disabled persons.

(3) Possess an associate's degree or completion of a 2 year program from an accredited college or university in Special Education, Psychology, Public Health, Rehabilitation, Social Work, Speech Pathology, Audiology, Occupational Therapy, Therapeutic Recreation or other human services field; and 3 years experience working directly with disabled persons.

(4) Possess a license or certification by the State Board of Nurse Examiners, the State Board of Physical Therapists Examiners, or the Committee on Rehabilitation Counselor Certification or be a licensed psychologist or registered occupational therapist; and 1 year experience working directly with disabled persons.

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**§ 2390.39. Staffing.**

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(d) A client may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the client's assessment and is part of the client's [ISP] PSP, as an outcome which requires the achievement of a higher level of independence.

(e) The staff qualifications and staff ratio as specified in the [ISP ] PSP shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

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**§ 2390.40. [Staff training.**

(a) A facility shall provide orientation for staff relevant to their appointed positions. Staff shall be instructed in the daily operation of the facility and policies and procedures of the agency.

(b) Staff positions required by this chapter shall have at least 24 hours of training relevant to vocational or human services annually.

(c) Records of orientation and training, including dates held and staff attending, shall be kept on file.]

**Annual training plan.**

(a) The facility shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, other data and analysis indicating staff person training needs and as required under § 2390.42 (relating to annual training).

(b) The annual training plan shall include an orientation program as specified in § 2390.41 (relating to orientation program).

(c) The annual training plan shall include training aimed at improving the knowledge, skills and core competencies of the staff persons to be trained.

(d) The annual training plan shall include the following:

(1) The title of the position to be trained.

(2) The required training courses, including training course hours, for each position.

**§ 2390.41. Orientation program.**

(a) Prior to working alone with individuals, and within 30 days after hire, the following shall complete an orientation program as described under subsection (b):

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons.

(3) Direct service workers, including full and part time staff persons.

(4) Volunteers who will work alone with individuals.

(5) Paid and unpaid interns who will work alone with individuals.

(6) Consultants who will work alone with individuals.

(b) The orientation program to encompass the following areas:

(1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. §§ 10225.701-10225.708 (relating to older adult protective services), 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101 – 10210.704 (relating to adult protective services) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) Job-related knowledge and skills.

**§ 2390.42. Annual training.**

(a) The following staff persons, including full and part time staff persons, shall complete 24 hours of training each year.

(1) Floor supervisors.

(2) Direct supervisors of floor supervisors

(3) Positions required by this chapter.

(b) The following staff persons shall complete 12 hours of training each year:

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons.

(3) Consultants who work alone with individuals.

(4) Volunteers who work alone with individuals.

(5) Paid and unpaid interns who work alone with individuals.

(c) A minimum of 8 of the annual training hours specified in subsections (a) and (b)

shall encompass the following areas:

(1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. §§ 10225.701-10225.708 (relating to older adult protective services), 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101 – 10210.704 (relating to adult protective services) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of positive interventions, if the staff person will provide a support to an individual with a dangerous behavior.

(d) The balance of the annual training hours shall be in areas identified by the facility in the facility's annual training plan as required under § 2390.40 (relating to annual training plan).

(e) All training, including those training courses identified in subsections (c) and (d), shall be included in the provider's annual training plan.

(f) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.

(g) A training record for each person trained shall be kept.

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## CLIENT RECORDS

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### **§ 2390.124. Content of records.**

Each client's record must include the following information:

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(8) [A copy of the invitation to:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(9) A copy of the signature sheet for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(10) A copy of the current ISP.

(11) Documentation of ISP reviews and ISP revisions under § 2390.156 (relating to ISP review and revision), including the following:

(i) ISP Review signature sheets.

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(12) Content discrepancy in the ISP, the annual update or revision under § 2390.156] PSP documents as required by this chapter.

[(13) Restrictive procedure protocols and] (9) Positive intervention records related to the client.

[(14) Unusual incident] (10) Incident reports related to the client.

[(15)] (11) Copies of psychological evaluations, if applicable.

[(16)] (12) Vocational evaluations as required under § 2390.159 (relating to vocational evaluation).

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## PROGRAM

### § 2390.151. Assessment.

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(b) If the program specialist is making a recommendation to revise a service or outcome in the [ISP as provided under § 2390.156(c)(4) (relating to ISP review and revision)] PSP, the client shall have an assessment completed as required under this section.

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(f) The program specialist shall provide the assessment to the SC or plan lead, as applicable, and plan team members at least 30 calendar days prior to an [ISP] PSP meeting for the development, annual update and revision of the [ISP] PSP under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP).

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### § 2390.152. [Development, annual update and revision of the ISP.

(a) A client shall have one ISP.

(b) When a client is not receiving services through an SCO and is not receiving services in a facility or home licensed under Chapters 2380, 6400 or 6500 (relating to adult training facilities; community homes for individuals with an intellectual disability; and family living homes), the vocational facility program specialist shall be the plan lead.

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the client's current assessment as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the client's admission date to the facility.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) And also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 2390.156 (relating to ISP review and revision), shall be provided as required under § 2390.157 (relating to copies).

**§ 2390.153. Content of the ISP.**

The ISP, including annual updates and revisions under § 2390.156 (relating to ISP review and revision) must include the following:

(1) Services provided to the client and expected outcomes chosen by the client and client's plan team.

(2) Services provided to the client to develop the skills necessary for promotion into a higher level of vocational programming or into competitive community-integrated employment as required under § 2390.158 (relating to provider services).

(3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.

(4) A protocol and schedule outlining specified periods of time for the client to be without direct supervision, if the client's current assessment states the client may be without direct supervision and if the client's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve a higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the client, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.

(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

(iii) The method and timeline for eliminating the use of restrictive procedures.

(iv) A protocol for intervention or redirection without utilizing restrictive procedures.

(7) Assessment of the client's potential to advance in the following:

(i) Vocational programming.

(ii) Competitive community-integrated employment.

**§ 2390.154. Plan team participation.**

(a) The plan team shall participate in the development of the ISP, including the annual updates and revisions under § 2390.156 (relating to ISP review and revision).

(1) A plan team must include as its members the following:

(i) The client.

(ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the client.

(iii) A direct service worker who works with the client from each provider delivering a service to the client.

(iv) Any other person the client chooses to invite.

(2) If the following have a role in the client's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the client from each provider delivering services to the client.

(iii) The client's parent, guardian or advocate.

(b) At least three plan team members, in addition to the client, if the client chooses to attend, shall be present for the ISP, annual update and ISP revision meetings.

(c) A plan team member who attends an ISP meeting under subsection (b) shall sign and date the signature sheet.

**§ 2390.155. Implementation of the ISP.**

(a) The ISP shall be implemented by the ISP's start date.

(b) The ISP shall be implemented as written.

**§ 2390.156. ISP review and revision.**

(a) The program specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the facility licensed under this chapter with the client every 3 months or more frequently if the client's needs change which impacts the services as specified in the current ISP.

(b) The program specialist and client shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of a client's participation and progress during the prior 3 months toward ISP outcomes supported by services provide by the facility licensed under this chapter.

(2) A review of each section of the ISP specific to the facility licensed under this chapter.

(3) The program specialist shall document a change in the client's needs, if applicable.

(4) The program specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the program specialist shall complete a revised assessment as required under § 2390.151(b) (relating to assessment).

(d) The program specialist shall provide the ISP review documentation, including recommendations if applicable, to the SC or plan lead, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The program specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead, as applicable, under § § 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.

**§ 2390.157. Copies.**

A copy of the ISP, ISP annual update and ISP revision, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP, ISP annual update and ISP revision meetings.

**§ 2390.158. Provider services.**

(a) The facility shall provide services including work experience and other developmentally oriented, vocational training designed to develop the skills necessary

for promotion into a higher level of vocational programming or competitive community-integrated employment.

(b) The facility shall provide opportunities and support to the client for participation in community life, including competitive community-integrated employment.

(c) The facility shall provide services to the client as specified in the client's ISP.

(d) The facility shall provide services that are age and functionally appropriate to the client.]

**Development of the PSP.**

(a) An individual shall have one, approved and authorized PSP at a given time.

(b) An individual's service implementation plan shall be consistent with the PSP in subsection (a).

(c) The support coordinator, targeted support manager or program specialist shall coordinate the development of the PSP, including revisions, in cooperation with the individual and the individual's PSP team.

(d) The initial PSP shall be developed based on the individual assessment within 60 days of the individual's date of admission to the facility.

(e) The PSP shall be initially developed, revised annually and revised when an individual's needs change, based upon a current assessment.

(f) The individual and persons designated by the individual shall be involved in and supported in the development and revisions of the PSP.

(g) The PSP, including revisions, shall be documented on a form specified by the Department.

**§ 2390.153. The PSP team.**

(a) The PSP shall be developed by an interdisciplinary team including the following:

(1) The individual.

(2) Persons designated by the individual.

(3) The individual's direct care staff persons.

(4) The program specialist.

(5) The program specialist for the individual's residential program, if applicable.

(6) Other specialists such as health care, behavior management, speech, occupational, physical therapy, as appropriate for the individual needs.

(b) At least three members of the PSP team, in addition to the individual and persons designated by the individual, shall be present at a PSP meeting at which the PSP is developed or revised.

(c) Members of the PSP team who attend the meeting shall sign and date the PSP.

**§ 2390.154. The PSP process.**

The PSP process shall:

(1) Provide necessary information and support to ensure that the individual directs the PSP process to the maximum extent possible.

- (2) Enable the individual to make informed choices and decisions.
- (3) Be conducted to reflect what is important to the individual to ensure that supports are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.
- (4) Be timely and occur at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.
- (5) Be communicated in clear and understandable language.
- (6) Reflect cultural considerations of the individual.
- (7) Include guidelines for solving disagreements among the PSP team members.
- (8) Include a method for the individual to request updates to the PSP.

**§ 2390.155. Content of the PSP.**

The PSP, including revisions, shall include the following:

- (1) The individual's strengths and functional abilities.
- (2) The individual's individualized clinical and support needs.
- (3) The individual's goals and preferences related to relationships, community participation, employment, income and savings, health care, wellness and education.
- (4) Individually identified, person-centered desired outcomes.
- (5) Supports to assist the individual to achieve desired outcomes.
- (6) The type, amount, duration and frequency for the support, specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.
- (7) Communication mode, abilities and needs.

- (8) Opportunities for new or continued community participation.
- (9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.
- (10) Modification of individual rights as necessary to mitigate risks, if applicable.
- (11) Health care information, including a health care history.
- (12) Financial information including how the individual chooses to use personal funds.
- (13) The person responsible for monitoring the implementation of the PSP.

**§ 2390.156. Implementation of the PSP.**

The facility shall implement the PSP, including revisions.

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**POSITIVE INTERVENTION**

**§ 2390.171. Use of a positive intervention.**

- (a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.
- (b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.
- (c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:
  - “Dangerous behavior” is an action with a high likelihood of resulting in harm to the individual or others.

“Positive intervention” is an action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.

**§ 2390.172. PSP.**

If the individual has a dangerous behavior as identified in the PSP, the PSP shall include the following:

- (1) The specific dangerous behavior to be addressed.
- (2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.
- (3) The outcome desired.
- (4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.
- (5) A target date to achieve the outcome.
- (6) Health conditions that require special attention.

**§ 2390.173. Prohibition of restraints.**

The following procedures are prohibited:

- (1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.

(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.

(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.

(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a non-emergency basis, or, for a period of more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor.

**§ 2390.174. Permitted interventions.**

(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.

(b) A physical protective restraint may be used only in accordance with § 2390.173(6)-(8).

(c) A physical protective restraint shall not be used until § 2390.42(c)(5) (relating to annual training) and § 2390.155(9) (relating to content of PSP) are met.

(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.

(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.

(f) A physical protective restraint may not be used for a period of more than 15 minutes within a 2-hour period.

(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 2390.42 (relating to annual training).

(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.

**§ 2390.175. Access to or the use of an individual's personal property.**

(a) Access to or the use of an individual's personal funds or property shall not be used as a reward or punishment.

(b) An individual's personal funds or property shall not be used as payment for damages unless the individual consents to make restitution for the damages as follows:

(1) A separate written consent by the individual is required for each incidence of restitution.

(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.

(3) There shall be no coercion in obtaining the consent of an individual.

(4) The facility shall keep a copy of the individual's written consent.

**§ 2390.176. Rights team.**

(a) The facility shall have a rights team. The facility may use a county mental health and intellectual disability program rights team that meets the requirements of this section.

(b) The role of the rights team shall be to:

(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified at § 2390.21 (relating to individual rights).

(2) Review each incidence of the use of a restraint as specified at § 2390.171-174 (relating to positive intervention) to:

(i) Analyze systemic concerns.

(ii) Design positive supports as an alternative to the use of a restraint.

(iii) Discover and resolve the reason for an individual's behavior.

(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for himself, the individual's support coordinator, a representative from the funding agency, if applicable, and a facility representative.

(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.

(e) If a restraint was used, the individual's health care practitioner shall be consulted.

(f) The rights team shall meet at least once every 3 months.

(g) The rights team shall report its recommendations to the affected person-centered support plan (PSP) team.

(h) The facility shall keep documentation of the rights team meetings and the decisions made at the meetings.

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## MEDICATION ADMINISTRATION

### § 2390.191. Self-administration.

- (a) The facility shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.
- (b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.
- (c) The facility shall provide or arrange for assistive technology to support the individual's self-administration of medications.
- (d) The PSP shall identify if the individual is unable to self-administer medications.
- (e) To be considered able to self-administer medications, an individual shall do all of the following:
  - (1) Recognize and distinguish the individual's medication.
  - (2) Know how much medication is to be taken.
  - (3) Know when the medication is to be taken. This knowledge may include reminders of the schedule and offering the medication at the prescribed times, as specified in subsection (b).
  - (4) Take or apply the individual's own medication with or without the use of assistive technology.

**§ 2390.192. Medication administration.**

(a) A facility whose staff persons are qualified to administer medications as specified in (b) may provide medication administration for an individual who is unable to self-administer his prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A person who has completed the medication administration training as specified in § 2390.199 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

(3) Crush or split the medication as ordered by the prescriber.

(4) Place the medication in a medication cup or other appropriate container or into

the individual's hand, mouth or other route as ordered by the prescriber.

(5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin or epinephrine in accordance with this chapter.

**§ 2390.193. Storage and disposal of medications.**

(a) Prescription and nonprescription medications shall be kept in their original labeled containers.

(b) A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.

(c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.

(d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.

(e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.

(f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to the Department of Environmental Protection and applicable Federal and State regulations.

(i) Subsections (a), (b), (c), (d) and (f) do not apply for an individual who self-administers medication and stores the medication on his person or in the individual's private property, such as a purse or backpack.

**§ 2390.194. Labeling of medications.**

The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

(1) The individual's name.

(2) The name of the medication.

(3) The date the prescription was issued.

(4) The prescribed dosage and instructions for administration.

(5) The name and title of the prescriber.

**§ 2390.195. Prescription medications.**

(a) A prescription medication shall be prescribed in writing by an authorized prescriber.

(b) A prescription order shall be kept current.

(c) A prescription medication shall be administered as prescribed.

(d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a registered nurse in accordance with regulations of the Department of State. The individual's medication record shall be updated as soon as a written notice of the change is received.

**§ 2390.196. Medication record.**

(a) A medication record shall be kept including the following for each individual for whom a prescription medication is administered:

- (1) Individual's name.
- (2) Name and title of the prescriber.
- (3) Drug allergies.
- (4) Name of medication.
- (5) Strength of medication.
- (6) Dosage form.
- (7) Dose of medication.
- (8) Route of administration.
- (9) Frequency of administration.
- (10) Administration times.
- (11) Diagnosis or purpose for the medication, including pro re nata.
- (12) Date and time of medication administration.
- (13) Name and initials of the person administering the medication.
- (14) Duration of treatment, if applicable.
- (15) Special precautions, if applicable.

(16) Side effects of the medication, if applicable.

(b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

(d) The directions of the prescriber shall be followed.

**§ 2390.197. Medication errors.**

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong amount of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(b) Documentation of medication errors, follow-up action taken and the prescriber's response shall be kept in the individual's record.

**§ 2390.198. Adverse reaction.**

- (a) If an individual has a suspected adverse reaction to a medication, the facility shall immediately consult a health care practitioner or seek emergency medical treatment.
- (b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction, and the action taken shall be documented.

**§ 2390.199. Medication administration training.**

- (a) A staff person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer the following:

  - (1) Oral medications.
  - (2) Topical medications.
  - (3) Eye, nose and ear drop medications.
- (b) A staff person may administer insulin injections following:

  - (1) Successful completion of the course specified in subsection (a).
  - (2) Successful completion of a Department-approved diabetes patient education program within the past 12 months.
- (c) A staff person may administer an epinephrine injection via an auto-injection device in response to anaphylaxis or another serious allergic reaction following:

  - (1) Successful completion of the course specified in subsection (a).
  - (2) Successful completion of training relating to the use of an auto-injection epinephrine injection device provided by a licensed, registered or certified health care professional within the past 12 months.

(d) A record of the training shall be kept including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

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**PART VIII. INTELLECTUAL DISABILITY AND AUTISM MANUAL**

**SUBPART C. ADMINISTRATION AND FISCAL MANAGEMENT**

**CHAPTER 6100.**

**SUPPORT FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR AUTISM**

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## GENERAL PROVISIONS

### § 6100.1. Purpose.

(a) The purpose of this chapter is to specify the program and operational requirements for applicants and providers of HCBS and supports to individuals provided through base-funding.

(b) This chapter supports Pennsylvanians with an intellectual disability or autism to achieve greater independence, choice and opportunity in their lives, through the effective and efficient delivery of HCBS and supports to individuals provided through base-funding.

### § 6100.2. Applicability.

(a) This chapter applies to HCBS provided through waiver programs under Section 1915(c) of the Social Security Act for individuals with an intellectual disability or autism.

(b) This chapter applies to state plan HCBS for individuals with an intellectual disability or autism.

(c) This chapter applies to intellectual disability programs, staffing and individual supports that are funded exclusively by grants to counties under the Mental Health and Intellectual Disabilities Act of 1966 or Article XIV-B of the Human Services Code.

(d) This chapter does not apply to the following:

(1) Intermediate care facilities licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability), except as provided under § 6100.447(d) (relating to facility characteristics relating to location of facility).

(2) Hospitals licensed in accordance with 28 Pa. Code Chapters 101-158.

- (3) Nursing facilities licensed in accordance with 28 Pa. Code Chapters 201-211.
- (4) Personal care homes licensed in accordance with Chapter 2600 (relating to personal care homes).
- (5) Assisted living residences licensed in accordance with Chapter 2800 (relating to assisted living residences).
- (6) Mental health facilities licensed in accordance with Chapters 5200, 5210, 5221, 5230, 5300 and 5320.
- (7) Privately-funded programs, supports and placements.
- (8) Placements by other states into Pennsylvania.
- (9) A vendor fiscal employer agent model for an individual-directed, financial management service.
- (10) The adult community autism program that is funded and provided in accordance with the Federally-approved 1915(a) waiver program.

**§ 6100.3. Definitions.**

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

*Allowable cost*—Expenses considered reasonable, necessary and related to the support provided.

*Applicant*—An entity that is in the process of enrolling in the medical assistance program as a provider of HCBS.

*Corrective action plan*—A document that specifies the following:

- (1) Action steps to be taken to achieve and sustain compliance.
- (2) The timeframe by which corrections will be made.

(3) The person responsible for taking the action step.

(4) The person responsible for monitoring compliance with the corrective action plan.

*Base-funded support*—A support funded exclusively by a grant to a county under the Mental Health and Intellectual Disability Act of 1996 or Article XIV-B of the Human Services Code.

*Department*—The Department of Human Services of the Commonwealth.

*Designated managing entity*—An entity that enters into an agreement with the Department to perform administrative functions delegated by the Department, as the Department's designee. For base-funding, this includes the county mental health and intellectual disability program.

*Eligible cost*—Expenses related to the specific procedure codes for which the Department receives Federal funding.

*Family*—A natural person that the individual considers to be part of his core family-unit.

*Fixed asset*—A major item, excluding real estate, which is expected to have a useful life of more than 1 year or that can be used repeatedly without materially changing or impairing its physical condition through normal repairs, maintenance or replacement of components.

*HCBS - Home and community-based support*—An activity, service, assistance or product provided to an individual that is funded through a Federally-approved waiver program or the state plan.

*Individual*—A woman, man or child, who receives a home and community-based intellectual disability or autism support or base-funded support.

*Natural support*—An activity or assistance that is provided voluntarily to the individual, in lieu of a reimbursed support.

*OVR* --The Department of Labor and Industry's Office of Vocational Rehabilitation.

*PSP*—Person-centered support plan.

*Provider*—The person, entity or agency that is contracted or authorized to deliver the support to the individual.

*Restraint* - A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the PSP or used on an emergency basis.

*SSI*—Supplemental security income.

*State plan*- The Commonwealth's approved Title XIX State Plan.

*Support*—An activity, service, assistance or product provided to an individual that is provided through a Federally-approved waiver program, the state plan or base-funding. A support includes a HCBS, support coordination, targeted support management, agency with choice, organized health care delivery system, vendor goods and services, base-funding support, unless specifically exempted in this chapter.

*TSM*—Targeted support management.

*Vacancy factor*—An adjustment to the full capacity rate to account for days when the residential habilitation provider cannot bill due to an individual not receiving supports.

## GENERAL REQUIREMENTS

### § 6100.41. Appeals.

Appeals related to this chapter shall be made in accordance with Chapter 41 (relating to medical assistance provider appeal procedures).

**§ 6100.42. Monitoring compliance.**

(a) The Department and the designated managing entity may monitor compliance with this chapter at any time, through an audit, provider monitoring or other monitoring method.

(b) The provider's policies, procedures, records and invoices may be reviewed, and the provider may be required to provide an explanation of its policies, procedures, records and invoices, related to compliance with this chapter or applicable Federal or State statutes and regulations, during an audit, provider monitoring or other monitoring method.

(c) The provider shall cooperate with the Department and the designated managing entity and provide the requested compliance documentation in the format required by the Department prior to, during and following an audit, provider monitoring or other monitoring method.

(d) The provider shall cooperate with authorized Federal and State regulatory agencies and provide the requested compliance documentation, in the format required by the regulatory agencies.

(e) The provider shall complete a corrective action plan for a violation or an alleged violation of this chapter, in the timeframe required by the Department.

(f) The provider shall complete the corrective action plan on a form specified by the Department.

(g) The Department or the designated managing entity may issue a directed corrective action plan to direct the provider to complete a specified course of action to correct a violation or alleged violation of this chapter.

(h) The directed corrective action plan in subsection (g) may include the following:

- (1) The acquisition and completion of an educational program, in addition to that required in §§ 6100.141-6100.144.
  - (2) Technical consultation.
  - (3) Monitoring.
  - (4) Audit.
  - (5) Oversight by an appropriate agency.
  - (6) Another appropriate course of action to correct the violation.
- (i) The directed corrective action plan shall be completed by the provider at the provider's expense and not eligible for reimbursement from the Department.
  - (j) The provider shall comply with the corrective action plan and directed corrective action plan, as approved by the Department or the designated managing entity.
  - (k) The provider shall keep documentation relating to an audit, provider monitoring or other monitoring method, including supporting compliance documents.

**§ 6100.43. Regulatory waiver.**

(a) A provider may submit a request for a waiver of a section, subsection, paragraph or subparagraph of this chapter, except for the following:

- (1) §§ 6100.1-6100.3 (relating to general provisions).
- (2) §§ 6100-41-6100.55 (relating to general requirements).
- (3) §§ 6100.181-6100.186 (relating to individual rights).
- (4) §§ 6100.341-6100.345 (relating to positive intervention).

(b) The waiver shall be submitted on a form specified by the Department.

(c) The Secretary of the Department or the Secretary's designee may grant a waiver if the following conditions are met:

- (1) There is no jeopardy to an individual's health, safety and well-being.
  - (2) An individual or group of individuals benefit from the granting of the waiver through increased person-centeredness, integration, independence, choice or community opportunities for individuals.
  - (3) There is no violation of the Department's Federally-approved waivers and waiver amendments, or the state plan, as applicable.
  - (4) Additional conditions deemed appropriate by the Department.
- (d) The Department will specify an effective date and an expiration date for a waiver that is granted.
  - (e) At least 45 days prior to the submission of a request for a waiver the provider shall provide a written copy of the waiver request to the affected individuals, and to persons designated by the individuals, allowing at least 20 days for review and comment to the provider, the designated managing entity and the Department.
  - (f) If the request for a waiver involves the immediate protection of an individual's health and safety, the provider shall provide a written copy of the waiver request to the affected individuals, and to persons designated by the individuals, at least 24 hours prior to the submission of the request for a waiver, allowing at least 20 hours for review and comment to the provider, the designated managing entity and the Department.
  - (g) The provider shall discuss and explain the request for a waiver with the affected individuals, and with persons designated by the individuals.
  - (h) The request for a waiver submitted to the Department shall include copies of comments received by the individuals and by persons designated by the individuals.

(i) The provider shall notify the affected individuals, and persons designated by the individuals, of the Department's waiver decision.

(j) The provider shall submit a request for the renewal of a waiver at least 60 days prior to the expiration of the waiver.

(k) A request for the renewal of a waiver shall follow the procedures specified in subsections (a)-(j).

(l) The provider shall notify an individual not previously notified under this section of an existing waiver that affects the individual.

**§ 6100.44. Innovation project.**

(a) A provider may submit a proposal to the Department to demonstrate an innovative project on a temporary basis.

(b) The innovation project proposal shall include the following:

(1) A comprehensive description of how the innovation encourages best practice and promotes the mission, vision and values of person-centeredness, integration, independence, choice and community opportunities for individuals.

(2) A description of the positive impact on the quality of life including the impact on individual choice, independence and person-centeredness.

(3) A discussion of alternate health and safety protections, if applicable.

(4) The number of individuals included in the innovation project.

(5) The geographic location of the innovation project.

(6) The proposed beginning and end date for the innovation project.

(7) The name, title and qualifications of the manager who will oversee and monitor the innovation project.

- (8) A description of the advisory committee who will advise the innovation project.
- (9) A description of how individuals will be involved in designing and evaluating the success of the innovation project.
- (10) The community partners who will be involved in implementing the innovation project.
- (11) A request for a waiver form as specified in § 6100.43 (relating to regulatory waivers), if applicable.
- (12) Proposed changes to supports.
- (13) A detailed budget for the innovation project.
- (14) A description of who will have access to information on the innovation project.
- (15) The impact on living wage initiatives for direct support professionals, if applicable.

(c) The innovation project shall comply with the Department's Federally-approved waivers and waiver amendments, or the state plan, as applicable.

(d) The Deputy Secretary for the Office of Developmental Programs of the Department shall review a proposal for an innovation project in accordance with the following criteria:

- (1) The effect on an individual's health, safety and well-being.
- (2) The benefit from the innovation project to an individual or group of individuals by providing increased person-centeredness, integration, independence, choice and community opportunities for individuals.

- (3) Compliance with the Department's Federally-approved waivers and waiver amendments, or the state plan, as applicable.
- (4) The soundness and viability of the proposed budget.
- (5) Additional criteria the Department deems relevant to its review, funding or oversight of the specific innovation project proposal.
- (e) If the innovation project proposal is approved by the Deputy, the provider shall be subject to the fiscal procedures, reporting, monitoring and oversight as directed by the Department.
- (f) The provider shall submit a comprehensive annual report to the Department, to be made available to the public, at the Department's discretion.
- (g) The annual report shall include the following:
  - (1) The impact on the quality of life outcomes for individuals.
  - (2) Budget,
  - (3) Costs.
  - (4) Cost benefit analysis.
  - (5) Other relevant data, evaluation and analysis.
- (h) The Department may expand, renew or continue an innovation project, or a portion of the project, at its discretion.

**§ 6100.45. Quality management.**

- (a) The provider shall develop and implement a quality management plan on a form specified by the Department.
- (b) The provider shall conduct a review of performance data in the following areas to evaluate progress and identify areas for performance improvement:

- (1) Progress in meeting the desired outcomes of the PSP.
  - (2) Incident management, to encompass a trend analysis of the incident data including the reporting, investigation, suspected causes and corrective action taken in response to incidents.
  - (3) Performance in accordance with 42 CFR § 441.302 (relating to state assurances).
  - (4) Grievances, to encompass a trend analysis of the grievance data.
  - (5) Individual and family satisfaction survey results and informal comments by individuals, families and others.
  - (6) An analysis of the successful learning and application of training in relation to established core competencies.
  - (7) Staff satisfaction survey results and suggestions for improvement.
  - (8) Turnover rates by position and suspected causes.
  - (9) Licensing and monitoring reports.
- (c) The quality management plan shall identify the plans for systemic improvement and measures to evaluate the success of the plan.
- (d) The provider shall review and document progress on the quality management plan quarterly.
- (e) The provider shall analyze and revise the quality management plan every 2 years.

**§ 6100.46. Protective services.**

(a) Abuse, suspected abuse and alleged abuse of an individual, regardless of the alleged location or alleged perpetrator of the abuse, shall be reported and managed in accordance with the following:

(1) The Adult Protective Services Act (35 P.S. §§ 10210.101-10210.704) and applicable regulations.

(2) The Child Protective Services Law (23 Pa.C.S. §§ 6301-6386) and applicable regulations.

(3) The Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102) and applicable regulations.

(b) If there is an incident of abuse, suspected abuse or alleged abuse of an individual involving a staff person, consultant, intern or volunteer, the staff person, consultant, intern or volunteer shall have no direct contact with an individual until the abuse investigation is concluded and the investigating agency has confirmed that no abuse has occurred.

(c) In addition to the reporting required in subsection (a), the provider shall immediately report the abuse, suspected abuse or alleged abuse to the following:

- (1) The individual.
- (2) Persons designated by the individual.
- (3) The Department.
- (4) The designated managing entity.
- (5) The county government office responsible for the intellectual disability program.

**§ 6100.47. Criminal history checks.**

(a) Criminal history checks shall be completed for the following:

- (1) Full and part-time staff persons in any staff position.
- (2) Support coordinators, targeted support managers and base-funding support managers.

(b) Criminal history checks shall be completed for the following persons who provide a support included in the PSP:

- (1) Household members who have direct contact with an individual.
- (2) Life sharers.
- (3) Consultants.
- (4) Paid or unpaid interns.
- (5) Volunteers.

(c) Criminal history checks as specified in subsections (a) and (b) shall be completed in accordance with the following:

- (1) The Older Adult Protective Services Act and applicable regulations.
- (2) The Child Protective Services Law and applicable regulations.
- (d) This section does not apply to natural supports.

**§ 6100.48. Funding, hiring, retention and utilization.**

(a) Funding, hiring, retention and utilization of persons who provide reimbursed support shall be in accordance with the applicable provisions of the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102), 6 Pa. Code Chapter 15, the Child Protective Services Law (23 Pa.C.S. §§ 6301-6386) and Chapter 3490 (relating to child protective services). This subsection applies to the following:

- (1) Household members who have direct contact with an individual
- (2) Full and part-time staff persons in any staff position.
- (3) Life sharers.
- (4) Consultants.
- (5) Paid or unpaid interns.
- (6) Volunteers.
- (7) Support coordinators, targeted support managers and base-funding support coordinators.

(b) Subsection (a) does not apply to natural supports.

**§ 6100.49. Child abuse history certification.**

A child abuse history certification shall be completed in accordance with the Child Protective Services Law and applicable regulations.

**§ 6100.50. Communication.**

(a) Written, oral and other forms of communication with the individual, and persons designated by the individual, shall occur in a language and means of communication understood by the individual or person designated by the individual.

(b) The individual shall be provided with the assistive technology necessary to effectively communicate.

**§ 6100.51. Grievances.**

(a) The provider shall develop procedures to receive, document and manage grievances.

(b) The provider shall inform the individual, and persons designated by the individual, upon initial entry into the provider's program and annually thereafter, of the right to file a grievance and the procedure for filing a grievance.

(c) The provider shall permit and respond to oral and written grievances from any source, including an anonymous source, regarding the delivery of a support.

(d) The provider shall assure that there is no retaliation or threat of intimidation relating to the filing or investigation of grievances.

(e) If an individual indicates the desire to file a grievance in writing, the provider shall offer and provide assistance to the individual to prepare and submit the written grievance.

(f) The providers shall document and manage grievances, including repeated grievances.

(g) The provider shall document the following information for each grievance, including oral, written and anonymous grievances, from any source:

(1) The name, position, telephone, email address and mailing address of the initiator of the grievance, if known.

(2) The date and time the grievance was received.

(3) The date of the occurrence, if applicable.

(4) The nature of the grievance.

(5) The provider's investigation process and findings relating to the grievance.

(6) The provider's actions to investigate and resolve the grievance, if applicable.

(7) The date the grievance was resolved.

(h) The grievance shall be resolved within 21 days from the date the grievance was received.

(i) The initiator of the grievance shall be provided a written notice of the resolution or findings within 30 days from the date the grievance was received.

**§ 6100.52. Rights team.**

(a) The provider shall have a rights team. The provider may use a county mental health and intellectual disability program rights team that meets the requirements of this section.

(b) The role of the rights team shall be to:

(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified at §§ 6100.181-186.

(2) Review each use of a restraint as defined at §§ 6100.341-345 to:

(i) Analyze systemic concerns.

(ii) Design positive supports as an alternative to the use of a restraint.

(iii) Discover and resolve the reason for an individual's behavior.

(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate appointed by the designated managing entity if the individual is unable to speak for himself, the individual's support coordinator or targeted support manager, a representative from the designated managing entity and a provider representative.

(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.

- (e) If a restraint was used, the individual's health care practitioner shall be consulted.
- (f) The rights team shall meet at least once every 3 months.
- (g) The rights team shall report its recommendations to the affected PSP team.
- (h) The provider shall document the rights team meetings and the decisions made at the meetings.

**§ 6100.53. Conflict of interest.**

- (a) The provider shall develop a conflict of interest policy that is reviewed and approved by the provider's full governing board.
- (b) The provider shall comply with the provider's conflict of interest policy.
- (c) An individual or a friend or family member of an individual may serve on the governing board.

**§ 6100.54. Recordkeeping.**

- (a) The provider shall keep individual records confidential and in a secure location.
- (b) The provider shall not make individual records accessible to anyone other than the Department, the designated managing entity, and the support coordinator, targeted support manager or base-funded support coordinator, without the written consent of the individual, or persons designated by the individual.
- (c) Records, documents, information and financial books as required by this chapter shall be kept by the provider in accordance with the following:
  - (1) For at least 4 years from the Commonwealth's fiscal year-end, or four years from the provider's fiscal year end, whichever is later.
  - (2) Until any audit or litigation is resolved.

(3) In accordance with Federal and State statute and regulation.

(d) If a program is completely or partially terminated, the records relating to the terminated program shall be kept for at least 5 years from the date of termination.

**§ 6100.55. Reserved capacity.**

An individual has the right to return to the individual's residential habilitation location following hospital or therapeutic leave, in accordance with reserved capacity timelines specified in the Department's Federally-approved waivers and waiver amendments.

**ENROLLMENT**

**§ 6100.81. HCBS provider requirements.**

(a) The provider shall be qualified by the Department for each HCBS the provider intends to provide, prior to providing the HCBS.

(b) Prior to enrolling as a provider of HCBS, and on an ongoing basis following provider enrollment, the applicant or provider shall comply with the following:

(1) Chapter 1101 (relating to general provisions).

(2) The Department's monitoring documentation requirements as specified in § 6100.42 (relating to monitoring compliance).

(3) The Department's pre-enrollment provider training.

(4) Applicable licensure regulations, including Departmental regulations under Chapters 2380, 2390, 3800, 5310, 6400, 6500 and 6600; Department of Health licensure regulations under 28 Pa. Code Chapters 51, 601 and 611 (relating to general information; home health care agencies; and home care agencies and home care registries); and any other applicable licensure regulations.

(c) Evidence of compliance with applicable licensure regulations in subsection (b)(4) is the possession of a valid regular license issued by the Department or the Department of Health.

(1) If the applicant possesses a provisional license for the specific HCBS for which the applicant is applying, the applicant is prohibited from enrolling in the HCBS program for that specific HCBS.

(2) This subsection does not prohibit a provider that possesses a provisional license from continuing participation in the HCBS program once a provider is enrolled.

(d) An applicant shall not be enrolled as a provider of HCBS if the Department issued a sanction in accordance with §§ 6100.741 – 6100.744 (relating to enforcement).

**§ 6100.82. HCBS documentation.**

An applicant who desires to operate a HCBS in accordance with this chapter must complete and submit the following completed documents to the Department:

- (1) A provider enrollment application on a form specified by the Department.
- (2) A HCBS waiver provider agreement on a form specified by the Department.
- (3) Copies of current licenses as specified in § 6100.81(b)(4) (relating to provider requirements).
- (4) Verification of compliance with § 6100.47 (relating to criminal history checks).
- (5) Verification of completion of the Department's monitoring documentation.
- (6) Verification of completion of the Department's pre-enrollment provider training.
- (7) Documents required in accordance with the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

**§ 6100.83. Submission of HCBS qualification documentation.**

The provider of HCBS shall submit written qualification documentation to the designated managing entity or to the Department at least 60 days prior to the expiration of its current qualification.

**§ 6100.84. Provision, update and verification of information.**

The provider of HCBS shall provide, update and verify information within the Department's system as part of the initial and ongoing qualification processes.

**§ 6100.85. Ongoing HCBS provider qualifications.**

(a) The provider shall comply with the Department's Federally-approved waivers and waiver amendments, or the state plan, as applicable.

(b) The provider's qualifications to continue providing HCBS will be verified at intervals specified in the Federally-approved waiver, including applicable Federally-approved waiver amendments, or the state plan, as applicable.

(c) The Department may require a provider's qualifications to be verified for continued eligibility at an interval more frequent than the Federally-approved waiver, including applicable Federally-approved waiver amendments, or the medical assistance state plan, due to one of the following:

- (1) Noncompliance with this chapter as determined by monitoring as specified in § 6100.42 (relating to monitoring compliance).
- (2) Noncompliance with a corrective action plan, or a directed correction action plan, as issued or approved by the designated managing entity or the Department.
- (3) The issuance of a provisional license by the Department.

(4) Improper enrollment in the HCBS program.

(d) Neither a provider nor its staff persons who may come into contact with an individual, may be listed on the Federal or State lists of excludable persons such as the following:

(1) System for award management.

(2) List of excludable persons, individuals and entities.

(3) Medichex list.

#### **§ 6100.86. Delivery of HCBS.**

(a) The provider shall deliver only the HCBS for which the provider is determined to be qualified by the designated managing entity or the Department.

(b) The provider shall deliver the HCBS in accordance with the Federally-approved waiver, including applicable Federally-approved waiver amendments, and the medical assistance state plan, as applicable.

(c) The provider shall deliver only the HCBS to an individual who is authorized to receive that HCBS.

(d) The provider shall deliver the support in accordance with the individual's PSP.

### **TRAINING**

#### **§ 6100.141. Annual training plan.**

(a) The provider shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, the provider's quality management plan and other data and analysis indicating training needs.

(b) The annual training plan shall include the provider's orientation program as specified in § 6100.142 (relating to orientation program).

(c) The annual training plan shall include training aimed at improving the knowledge, skills and core competencies of the staff persons and others to be trained.

(d) The annual training plan shall include the following:

(1) The title of the position to be trained.

(2) The required training courses, including training course hours, for each position.

(e) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending shall be kept.

(f) The provider shall keep a training record for each person trained.

**§ 6100.142. Orientation program.**

(a) Prior to working alone with individuals, and, within 30 days after hire or starting to provide support to an individual the following shall complete an orientation program as described in subsection (b):

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons.

(3) Direct support staff persons, including full and part time staff persons.

(4) Household members who will provide reimbursed supports to the individual.

(5) Life sharers.

(6) Volunteers who will work alone with individuals.

- (7) Paid and unpaid interns who will work alone with individuals.
- (8) Consultants who will work alone with individuals.
- (b) The orientation program shall encompass the following areas:
  - (1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.
  - (2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. §§ 10225.701-10225.708 (relating to older adult protective services), 6 Pa. Code Chapter 15, 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101-10210.704 (relating to adult protective services) and applicable protective services regulations.
  - (3) Individual rights.
  - (4) Recognizing and reporting incidents.
  - (5) Job-related knowledge and skills.

**§ 6100.143. Annual training.**

- (a) The following persons shall complete 24 hours of training each year:
  - (1) Direct support staff persons, including household members and life sharers who provide reimbursed support to the individual.
  - (2) Direct supervisors of direct support staff persons.
- (b) The following staff persons and others shall complete 12 hours of training each year.
  - (1) Management, program, administrative, fiscal, dietary, housekeeping, maintenance and ancillary staff persons.

- (2) Consultants who provide reimbursed supports to an individual and who work alone with individuals.
  - (3) Volunteers who provide reimbursed supports to an individual and who work alone with individuals.
  - (4) Paid and unpaid interns who provide reimbursed supports to an individual and who work alone with individuals.
- (c) A minimum of 8 of the annual training hours specified in subsections (a) and (b) shall encompass the following areas:
- (1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.
  - (2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. §§ 10225.701-10225.708 (relating to older adult protective services), 6 Pa. Code Chapter 15, 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101-10210.704 (relating to adult protective services) and applicable protective services regulations.
  - (3) Individual rights.
  - (4) Recognizing and reporting incidents.
  - (5) The safe and appropriate use of positive interventions, if the person will provide a support to an individual with a dangerous behavior.
- (d) The balance of the annual training hours shall be in areas identified by the provider in the provider's annual training plan in § 6100.141 (relating to annual training plan).

(e) All training, including the training courses identified in subsections (c) and (d), shall be included in the provider's annual training plan.

**§ 6100.144. Natural supports.**

Sections 6100.141-143 do not apply to natural supports.

**INDIVIDUAL RIGHTS**

**§ 6100.181. Exercise of rights.**

- (a) An individual may not be deprived of rights, as provided under §§ 6100.182 and 6100.183 (relating to rights of the individual and additional rights of the individual in a residential facility).
- (b) An individual shall be continually supported to exercise the individual's rights.
- (c) An individual shall be provided the support and accommodation necessary to be able to understand and actively exercise the individual's rights.
- (d) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.
- (e) A court's written order that restricts an individual's rights shall be followed.
- (f) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual, in accordance with a court order.
- (g) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in decision-making in accordance with the court order.
- (h) An individual has the right to designate persons to assist in decision-making on behalf of the individual.

**§ 6100.182. Rights of the individual.**

(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

(b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely and practice the religion of his choice or to practice no religion.

(c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

(d) An individual shall be treated with dignity and respect.

(e) An individual has the right to make choices and accept risks.

(f) An individual has the right to refuse to participate in activities and supports.

(g) An individual has the right to control the individual's own schedule and activities.

(h) An individual has the right to privacy of person and possessions.

(i) An individual has the right of access to and security of the individual's possessions.

(j) An individual has the right to choose a willing and qualified provider.

(k) An individual has the right to choose where, when and how to receive needed supports.

(l) An individual has the right to voice concerns about the supports the individual receives.

(m) An individual has the right to assistive devices and support to enable communication at all times.

(n) An individual has the right to participate in the development and implementation of the PSP.

**§ 6100.183. Additional rights of the individual in a residential facility.**

(a) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with persons of the individual's choice, at any time.

(b) An individual has the right to unrestricted access to send and receive mail and other forms of communications, unopened and unread by others.

(c) An individual has the right to unrestricted and private access to telecommunications.

(d) An individual has the right to manage and access the individual's own finances.

(e) An individual has the right to choose persons with whom to share a bedroom.

(f) An individual has the right to furnish and decorate the individual's bedroom and the common areas of the home, in accordance with §§ 6100.184 (relating to negotiation of choices) and 6100.444(b) (relating to lease or ownership).

(g) An individual has the right to lock the individual's bedroom door.

(h) An individual has the right to access food at any time.

(i) An individual has the right to make informed health care decisions.

**§ 6100.184. Negotiation of choices.**

(a) An individual's rights shall be exercised so that another individual's rights are not violated.

(b) Choices shall be negotiated by the affected individuals in accordance with the provider's procedures for the individuals to resolve differences and make choices.

**§ 6100.185. Informing of rights.**

(a) The provider shall inform and explain individual rights to the individual, and persons designated by the individual, upon entry into the program and annually thereafter.

(b) The provider shall keep a statement signed by the individual, or an individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

**§ 6100.186. Role of family and friends.**

(a) The provider shall facilitate and make the accommodations necessary to support an individual's visits with family, friends and others, at the direction of the individual.

(b) The provider shall facilitate and make the accommodations necessary to involve the individual's family, friends and others in decision-making, planning and other activities, at the direction of the individual.

**PERSON-CENTERED SUPPORT PLAN**

**§ 6100.221. Development of the PSP.**

(a) An individual shall have one approved and authorized PSP that identifies the need for supports, the supports to be provided and the expected outcomes.

(b) An individual's service implementation plan shall be consistent with the PSP in subsection (a).

- (c) The support coordinator or targeted support manager shall be responsible for the development of the PSP, including revisions, in cooperation with the individual and the individual's PSP team.
- (d) The initial PSP shall be developed prior to the individual receiving a reimbursed support.
- (e) The PSP shall be revised when an individual's needs or support system changes and upon the request of an individual.
- (f) The initial PSP and PSP revisions shall be based upon a current assessment.
- (g) The individual and persons designated by the individual shall be involved in and supported in the initial development and revisions of the PSP.
- (h) The initial PSP and PSP revisions shall be documented on a form specified by the Department.

**§ 6100.222. The PSP process.**

- (a) The PSP process shall be directed by the individual.
- (b) The PSP process shall:
  - (1) Invite and include persons designated by the individual.
  - (2) Provide accommodation and facilitation to enable the individual's family, friends and others to attend the PSP meeting, at the direction of the individual.
  - (3) Be conducted to reflect what is important to the individual to ensure that supports are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.
  - (4) Provide necessary information and support to ensure that the individual directs the PSP process to the maximum extent possible.

- (5) Enable the individual to make informed choices and decisions.
- (6) Be timely in relation to the needs of the individual and occur at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.
- (7) Be communicated in clear and understandable language.
- (8) Reflect cultural considerations of the individual.
- (9) Specify and follow guidelines for solving disagreements among the PSP team members.
- (10) Establish a method for the individual to request updates to the PSP.
- (11) Record the alternative supports that were considered by the individual.

**§ 6100.223. Content of the PSP.**

The PSP shall include the following:

- (1) The individual's strengths and functional abilities.
- (2) The individual's assessed clinical and support needs.
- (3) The individual's goals and preferences related to relationships, community participation, employment, income and savings, health care, wellness and education.
- (4) Individually identified, person-centered desired outcomes.
- (5) Support necessary to assist the individual to achieve desired outcomes.
- (6) The provider of the support.
- (7) Natural supports.
- (8) The type, amount, duration and frequency for the support, specified in a manner that reflects the assessed needs and choices of the individual. The schedule of

support delivery shall be determined by the PSP team and provide sufficient flexibility to provide choice by the individual.

- (9) The individual's communication mode, abilities and needs.
- (10) Opportunities for new or continued community participation.
- (11) Active pursuit of competitive, integrated employment as a first priority, before other activities or supports are considered.
- (12) Education and learning history and goals.
- (13) The level of needed support, risk factors, dangerous behaviors and risk mitigation strategies, if applicable.
- (14) Modification of individual rights as necessary to mitigate risks, if applicable.
- (15) Health care information, including a health care history.
- (16) The individual's choice of the provider and setting in which to receive supports.
- (17) Excluded, unnecessary or inappropriate supports.
- (18) Financial information, including how the individual chooses to use personal funds.
- (19) A back-up plan to identify a needed support as identified by the PSP team, if the absence of the designated support person would place the individual at a health and safety risk.
- (20) The person responsible for monitoring the implementation of the PSP.
- (21) Signatures of the PSP team members and the date signed.

**§ 6100.224. Implementation of the PSP.**

The provider identified in the PSP shall implement the PSP, including revisions.

**§ 6100.225. Support coordination and targeted support management.**

(a) A support coordinator or targeted support manager shall assure the completion of the following activities when developing an initial PSP and the annual review of the PSP:

(1) Coordination of information gathering and assessment activity, which includes the results from assessments prior to the initial and annual PSP meeting.

(2) Collaboration with the individual and persons designated by the individual to coordinate a date, time and location for initial and annual PSP meetings.

(3) Distribution of invitations to PSP team members.

(4) Facilitation of the PSP meeting, or the provision of support for an individual who chooses to facilitate his own meeting.

(5) Documentation of agreement with the PSP from the individual, persons designated by the individual and other team members.

(6) Documentation and submission of the PSP reviews, and revisions to the PSP, to the Department and the designated managing entity for approval and authorization.

(7) If the PSP is returned for revision, resubmission of the amended PSP for approval and authorization.

(8) Distribution of the PSP to the PSP team members who do not have access to the Department's information management system.

(9) Revision of the PSP when there is a change in an individual's needs.

(b) A support coordinator or targeted support manager shall monitor the implementation of the PSP, as well as the health, safety and well-being of the individual, using the Department's monitoring tool.

**§ 6100.226. Documentation of support delivery.**

(a) Documentation of support delivery related to the individual shall be prepared by the provider, for the purposes of substantiating a claim.

(b) Documentation of support delivery shall relate to the implementation of the PSP, rather than the individual's service implementation plan as specified in § 6100.221(b) (relating to development of the PSP).

(c) The provider shall document support delivery each time a support is delivered.

(d) Documentation of support delivery may be made on the same form if multiple supports are provided to the same individual, by the same provider and at the same location.

(e) Documentation of support delivery shall include the following:

(1) The name of the individual.

(2) The name of the provider.

(3) The date, name, title and signature of the person completing the documentation.

(4) A summary documenting what support was delivered, who delivered the support, when the support was delivered and where the support was delivered.

(5) The amount, frequency and duration of the support as specified in the PSP.

(6) The outcome of the support delivery.

(7) A record of the time worked, or the time that a support was delivered, to support the claim.

(f) The provider, in cooperation with the support coordinator or the targeted support manager and the individual, shall complete a review of the documentation of support

delivery for each individual, every 3 months, and document the progress made to achieving the desired outcome of the supports provided.

(g) The provider shall keep documentation of support delivery.

## **EMPLOYMENT, EDUCATION AND COMMUNITY PARTICIPATION**

### **§ 6100.261. Access to the community.**

(a) The provider shall provide the individual with the support necessary to access the community in accordance with the individual's PSP.

(b) The individual shall be provided ongoing opportunities and support necessary to participate in community activities of the individual's choice.

(c) The individual shall be afforded the same degree of community access and choice as an individual who is similarly situated in the community, who does not have a disability and who does not receive a HCBS.

### **§ 6100.262. Employment.**

(a) The individual shall have active and ongoing opportunities and the supports necessary to seek and retain employment and work in competitive, integrated settings.

(b) Authorization for a new prevocational support for an individual who is under 25 years of age shall be permitted only after a referral is made to the OVR and the OVR either determines that the individual is ineligible or closes the case.

(c) At the annual PSP revision, the individual shall be offered appropriate opportunities related to the individual's skills and interests, and encouraged to seek competitive, integrated employment.

(d) The support coordinator or targeted support manager shall provide education and information to the individual about competitive, integrated employment and the OVR services.

**§ 6100.263. Education.**

If identified in the individual's PSP as necessary to support the individual's pursuit of a competitive, integrated employment outcome or identified in the individual's PSP for employment approved by the OVR, an individual shall have access to a full range of options that support participation in the following post-secondary education:

- (1) Technical education.
- (2) College and university programs.
- (3) Lifelong learning.
- (4) Career development.

**TRANSITION**

**§ 6100.301. Individual choice.**

(a) No influence shall be exerted by a provider when the individual is considering a transition to a new provider.

(b) An individual shall be supported by the support coordinator or the targeted support manager in exercising choice in transitioning to a new provider.

(c) An individual's choice to transition to a new provider shall be accomplished in the timeframe desired by the individual, to the extent possible and in accordance with this chapter.

**§ 6100.302. Transition to a new provider.**

(a) When an individual transitions to a new provider, both the current provider and new provider shall cooperate with the Department, the designated managing entity and the support coordinator or the targeted support manager, during the transition between providers.

(b) The current provider shall:

(1) Participate in transition planning to aid in the successful transition to the new provider.

(2) Arrange for transportation of the individual to visit the new provider, if transportation is included in the support.

(3) Close pending incidents in the Department's information management system.

**§ 6100.303. Reasons for a transfer or a change in a provider.**

(a) The following are the only grounds for a change in a provider or a transfer of an individual against the individual's wishes:

(1) The individual is a danger to the individual's self or others, at the particular support location, even with the provision of supplemental supports.

(2) The individual's needs have changed, advanced or declined so that the individual's needs cannot be met by the provider, even with the provision of supplemental supports.

(3) Meeting the individual's needs would require a significant alteration of the provider's program or building.

(b) The provider may not change a support provider or transfer an individual against the individual's wishes in response to an individual's exercise of rights, voicing choices or concerns or in retaliation to filing a grievance.

**§ 6100.304. Written notice.**

(a) If the individual chooses another provider, the PSP team shall provide written notice to the following at least 30 days prior to the transition to a new provider:

- (1) The provider.
- (2) The individual.
- (3) Persons designated by the individual.
- (4) The PSP team members.
- (5) The designated managing entity.
- (6) The support coordinator or targeted support manager.

(b) If the provider is no longer able or willing to provide a support for an individual in accordance with the provisions specified in § 6100.303 (relating to reasons for a transfer or change in a provider), the provider shall provide written notice to the following at least 45 days prior to the date of the proposed change in support provider or transfer:

- (1) The individual.
- (2) Persons designated by the individual.
- (3) The PSP team members.
- (4) The designated managing entity.
- (5) The support coordinator or targeted support manager.
- (6) The Department.

(c) The provider's written notice specified in subsection (b) shall include the following:

- (1) The individual's name and master client index number.
- (2) The current provider's name, address and master provider index number.
- (3) The support that the provider is unable or unwilling to provide or for which the individual chooses another provider.
- (4) The location where the support is currently provided.
- (5) The reason the provider is no longer able or willing to provide the support as specified in § 6100.303.
- (6) A description of the efforts made to address or resolve the issue that has led to the provider becoming unable or unwilling to provide the support or for which the individual chooses another provider.
- (7) Suggested time frames for transitioning the delivery of the support to the new provider.

**§ 6100.305. Continuation of support.**

The provider shall continue to provide the authorized support during the transition period to ensure continuity of care until a new provider is approved by the Department and the new support is in place, unless otherwise directed by the Department or the designated managing entity.

**§ 6100.306. Transition planning.**

The support coordinator or targeted support manager shall coordinate the transition planning activities, including scheduling and participating in all transition planning meetings during the transition period.

**§ 6100.307. Transfer of records.**

(a) The provider shall transfer a copy of the individual record to the new provider prior to the day of the transfer.

(b) The previous provider shall maintain the original individual record in accordance with § 6100.54 (relating to recordkeeping).

**POSITIVE INTERVENTION**

**§ 6100.341. Use of a positive intervention.**

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

“Dangerous behavior” is an action with a high likelihood of resulting in harm to the individual or others.

“Positive intervention” is an action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communication, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise, wellness practice, redirection, praise, modeling, conflict resolution and de-escalation.

**§ 6100.342. PSP.**

If the individual has a dangerous behavior as identified in the PSP, the PSP shall include the following:

- (1) The specific dangerous behavior to be addressed.
- (2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.
- (3) The outcome desired.
- (4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.
- (5) A target date to achieve the outcome.
- (6) Communication needs.
- (7) Health conditions that require special attention.

**§ 6100.343. Prohibition of restraints.**

The following procedures are prohibited:

- (1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.
- (2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.
- (3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.

(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a non-emergency basis, or, for a period of more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor.

**§ 6100.344. Permitted interventions.**

- (a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.
- (b) A physical protective restraint may be used only in accordance with § 6100.343(6)-(8).
- (c) A physical protective restraint shall not be used until § 6100.143(c)(5) (relating to annual training) and § 6100.223(13) (relating to content of PSP) are met.
- (d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.
- (e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.
- (f) A physical protective restraint may not be used for a period of more than 15 minutes within a 2-hour period.
- (g) A physical protective restraint may only be used by a person who is trained as specified in § 6100.143(c)(5).
- (h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.

**§ 6100.345. Access to or the use of an individual's personal property.**

(a) Access to or the use of an individual's personal funds or property shall not be used as a reward or punishment.

(b) An individual's personal funds or property shall not be used as payment for damages unless the individual consents to make restitution for the damages as follows:

(1) A separate written consent is required for each incidence of restitution.

(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.

(3) There shall be no coercion in obtaining the consent of an individual.

**INCIDENT MANAGEMENT**

**§ 6100.401. Types of incidents and timelines for reporting.**

(a) The provider shall report the following incidents, alleged incidents and suspected incidents through the Department's information management system within 24 hours of discovery by a staff person:

(1) Death.

(2) Suicide attempt.

(3) Inpatient admission to a hospital.

(4) Emergency room visit.

(5) Abuse.

(6) Neglect.

(7) Exploitation.

(8) Missing individual.

(9) Law enforcement activity.

(10) Injury requiring treatment beyond first aid.

(11) Fire requiring the services of the fire department.

(12) Emergency closure.

(13) Use of a restraint.

(14) Theft or misuse of individual funds.

(15) A violation of individual rights.

(16) A medication administration error, including prescription and over the counter medication administration errors.

(17) A critical health and safety event that requires immediate intervention such a significant behavioral event or trauma.

(b) The individual, and persons designated by the individual, shall be notified immediately upon discovery of an incident relating to the individual.

(c) The provider shall keep documentation of the notification in subsection (b).

(d) The incident report, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual, and persons designated by the individual, upon request.

**§ 6100.402. Incident investigation.**

(a) The provider shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or notice of an incident, alleged incident and suspected incident.

(b) The provider shall initiate an investigation of an incident within 24 hours of discovery by a staff person.

(c) A Department-certified incident investigator shall conduct the investigation of the incident listed under § 6100.401 (a) (relating to types of incidents and timelines for reporting).

**§ 6100.403. Individual needs.**

(a) In investigating an incident, the provider shall review and consider the following needs of the affected individual:

- (1) Potential risks.
- (2) Health care information.
- (3) Medication history and current medication.
- (4) Behavioral health history.
- (5) Incident history.
- (6) Social needs.
- (7) Environmental needs.
- (8) Personal safety.

(b) The provider shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The provider shall work cooperatively with the support coordinator or targeted support manager and the PSP team, to revise the individual's PSP if indicated by the incident.

**§ 6100.404. Final incident report.**

- (a) The provider shall finalize the incident report in the Department's information management system within 30 days of discovery of the incident by a staff person.
- (b) The provider shall provide the following information to the Department as part of the final incident report:
  - (1) Additional detail about the incident.
  - (2) The results of the incident investigation.
  - (3) A description of the corrective action taken in response to an incident.
  - (4) Action taken to protect the health, safety and well-being of the individual.
  - (5) The person responsible for implementing the corrective action.
  - (6) The date the corrective action was implemented or is to be implemented.

**§ 6100.405. Incident analysis.**

- (a) The provider shall complete the following for each confirmed incident:
  - (1) Analysis to determine the root cause of the incident.
  - (2) Corrective action.
  - (3) A strategy to address the potential risks to the individual.
- (b) The provider shall review and analyze incidents and conduct a trend analysis at least every 3 months.
- (c) The provider shall identify and implement preventive measures to reduce:
  - (1) The number of incidents.
  - (2) The severity of the risks associated with the incident.
  - (3) The likelihood of an incident recurring.

(d) The provider shall educate staff persons, others and the individual based on the circumstances of the incident.

(e) The provider shall analyze incident data continuously and take actions to mitigate and manage risks.

## **PHYSICAL ENVIRONMENT**

### **§ 6100.441. Request for and approval of changes.**

(a) A residential provider shall submit a written request to the Department on a form specified by the Department and receive written approval from the Department prior to increasing or decreasing the Department-approved program capacity of a residential facility.

(b) To receive written approval from the Department as specified in subsection (a), the provider shall submit a description of the following:

(1) The circumstances surrounding the change.

(2) How the change will meet the setting size, staffing patterns, assessed needs and outcomes for the individuals.

(c) If a facility is licensed as a community home for individuals with an intellectual disability or autism, the program capacity, as specified in writing by the Department, may not be exceeded. No additional individuals funded through any funding source, including private-pay, may live in the home to exceed the Department-approved program capacity.

(d) A copy of the written request specified in subsections (a) and (b) shall be provided to the affected individuals, and persons designated by the individuals, prior to the submission to the Department.

(e) A copy of the Department's response to the written request specified in subsections (a) and (b) shall be provided to the affected individuals, and persons designated by the individuals, within 7 days following the receipt of the Department's response.

**§ 6100.442. Physical accessibility.**

(a) The provider shall provide for or arrange for physical site accommodations and assistive equipment to meet the health, safety and mobility needs of the individual.

(b) Mobility equipment and other assistive equipment shall be maintained in working order, clean, in good repair and free from hazards.

**§ 6100.443. Access to the bedroom and the home.**

(a) In a residential facility, an individual shall have a lock with a key, access card, keypad code or other entry mechanism to unlock and lock the individual's bedroom door and the entrance of the home.

(b) Assistive technology, as needed, shall be used to allow the individual to open and lock the door without assistance.

(c) The locking mechanism shall allow easy and immediate access in the event of an emergency.

(d) Appropriate persons shall have the key and entry device to lock and unlock the doors to the bedroom and the home.

(e) Only authorized persons shall access the individual's bedroom.

(f) Access to an individual's bedroom shall be provided only in a life-safety emergency or with the express permission of the individual for each incidence of access.

**§ 6100.444. Lease or ownership.**

(a) In residential habilitation, the individual shall have a legally enforceable agreement such as the lease or residency agreement for the physical space, or ownership of the physical space, that offers the same responsibilities and protections from eviction that tenants have under the Landlord and Tenant Act of 1951 (68 P.S. §§ 250.101-399.18).

(b) Landlords may establish reasonable limits for the furnishing and decorating of leased space as long as the limits are not discriminatory and do not otherwise deny rights granted to tenants under applicable laws and regulations.

**§ 6100.445. Integration.**

A setting in which a support is provided shall be integrated in the community and the individual shall have the same degree of community access and choice as an individual who is similarly situated in the community, who does not have a disability and who does not receive a HCBS.

**§ 6100.446. Facility characteristics relating to size of facility.**

(a) A residential facility that serves primarily persons with a disability, which is funded in accordance with Chapter 51 (relating to Office of Developmental Programs home and community-based services) prior to the effective date of this chapter, shall not exceed a program capacity of eight.

(1) A duplex, two bi-level units and two side-by-side apartments are permitted as long as the total in both units does not exceed a program capacity of eight.

(2) With the Department's written approval, a residential facility with a program capacity of eight may move to a new location and retain the program capacity of eight.

(b) A residential facility that serves primarily persons with a disability, which is newly funded in accordance with this chapter on or after the effective date of this chapter, shall not exceed a program capacity of four.

(1) A duplex, two bi-level units and two side-by-side apartments are permitted as long as the total in both units does not exceed a program capacity of four.

(2) With the Department's written approval, an intermediate care facility for individuals with an intellectual disability licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) with a licensed capacity of five, six, seven or eight individuals may convert to a residential facility funded in accordance with this chapter exceeding the program capacity of four.

(c) A day facility that serves primarily persons with a disability, which is newly-funded in accordance with this chapter on or after March 17, 2019, including an adult training facility licensed in accordance with Chapter 2380 (relating to adult training facilities) and a vocational facility licensed in accordance with Chapter 2390 (relating to vocational facilities), shall not exceed a program capacity of 15 at any one time.

(1) The program capacity includes all individuals served by the facility including individuals funded through any funding source such as private-pay.

(2) No additional individuals funded through any funding source, including private pay, may be served in the day facility to exceed the program capacity of 15 individuals at any one time.

**§ 6100.447. Facility characteristics relating to location of facility.**

(a) A residential or day facility, which is newly-funded in accordance with this chapter on or after the effective date of this chapter, shall be not be located adjacent or in close proximity to the following:

- (1) Another human service residential facility,
- (2) Another human service day facility serving primarily persons with a disability.
- (3) A hospital.
- (4) A nursing facility.
- (5) A health or human service public or private institution.

(b) No more than 10% of the units in an apartment, condominium or townhouse development may be funded in accordance with this chapter.

(c) With the Department's written approval, a residential or day facility that is licensed in accordance with Chapters 2380, 2390, 6400 or 6500 prior to the effective date of this chapter and funded in accordance with Chapter 51 prior to the effective date of this chapter, may continue to be eligible for HCBS participation.

(d) With the Department's written approval, an intermediate care facility for individuals with an intellectual disability licensed in accordance with Chapter 6600 with a licensed capacity of 8 or fewer individuals may be eligible for HCBS participation.

## MEDICATION ADMINISTRATION

### § 6100.461. Self-administration.

- (a) The provider shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.
- (b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.
- (c) The provider shall provide or arrange for assistive technology to support the individual's self-administration of medications.
- (d) The PSP shall identify if the individual is unable to self-administer medications.
- (e) To be considered able to self-administer medications, an individual shall do all of the following:
  - (1) Recognize and distinguish the individual's medication.
  - (2) Know how much medication is to be taken.
  - (3) Know when the medication is to be taken. This knowledge may include reminders of the schedule and offering the medication at the prescribed times, as specified in subsection (b).
  - (4) Take or apply the individual's medication with or without the use of assistive technology.

**§ 6100.462. Medication administration.**

- (a) A provider whose staff persons or others are qualified to administer medications as specified in subsection (b), may provide medication administration for an individual who is unable to self-administer the individual's prescribed medication.
- (b) A prescription medication that is not self-administered shall be administered by one of the following:
- (1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
  - (2) A person who has completed the medication administration training as specified in § 6100.469 (relating to medication administration training) for the medication administration of the following:
    - (i) Oral medications.
    - (ii) Topical medications.
    - (iii) Eye, nose and ear drop medications.
    - (iv) Insulin injections.
    - (v) Epinephrine injections for insect bites or other allergies.
- (c) Medication administration includes the following activities, based on the needs of the individual:
- (1) Identify the correct individual.
  - (2) Remove the medication from the original container.
  - (3) Crush or split the medication as ordered by the prescriber.

- (4) Place the medication in a medication cup or other appropriate container or into the individual's hand, mouth or other route as ordered by the prescriber.
- (5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.
- (6) Injection of insulin or epinephrine in accordance with this chapter.

**§ 6100.463. Storage and disposal of medications.**

- (a) Prescription and nonprescription medications shall be kept in their original labeled containers.
- (b) A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.
- (c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.
- (d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.
- (e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.
- (f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.
- (g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

- (h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to the Department of Environmental Protection and applicable Federal and State regulations.
- (i) Subsections (a), (b), (c), (d) and (f) do not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom.

**§ 6100.464. Labeling of medications.**

The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- (1) The individual's name.
- (2) The name of the medication.
- (3) The date the prescription was issued.
- (4) The prescribed dosage and instructions for administration.
- (5) The name and title of the prescriber.

**§ 6100.465. Prescription medications.**

- (a) A prescription medication shall be prescribed in writing by an authorized prescriber.
- (b) A prescription order shall be kept current.
- (c) A prescription medication shall be administered as prescribed.
- (d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a registered nurse in accordance with regulations of the Department of State. The individual's medication record shall be updated as soon as a written notice of the change is received.

**§ 6100.466. Medication records.**

(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:

- (1) Individual's name.
- (2) Name and title of the prescriber.
- (3) Drug allergies.
- (4) Name of medication.
- (5) Strength of medication.
- (6) Dosage form.
- (7) Dose of medication.
- (8) Route of administration.
- (9) Frequency of administration.
- (10) Administration times.
- (11) Diagnosis or purpose for the medication, including pro re nata.
- (12) Date and time of medication administration.
- (13) Name and initials of the person administering the medication.
- (14) Duration of treatment, if applicable.
- (15) Special precautions, if applicable.

- (16) Side effects of the medication, if applicable.
- (b) The information in subsections (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.
- (c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.
- (d) The directions of the prescriber shall be followed.

**§ 6100.467. Medication errors.**

- (a) Medication errors include the following:
  - (1) Failure to administer a medication.
  - (2) Administration of the wrong medication.
  - (3) Administration of the wrong amount of medication.
  - (4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.
  - (5) Administration to the wrong person.
  - (6) Administration through the wrong route.
- (b) A medication error shall be immediately reported as an incident as specified in § 6100.401 (relating to types of incidents and timelines for reporting) and to the prescriber.
- (c) Documentation of medication errors and the prescriber's response shall be kept in the individual's record.

**§ 6100.468. Adverse reaction.**

- (a) If an individual has a suspected adverse reaction to a medication, the provider shall immediately consult a health care practitioner or seek emergency medical treatment.
- (b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction, and the action taken shall be documented.

**§ 6100.469. Medication administration training.**

- (a) A person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer the following:
  - (1) Oral medications.
  - (2) Topical medications.
  - (3) Eye, nose and ear drop medications.
- (b) A person may administer insulin injections following:
  - (1) Successful completion of the course specified in subsection (a).
  - (2) Successful completion of a Department-approved diabetes patient education program within the past 12 months.
- (c) A person may administer an epinephrine injection via an auto-injection device in response to anaphylaxis or another serious allergic reaction following:
  - (1) Successful completion of the course specified in subsection (a).
  - (2) Successful completion of training relating to the use of an auto-injection epinephrine injection device provided by a licensed, registered or certified health care professional within the past 12 months.

(d) A record of the training shall be kept including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

**§ 6100.470. Exception for family members.**

Sections 6100.461-463 (relating to self-administration, medication administration and storage and disposal of medications) and §§ 6100.466-469 do not apply to an adult relative of the individual who provides medication administration. An adult relative of the individual may administer medications to an individual without the completion of the Department-approved medications administration course.

**GENERAL PAYMENT PROVISIONS**

**§ 6100.481. Departmental rates and classifications.**

(a) A HCBS will be paid based on one of the following:

- (1) Fee schedule rates.
- (2) Cost-based rates.
- (3) Department-established fees for the ineligible portion of residential habilitation.
- (4) Managed care or other capitated payment methods.
- (5) Vendor goods and services.
- (6) A method established in accordance with a Federally-approved waiver, including a Federally-approved waiver amendment.

(b) The Department will establish a fee per unit of HCBS as a Department-established fee by publishing a notice in the *Pennsylvania Bulletin*.

(c) The fee is the maximum amount the Department will pay.

(d) The fee applies to a specific location and to a specific HCBS.

(e) The provider may not negotiate a different fee or rate with a county mental health and intellectual disability program if there is a fee or rate for the same HCBS at the specific HCBS location.

**§ 6100.482. Payment.**

(a) The Department will only pay for a HCBS in accordance with this chapter, Chapter 1101 (relating to general provisions), Chapter 1150 (medical assistance program payment policies), the Department's Federally-approved waivers and waiver amendments and the state plan.

(b) When a provision in Chapters 1101 or 1150 is inconsistent with this chapter, this chapter applies.

(c) The Department will only pay for a reimbursable HCBS up to the maximum amount, duration and frequency as specified in the individual's approved PSP and as delivered by the provider.

(d) If a HCBS is payable under a third-party medical resource, the provider shall bill the third-party medical resource in accordance with § 1101.64 (relating to third-party medical resources) before billing a Federal or State-funded program.

(e) If the HCBS is eligible under the state plan, the provider shall bill the program under the state plan before billing the HCBS waiver or State-funded programs.

(f) The provider shall document a third-party medical resource claim submission and denial for a HCBS under the state plan or a third-party medical resource agency.

(g) Medicaid payment, once accepted by the provider, constitutes payment in full.

(h) A provider who receives a supplemental payment for a support that is included as a support in the PSP, or that is eligible as a HCBS, shall return the supplemental payment to the payer. If the payment is for an activity that is beyond the supports specified in the PSP and for an activity that is not eligible as a HCBS, the private payment from the individual or another person is permitted.

(i) The Department will recoup payments that are not made in accordance with this chapter and the Department's Federally-approved waivers and waiver amendments.

**§ 6100.483. Title of a residential building.**

The title of a debt-free residential building owned by an enrolled provider shall remain with the enrolled provider.

**§ 6100.484. Provider billing.**

(a) The provider shall submit claims in accordance with § 1101.68 (relating to invoicing for services).

(b) The provider shall use the Department's information system, and forms specified by the Department, to submit claims.

(c) The provider shall only submit claims that are substantiated by documentation as specified in § 6100.226 (relating to documentation of support delivery).

(d) The provider shall not submit a claim for a support that is inconsistent with this chapter, inappropriate to an individual's needs or inconsistent with the individual's PSP.

**§ 6100.485. Audits.**

(a) The provider shall comply with the following audit requirements:

(1) 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards.

(2) The Single Audit Act of 1984 (31 U.S.C.A. §§ 7501-7507).

(3) Applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

(4) Applicable Federal and State statutes, regulations and audit requirements.

(b) A provider that is required to have a single audit or financial-related audit, as defined in Generally Accepted Government Auditing Standards, in accordance with 45 CFR 74.26 (relating to non-Federal audits) shall comply with the Federal audit requirements.

(c) The Department or the designated managing entity may require the provider to have the provider's auditor perform an attestation engagement in accordance with any of the following:

(1) Government Auditing Standards issued by the Comptroller General of the United States, known as Generally Accepted Government Auditing Standards.

(2) Standards issued by the Auditing Standards Board.

(3) Standards issued by the American Institute of Certified Public Accountants.

(4) Standards issued by the International Auditing and Assurance Standards Board.

(5) Standards issued by the Public Company Accounting Oversight Board.

(6) Standards of a successor organization to the organizations listed in paragraphs (1)—(5).

(d) The Department or the designated managing entity may perform an attestation engagement in accordance with subsection (c).

(e) A Federal or State agency may request the provider to have the provider's auditor perform an attestation engagement in accordance with subsection (c).

(f) The Department or the designated managing entity may perform non-audit services such as technical assistance or consulting engagements.

(g) The Department or the designated managing entity may conduct a performance audit in accordance with the standards in subsection (c).

(h) The Department, a designated managing entity, an authorized Federal agency or an authorized State agency may direct the provider to have a performance audit conducted in accordance with the standards in subsection (c).

(i) A provider that is not required to have a single audit during the Commonwealth fiscal year shall keep records in accordance with subsection (c).

(j) The Department or the designated managing entity may perform a fiscal review of a provider.

**§ 6100.486. Bidding.**

(a) For a supply or equipment over \$10,000, the provider shall obtain the supply or equipment using a process of competitive bidding or written estimates.

(b) The cost shall be the best price made by a prudent buyer.

(c) If a sole source purchase is necessary, the provider shall keep records supporting the justification for the sole source purchase.

(d) As used in this section, a "sole source purchase" is one for which only one bid is obtained.

**§ 6100.487. Loss or damage to property.**

If an individual's personal property is lost or damaged during the provision of a HCBS, the provider shall replace the lost or damaged property, or pay the individual the replacement value for the lost or damaged property, unless the damage or loss was the result of the individual's actions.

**FEE SCHEDULE**

**§ 6100.571. Fee schedule rates.**

(a) Fee schedule rates will be established by the Department using a market-based approach based on current data and independent data sources.

(b) The Department will refresh the market-based data used in subsection (a) to establish fee schedule rates at least every 3 years.

(c) The market-based approach specified in subsection (a) shall review and consider the following factors:

- (1) The support needs of the individuals.
- (2) Staff wages.
- (3) Staff-related expenses.
- (4) Productivity.
- (5) Occupancy.
- (6) Program expenses and administration-related expenses.
- (7) Geographic costs.
- (8) A review of Federally-approved HCBS definitions in the waiver and determinations made about cost components that reflect costs necessary and related to the delivery of each HCBS.

(9) A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.

(10) Other criteria that impact costs.

(d) The Department will publish as a notice in the *Pennsylvania Bulletin* the factors in subsection (c) used to establish the rates and the fee schedule rates for public review and comment.

(e) The Department will pay for fee schedule supports at the fee schedule rate determined by the Department.

## **COST-BASED RATES AND ALLOWABLE COSTS**

### **§ 6100.641. Cost-based rate.**

(a) Sections 6100.642-6100.672 (relating to cost-based rates and allowable costs) apply to cost-based rates.

(b) A HCBS eligible for reimbursement in accordance with §§ 6100-642 -- 6100.672 includes residential habilitation and transportation.

### **§ 6100.642. Assignment of rate.**

(a) The provider will be assigned a cost-based rate for an existing HCBS at the location where the HCBS is delivered, with an approved cost report and audit, as necessary.

(b) If the provider seeks to provide a new HCBS, the provider will be assigned the area adjusted average rate of approved provider cost-based rates.

(c) A new provider with no historical experience will be assigned the area adjusted average rate of approved provider cost-based rates.

(d) If the provider fails to comply with the cost reporting requirements specified in this chapter after consultation with the Department, the provider will be assigned the lowest rate calculated statewide based on all provider cost-based rates for a HCBS.

(e) Compliance with cost reporting requirements will be verified by the Department through a designated managing agency review or an audit, as necessary.

**§ 6100.643. Submission of cost report.**

(a) A cost report is a data collection tool issued by the Department to collect expense and utilization information from a provider that may include supplemental schedules or addenda as requested by the Department.

(b) The provider shall submit a cost report on a form specified by and in accordance with the instructions provided by the Department.

(c) Unless a written extension is granted by the Department, the cost report or the cost report addenda shall be submitted to the Department on or before the last Thursday in October for residential habilitation and on or before the last business day in the third week of February for transportation.

(d) A provider with one master provider index number shall submit one cost report for the master provider index number.

(e) A provider with multiple master provider index numbers may submit one cost report for all of its master provider index numbers or separate cost reports for each master provider index number.

(f) The provider shall submit a revised cost report if the provider's audited financial statement is materially different from a provider's cost report by more than 1%.

**§ 6100.644. Cost report.**

- (a) The provider shall complete the cost report to reflect the actual cost and the allowable administrative cost of the HCBS provided.
- (b) The cost report shall contain information for the development of a cost-based rate as specified on the Department's form.
- (c) A provider of a cost-based service shall allocate eligible and ineligible allowable costs in accordance with the applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

**§ 6100.645. Rate-setting.**

- (a) The Department will use the cost-based rate-setting methodology to establish a rate for cost-based services for each provider with a Department-approved cost report.
- (b) The approved cost report will be used as the initial factor in the rate setting methodology to develop the allowable costs for cost-based services.
- (c) The provider shall complete the cost report in accordance with this chapter.
- (d) The cost data submitted by the provider on the approved cost report will be used to set the rates.
- (e) The Department will adjust the cost report form and instructions based on changes in the support definitions in the Federally-approved waivers and waiver amendments, from the prior cost reporting period.
- (f) Prior to the effective date of the rates, the Department will publish as a notice in the *Pennsylvania Bulletin* the cost-based rate-setting methodology, including the cost report review, outlier analysis, vacancy factor and rate assignment processes.

**§ 6100.646. Cost-based rates for residential habilitation.**

- (a) The Department will review unit costs reported on a cost report.
- (b) The Department will identify a unit cost as an outlier when that unit cost is at least one standard deviation outside the average unit cost as compared to other cost reports submitted.
- (c) The Department will apply a vacancy factor to residential habilitation rates.
- (d) A provider may request additional staffing costs above what is included in the Department-approved cost report rate for current staffing if there is a new individual entering the program who has above-average staffing needs or if an individual's needs have changed significantly as specified in the individual's PSP.

**§ 6100.647. Allowable costs.**

- (a) A cost shall be the best price made by a prudent buyer.
- (b) A cost shall relate to the administration or provision of the HCBS.
- (c) A cost shall be allocated and distributed to various HCBS or other lines of business among cost categories in a reasonable and fair manner and in proportion with the benefits provided to the HCBS or other lines of business among cost categories.
- (d) Allowable costs shall include costs specified in this chapter and costs that are in accordance with the Department's Federally-approved waivers and waiver amendments.
- (e) To be an allowable cost, the cost shall be documented and comply with the following:
  - (1) Applicable Federal and State statutes, regulations and policies.

(2) Generally Accepted Government Auditing Standards and applicable Departmental procedures.

(f) A cost used to meet cost sharing or matching requirements of another Federally-funded program in either the current or a prior period adjustment is not allowable.

(g) Transactions involving allowable costs between related parties shall be disclosed on the cost report.

**§ 6100.648. Donations.**

(a) A provider shall not report a donation that is restricted for a purpose other than for an allowable HCBS cost, and a donation that is unrestricted, but not used for an allowable HCBS cost.

(b) If an unrestricted donation is used for an allowable HCBS cost, the provider shall claim an expense and offsetting revenue for the donation.

(c) The provider shall report unrestricted donations used for a HCBS in accordance with the following:

(1) List the cash donation that benefits the direct or indirect expenditures on the cost report as income.

(2) Reduce gross eligible expenditures in calculating the amount eligible for Departmental participation by the amount of the donation.

(3) Fully disclose a noncash donation that exceeds \$1,000.00, either individually or in the aggregate, including the estimated value and intended use of the donated item.

(4) If a donated item is sold, treat the proceeds from the sale as an unrestricted cash donation.

**§ 6100.649. Management fees.**

A cost included in the provider's management fees must meet the standards in § 6100.647 (relating to allowable costs).

**§ 6100.650. Consultants.**

(a) The cost of an independent consultant necessary for the administration or provision of a HCBS is an allowable cost.

(b) The provider shall have a written agreement with a consultant. The written agreement shall include the following:

- (1) The administration or provision of the HCBS to be provided.
- (2) The rate of payment.
- (3) The method of payment.

(c) The provider shall not include benefits as an allowable cost for a consultant.

**§ 6100.651. Governing board.**

(a) Compensation for governing board member duties is not an allowable cost.

(b) Allowable costs for a governing board member include the following:

(1) Meals, lodging and transportation while participating in a board meeting or function.

(2) Liability insurance coverage for a claim against a board member that was a result of the governing board member performing official governing board duties.

(3) Training related to the delivery of a HCBS.

(c) Allowable expenses for governing board meals, lodging and transportation, paid through HCBS funding, shall be limited to the Commonwealth-established reimbursement limits applicable for Commonwealth employees.

(1) Nothing in this subsection restricts the amount supplemented by the provider.

(2) Nothing in this subsection applies Commonwealth-established policies and practices beyond the reimbursement limits for meals, lodging and transportation.

**§ 6100.652. Compensation.**

(a) Compensation for staff persons, including pension, health care and accrued leave benefits, is an allowable cost.

(b) A bonus or severance payment, that is part of a separation package, is not an allowable cost.

(c) Internal Revenue Service statutes and regulations and applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget apply regarding compensation, benefits, bonuses and severance payments.

**§ 6100.653. Training.**

The cost of training related to the delivery of a HCBS is an allowable cost.

**§ 6100.654. Staff recruitment.**

The cost relating to staff recruitment is an allowable cost.

**§ 6100.655. Travel.**

(a) A travel cost, including meals, lodging and transportation, is allowable.

(b) Allowable expenses for meals, lodging and transportation, paid through HCBS funding, shall be limited to the Commonwealth-established reimbursement limits applicable for Commonwealth employees.

(1) Nothing in this subsection restricts the amount supplemented by the provider.

(2) Nothing in this subsection applies Commonwealth-established policies and practices beyond the reimbursement limits for meals, lodging and transportation.

**§ 6100.656. Supplies.**

The purchase of a supply is an allowable cost if the supply is used in the normal course of business and purchased in accordance with applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

**§ 6100.657. Rental equipment and furnishing.**

Rental of equipment or furnishing is an allowable cost if the rental is more cost-efficient than purchasing.

**§ 6100.658. Communication.**

The following communication costs that support the administration or provision of an HCBS are allowable costs:

- (1) Telephone.
- (2) Internet connectivity.
- (3) Digital imaging.
- (4) Postage.
- (5) Stationary.

(6) Printing.

**§ 6100.659. Rental of administrative space.**

(a) The cost of rental of an administrative space, from a related or unrelated party for a programmatic purpose for a HCBS, is allowable, subject to the following:

(1) A new lease with an unrelated party shall contain a provision that the cost of rent may not exceed the rental charge for similar space in that geographical area.

(2) The cost of rent under a lease with a related party is limited to the lessor's actual allowable costs, as provided in § 6100.663 (relating to fixed assets for administrative buildings).

(3) The rental cost under a sale-leaseback transaction, as described in Financial Accounting Standards Board Accounting Standards Codification Section 840-40, as amended, is allowable up to the amount that would have been allowed had the provider continued to own the property.

(b) The allowable cost amount may include an expense for the following:

(1) Maintenance.

(2) Real estate taxes, as limited by § 6100.660 (relating to occupancy expenses for administrative buildings).

(c) The provider shall only include expenses related to the minimum amount of space necessary for the provision of the HCBS.

(d) A rental cost under a lease which is required to be treated as a capital lease under the Financial Accounting Standards Board Accounting Standards Codification Section 840-10-25-1, as amended, is allowable up to the amount that would have been

allowed had the provider purchased the property on the date the lease agreement was executed.

(e) An unallowable cost includes the following:

- (1) Profit.
- (2) Management fee.
- (3) A tax not incurred had the provider purchased the space.

**§ 6100.660. Occupancy expenses for administrative buildings.**

(a) The following costs are allowable costs for administrative buildings:

(1) The cost of a required occupancy-related tax and payment made instead of a tax.

(2) An associated occupancy cost charged to a specified service location. The associated occupancy cost shall be prorated in direct relation to the amount of space utilized by the service location.

(3) The cost of an occupancy-related tax or payment made instead of a tax, if it is stipulated in a lease agreement.

(4) The cost of a certificate of occupancy.

(b) The provider shall keep documentation that a utility charge is at fair market value.

(c) The cost of real estate taxes, net of available rebates and discounts, whether the rebate or discount is taken, is an allowable cost.

(d) The cost of a penalty resulting from a delinquent tax payment, including a legal fee, is not an allowable cost.

**§ 6100.661. Fixed assets.**

(a) A fixed asset cost is an allowable cost.

(b) The provider shall determine whether an allowable fixed asset shall be capitalized, depreciated or expensed in accordance with the following conditions:

(1) The maximum allowable fixed asset threshold as defined in applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

(2) Purchases below the maximum allowable fixed asset threshold shall be expensed.

(c) The provider shall select the method used to determine the amount of depreciation charged in that year for the year of acquisition.

(d) The provider shall include depreciation based on the number of months or quarters the asset is in service or a half-year or full-year of depreciation expense.

(e) The provider may not change the method or procedure, including the estimated useful life and the convention used for an acquisition, for computing depreciation without prior written approval from the Department.

(f) The provider acquiring a new asset shall have the asset capitalized and depreciated in accordance with the Generally Accepted Government Auditing Standards. The provider shall continue using the depreciation method previously utilized by the provider for assets purchased prior to July 1, 2011.

(g) The provider shall keep the following:

(1) The title to any fixed assets that are depreciated.

(2) The title to any fixed assets that are expensed or loans amortized using Department funding.

(h) The provider shall use income received when disposing of fixed assets to reduce gross eligible expenditures in determining the amount eligible for Departmental participation as determined by the cost report.

(i) A provider in possession of a fixed asset shall do the following:

(1) Maintain a fixed asset ledger or equivalent document.

(2) Utilize reimbursement for loss, destruction or damage of a fixed asset by using the proceeds towards eligible waiver program expenditures.

(3) Perform an annual physical inventory at the end of the funding period or Commonwealth fiscal year. An annual physical inventory is performed by conducting a physical verification of the inventory listings.

(4) Document discrepancies between physical inventories or fixed asset ledgers.

(5) Maintain inventory reports and other documents in accordance with this chapter.

(6) Offset the provider's total depreciation expense in the period in which the asset was sold or retired from service by the gains on the sale of assets.

(j) The cost basis for depreciable assets must be determined and computed as follows:

(1) The purchase price if the sale was between unrelated parties.

(2) The seller's net book value at the date of transfer for assets transferred between related parties.

(3) The cost basis for assets of an agency acquired through stock purchase will remain unchanged from the cost basis of the previous owner.

(k) Participation allowance is permitted up to 2% of the original acquisition cost for fully depreciated fixed assets.

(1) Participation allowances shall only be taken for as long as the asset is in use.

(2) Participation amounts shall be used for maintaining assets, reinvestment in the program or restoring the program due to an unforeseen circumstance.

(3) Depreciation and participation allowance may not be expensed at the same time for the same asset.

#### **§ 6100.662. Motor vehicles.**

The cost of the purchase or lease of motor vehicles and the operating costs of the vehicles is an allowable cost in accordance with the following:

(1) The cost of motor vehicles through depreciation, expensing or amortization of loans for the purchase of a vehicle is an allowable expense. Depreciation and lease payments are limited in accordance with the annual limits established under section 280F of the Internal Revenue Code (26 U.S.C.A. § 280F).

(2) The provider shall keep a daily log detailing the use, maintenance and services activities of vehicles.

(3) The provider shall analyze the cost differences between leasing and purchase of vehicles and the most practicable economic alternative shall be selected.

(4) The provider shall keep documentation of the cost analysis.

(5) The personal use of the provider's motor vehicles is prohibited unless a procedure for payback is established and the staff person reimburses the program for the personal use of the motor vehicle.

**§ 6100.663. Fixed assets of administrative buildings.**

(a) An administrative building acquired prior to June 30, 2009, that is in use for which the provider has an outstanding original loan with a term of 15 years or more is an allowable cost for the provider to continue to claim principal and interest payments for the administrative or nonresidential building over the term of the loan.

(b) The provider shall ensure a down payment made as part of the asset purchase shall be considered part of the cost of the administrative building or capital improvement and depreciated over the useful life of the administrative building or capital improvement.

(c) The provider shall receive prior written approval from the Department for a planned major renovation of an administrative building with a cost above 25% of the original cost of the administrative building being renovated.

(d) The provider shall use the depreciation methodology in accordance with § 6100.661 (relating to fixed assets).

(e) The provider shall not claim a depreciation allowance on an administrative building that is donated.

(f) If an administrative building is sold or the provider no longer utilizes the administrative building for a HCBS, the Department shall recoup the funded equity either directly or through rate setting. As used in this subsection, "funded equity" is the value of property over the liability on the property.

(1) The provider shall be responsible for calculating the amounts reimbursed and the amounts shall be verified by an independent auditor.

(2) As an alternative to recoupment, with Department approval, the provider may reinvest the reimbursement amounts from the sale of the administrative or nonresidential building into any capital asset used in the program.

(g) The title of any administrative building acquired and depreciated shall remain with the enrolled provider.

**§ 6100.664. Residential habilitation vacancy.**

(a) The Department will establish a vacancy factor for residential habilitation that is included in the cost-based rate setting methodology.

(b) The vacancy factor for residential habilitation shall be calculated based on all the provider's residential habilitation locations.

(c) The provider may not limit the individual's leave days.

(d) The grounds for a change in a provider or a transfer of an individual against the individual's wishes under § 6100.303 (relating to reasons for a transfer or change in a provider) do not apply to a transfer under subsection (e).

(e) The provider may not transfer an individual due to the individual's absence until after the provider has received written approval from the Department.

**§ 6100.665. Indirect costs.**

(a) An indirect cost is an allowable cost if the following criteria are met:

(1) The provider shall have a cost allocation plan.

(2) Costs are authorized in accordance with applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget and § 6100.647 (relating to allowable costs).

(b) The provider shall consider the reason the cost is an indirect cost, as opposed to a direct cost, to determine the appropriate cost allocation based on the benefit to the HCBS.

(c) If a cost is identified as an indirect cost, the cost will remain an indirect cost as long as circumstances remain unchanged.

(d) The provider shall select an allocation method to assign an indirect cost in accordance with the following:

(1) The method is best suited for assigning a cost with a benefit derived.

(2) The method has a traceable cause and effect relationship.

(3) The cost cannot be directly attributed to a HCBS.

(e) The provider shall allocate a general expense in a cost group that is more general in nature to produce a result that is equitable to both the Department and the provider.

**§ 6100.666. Moving expenses.**

(a) The actual cost associated with the relocation of a waiver support location is allowable.

(b) Moving expenses for an individual is allowable if the provider receives approval from the Department or the designated managing entity prior to the move.

**§ 6100.667. Interest expense.**

(a) Short-term borrowing is a debt incurred by a provider that is due within 1 year.

(b) Interest cost of short-term borrowing from an unrelated party to meet actual cash flow requirements for the administration or provision of an HCBS is an allowable cost.

**§ 6100.668. Insurance.**

The cost for an insurance premium is allowable if it is limited to the minimum amount needed to cover the loss or provide for replacement value, including the following:

- (1) General liability.
- (2) Casualty.
- (3) Property.
- (4) Theft.
- (5) Burglary insurance.
- (6) Fidelity bonds.
- (7) Rental insurance.
- (8) Flood insurance, if required.
- (9) Errors and omissions.

**§ 6100.669. Other allowable costs.**

(a) The following costs are allowable if they are related to the administration of HCBS:

- (1) Legal fees with the exception of those listed in subsection (b).
- (2) Accounting fees, including audit fees.
- (3) Information technology costs.
- (4) Professional membership dues for the provider, excluding dues or contributions paid to lobbying groups.
- (5) Self-advocacy or advocacy organization dues for an individual, excluding dues or contributions paid to lobbying groups. This does not include dues paid to an organization that has as its members, or is affiliated with an organization that represents, individuals or entities that are not self-advocates or advocates.

(b) Legal fees for prosecution of claims against the Commonwealth and expenses incurred for claims against the Commonwealth are not allowable unless the provider prevails at the hearing.

**§ 6100.670. Start-up cost.**

(a) A start-up cost shall be utilized only for a one-time activity related to one of the following:

- (1) Opening a new location.
- (2) Introducing a new product or support.
- (3) Conducting business in a new geographic area.
- (4) Initiating a new process.
- (5) Commencing a new operation.

(b) Within the approved waiver appropriation, a start-up cost may be approved and authorized by the Department in accordance with the Department's Federally-approved waivers and waiver amendments.

(c) A start-up cost shall be authorized in accordance with Standard Operating Procedure 98-5 issued by the American Institute of Certified Public Accountants (SOP 98-5), as amended.

**§ 6100.671. Reporting of start-up cost.**

(a) A start-up cost that has been reimbursed by the Department shall be reported as income.

(b) A start-up cost within the scope of Standard Operating Procedure 98-5 shall be expensed as the costs are incurred, rather than capitalized.

**§ 6100.672. Cap on start-up cost.**

- (a) A cap on start-up cost will be established by the Department.
- (b) A request for a waiver in accordance with § 6100.43 (relating to regulatory waiver) may be requested if the waiver conditions in § 6100.43 and one of the following conditions are met:
  - (1) The start-up cost provides greater independence and access to the community.
  - (2) The start-up cost is necessary to meet life safety code standards.
  - (3) The cost of the start-up activity is more cost effective than an alternative approach.

**ROOM AND BOARD**

**§ 6100.681. Room and board applicability.**

Sections 6100.682-6100.694 apply for the room and board rate charged to the individual for residential habilitation.

**§ 6100.682. Support to the individual.**

- (a) If an individual is not currently receiving SSI benefits, the provider shall provide support to the individual to contact the appropriate county assistance office.
- (b) If an individual is denied SSI benefits, the provider shall assist the individual in filing an appeal, if desired by the individual.
- (c) The provider shall assist the individual to secure information regarding the continued eligibility of SSI for the individual.

**§ 6100.683. No delegation permitted.**

The provider shall collect the room and board from the individual or the person designated by the individual directly and shall not delegate that responsibility.

**§ 6100.684. Actual provider room and board cost.**

(a) The total amount charged for the individual's share of room and board shall not exceed the actual documented value of room and board provided to the individual, minus the benefits received as specified in § 6100.685 (relating to benefits).

(b) The provider shall compute and document actual provider room and board costs each time an individual signs a new room and board residency agreement.

(c) The provider shall keep documentation of actual provider room and board costs.

**§ 6100.685. Benefits.**

(a) The provider shall assist an individual in applying for energy assistance, rent rebates, food stamps and similar benefits.

(b) If energy assistance, rent rebates, food stamps or similar benefits are received, the provider shall deduct the value of these benefits from the documented actual provider room and board cost as specified in § 6100.684 (relating to actual provider room and board costs) before deductions are made to the individual's share of room and board costs.

(c) An individual's energy assistance, rent rebates, food stamps or similar benefits shall not be considered as part of an individual's income or resources.

(d) The provider shall not use the value of energy assistance, rent rebates, food stamps or similar benefits to increase the individual's share of room and board costs

beyond actual room and board costs as specified in § 6100.684 (relating to actual provider room and board cost).

**§ 6100.686. Room and board rate.**

(a) If the actual provider room and board cost as specified in § 6100.684 (relating to actual provider room and board cost), less any benefits as specified in § 6100.685 (relating to benefits), is more than 72% of the SSI maximum rate, the following criteria shall be used to establish the room and board rate:

(1) An individual's share of room and board shall not exceed 72% of the SSI maximum rate.

(2) The proration of board costs shall occur after an individual is on leave from the residence for a consecutive period of 8 or more days. This proration may occur monthly, quarterly or semiannually, as long as there is a record of the board costs that were returned to the individual.

(d) If an individual has earned wages, personal income from inheritance, Social Security or other types of income, the provider may not assess the room and board cost for the individual in excess of 72% of the SSI maximum rate.

(e) If available income for an individual is less than the SSI maximum rate, the provider shall charge 72% of the individual's available monthly income as the individual's monthly obligation for room and board.

(f) An individual shall receive at least the monthly amount as established by the Commonwealth and the Social Security Administration for the individual's personal needs allowance.

**§ 6100.687. Documentation.**

If the actual provider room and board cost charged to an individual as specified in § 6100.684 (relating to actual provider room and board cost) is less than 72% of the SSI maximum rate, the provider shall keep the following documentation:

- (1) The actual value of the room and board is less than 72% of the current maximum SSI monthly benefit.
- (2) The Social Security Administration's initial denial of the individual's initial application for SSI benefits and the upholding of the initial denial through at least one level of appeal.

**§ 6100.688. Completing and signing the room and board residency agreement.**

(a) The provider shall ensure that a room and board residency agreement, on a form specified by the Department, is completed and signed by the individual annually.

(b) If an individual is adjudicated incompetent to handle finances, the individual's court-appointed legal guardian shall sign the room and board residency agreement.

(c) If an individual is 18 years of age or older and has a designated person for the individual's benefits, the designated person and the individual shall sign the room and board residency agreement.

(d) The room and board residency agreement shall be completed and signed in accordance with one of the following:

- (1) Prior to an individual's admission to residential habilitation.
- (2) Prior to an individual's transfer from one residential habilitation location or provider to another residential habilitation location or provider.
- (3) Within 15 days after an emergency residential habilitation placement.

**§ 6100.689. Modifications to the room and board residency agreement.**

(a) If an individual pays rent directly to a landlord, but food is supplied through a provider, the room provisions shall be deleted from the room and board residency agreement and the following shall apply:

- (1) The individual shall pay 32% of the SSI maximum rate for board.
- (2) If an individual's income is less than the SSI maximum rate, 32% of the available income shall be charged to fulfill the individual's monthly obligations for board.

(b) If an individual pays rent to a provider, but the individual purchases the individual's own food, the board provisions shall be deleted from the room and board residency agreement and the following shall apply:

- (1) The individual shall pay 40% of the SSI maximum rate for room.
- (2) If an individual's income is less than the SSI maximum rate, 40% of the available income shall be charged to fulfill the individual's monthly obligations for room.

**§ 6100.690. Copy of room and board residency agreement.**

(a) A copy of the completed and signed room and board residency agreement shall be given to the individual, the individual's designated person and the individual's court-appointed legal guardian, if applicable.

(b) A copy of the completed and signed room and board residency agreement shall be kept in the individual's record.

**§ 6100.691. Respite care.**

There shall not be a charge for room and board to the individual for respite care if respite care is provided for 30 or fewer days in a Commonwealth fiscal year.

**§ 6100.692. Hospitalization.**

There shall not be a charge for room and board to the individual after 30 consecutive days of being in a hospital or rehabilitation facility and the individual is placed in reserved capacity.

**§ 6100.693. Exception.**

There shall be no charge for board to the individual if the individual takes no food by mouth.

**§ 6100.694. Delay in an individual's income.**

If a portion or all of the individual's income is delayed for 1 month or longer, the following apply:

(1) The provider shall inform the individual, the individual's designated person or the individual's court-appointed legal guardian in writing that payment is not required or that only a small amount of room and board payments is required until the individual's income is received.

(2) Room and board shall be charged to make up the accumulated difference between room and board paid and room and board charged according to the room and board residency agreement.

## DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION

### § 6100.711. Fee for the ineligible portion of residential habilitation.

- (a) The Department will establish a fee for the ineligible portion of payment for residential habilitation services.
- (b) The Department-established fee will be established using a market-based approach based on current data and independent data sources.
- (c) The Department will refresh the market-based data used in subsection (a) to establish Department-established fees at least every 3 years.
- (d) The market-based approach specified in subsection (c) shall review and consider the following factors:
  - (1) The support needs of the individuals.
  - (2) Staff wages.
  - (3) Staff-related expenses.
  - (4) Productivity.
  - (5) Occupancy.
  - (6) Custodial and maintenance expenses.
  - (7) Geographic costs.
  - (8) A review of approved HCBS definitions and determinations made about cost components that reflect costs necessary and related to the delivery of each HCBS.
  - (9) A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.

- (10) Other criteria that impact costs.
- (e) The Department will publish as a notice in the *Pennsylvania Bulletin* the factors in subsection (d) used to establish the rates and the fee schedule rates for public review and comment
- (f) The Department will pay for Department-established fee supports at the fees determined by the Department.

## ENFORCEMENT

### § 6100.741. Sanctions.

- (a) The Department has the authority to enforce compliance with this chapter through an array of sanctions.
- (b) A sanction may be implemented by the Department for the following:
  - (1) One or more regulatory violations of this chapter.
  - (2) Failure to submit an acceptable corrective action plan in accordance with the timeframe specified by the Department and as specified § 6100.42(e) (relating to monitoring compliance).
  - (3) Failure to implement a corrective action plan or a directed corrective action plan, including the compliance steps and the timelines in the plan.
  - (4) Fraud, deceit or falsification of documents or information related to this chapter.
  - (5) Failure to provide free and full access to the Department, the designated managing entity or other authorized Federal or State officials.

(6) Failure to provide documents or other information in a timely manner upon the request of the Department, the designated managing entity or an authorized Federal or State agency.

**§ 6100.742. Array of sanctions.**

The Department may implement the following sanctions:

- (1) Recouping, suspending or disallowing payment.
- (2) Terminating a provider agreement for participation in a HCBS waiver program.
- (3) Prohibiting the delivery of supports to a new individual.
- (4) Prohibiting the provision of specified supports at a specified location.
- (5) Prohibiting the enrollment of a new support location.
- (6) Ordering the appointment of a master as approved by the Department, at the provider's expense and not eligible for reimbursement from the Department, to manage and direct the provider's operational, program and fiscal functions.
- (7) Removing an individual from a premise.

**§ 6100.743. Consideration as to type of sanction utilized.**

(a) The Department has full discretion to determine and implement the type of sanction it deems appropriate in each circumstance specified in § 6100.741(b) (relating to sanctions).

(b) The Department has the authority to implement a single sanction or a combination of sanctions.

(c) The Department may consider the following variables when determining and implementing a sanction or combination of sanctions:

- (1) The seriousness of the condition specified in § 6100.741(b).
- (2) The continued nature of the condition specified in § 6100.741(b).
- (3) The repeated nature of the condition specified in § 6100.741(b).
- (4) A combination of the conditions specified in § 6100.741(b).
- (5) The history of provisional licenses issued by the Department.
- (6) The history of compliance with this chapter, Departmental regulations such as licensure regulations and applicable regulations of other State and Federal agencies.

**§ 6100.744. Additional conditions and sanctions.**

In addition to sanctions and sanction conditions specified in this chapter, the provider shall be subject to the following:

- (1) Sections 1101.74- 1101.77.
- (2) Other Departmental sanctions as provided by applicable law.

**SPECIAL PROGRAMS**

**§ 6100.801. Adult autism waiver.**

(a) The adult autism waiver is a HCBS Federal waiver program under Section 1915(c) of the Social Security Act designed to provide community-based supports to meet the specific needs of adults with autism spectrum disorders.

(b) The following requirements of this chapter do not apply to the adult autism waiver program:

- (1) Section 6100.441 (relating to request for and approval of changes) does not apply to the adult autism waiver program.
- (2) Section 6100.481(d) (relating to departmental rates and classifications).
- (3) Section 6100.571 (c)(5) (relating to fee schedule rates).

(4) Sections 6100.641-6100.672.

(5) Section 6100.711(d)(7) (relating to fees for the ineligible portion of residential habilitation).

**§ 6100.802. Agency with choice.**

(a) AWC is a type of individual-directed, financial management service in which the agency is the common law employer and the individual or his representative is the managing employer.

(b) The requirements in this chapter do not apply to AWC, with the exception of the following provisions:

(1) General provisions as specified at §§ 6100.1-6100.3.

(2) General requirements as specified at §§ 6100.41-6100.44 and 6100.46-6100.55.

(3) Training as specified at §§ 6100.141-6100.144.

(4) Individual rights as specified at §§ 6100.181-6100.6100.186.

(5) PSP as specified at §§ 6100.221-6100.6100.224.

(6) Positive interventions as specified at §§ 6100.341-6100.345.

(7) Incident management as specified at §§ 6100.401-6100.405.

(c) The AWC shall ensure that the managing employer complies with the requirements of the managing employer agreement.

(d) The AWC shall fulfill unmet responsibilities of the managing employer.

(e) The AWC shall identify and implement corrective action for managing employer performance in accordance with the managing employer agreement.

(f) The AWC shall develop and implement procedures to ensure that the managing employer reports incidents in accordance with this chapter.

(g) The AWC shall process and provide vendor goods and services authorized by the Department or the designated managing entity covered by the monthly per individual administrative fee.

(h) The AWC shall distribute a customer satisfaction survey to individuals who receive the financial management services, collect and analyze survey responses and act to improve services.

(i) If an AWC intends to close, a written notice shall be provided to the Department at least 60 days prior to the planned closure date. The written notice shall include the following:

(i) The effective date of closure.

(ii) A transition plan for each individual that affords choice.

(j) If an AWC intends to close, the provider shall complete the following duties:

(i) Provide suggested timeframes for transitioning the individual to a new provider.

(ii) Continue to provide financial management services to individuals in accordance with this chapter and the managing employer agreement until the date of the closure or until the Department directs otherwise.

(iii) Notify each individual in writing of the closure.

(iv) Prepare individual records for transfer to the selected provider within 14 days of the selected provider's accepting the transfer.

(v) Maintain data and records in accordance with this chapter until the date of the transfer.

(k) As used in this section, AWC is agency with choice.

**§ 6100.803. Support coordination, TSM and base-funded support coordination.**

(a) Support coordination is a HCBS Federal waiver program under Section 1915(c) of the Social Security Act designed to provide community-based support to locate, coordinate and monitor needed HCBS and other support for individuals.

(b) TSM is a service under the state plan that is designed to provide community-based support to locate, coordinate and monitor needed support for an individual. TSM is not a HCBS.

(c) Base-funded support coordination is a program designed to provide community-based support to locate, coordinate and monitor needed support for individuals who receive support through base-funding.

(d) The following requirements of this chapter do not apply to support coordination, TSM or base-funded support coordination.

- (1) Section 6100.81(b)(4) (relating to HCBS provider requirements).
- (2) Section 6100.226(d)(6) (relating to documentation of support delivery).
- (3) Section 6100.441 (relating to request for and approval of changes).
- (4) Sections 6100.461-6100.470.
- (5) Sections 6100.641-6100.711.
- (6) Section 6100.806 (relating to vendor goods and services).

(e) In addition to this chapter, the following requirements apply for support coordination, TSM and base-funded support coordination.

(1) In addition to the training and orientation required in §§ 6100.141-6100.143 (relating to annual training plan; orientation program; and annual training), a support coordinator, targeted support manager, support coordinator supervisor, and targeted support manager supervisor shall complete the following training within the first year of employment:

- (i) Facilitation of person-centered planning.
- (ii) Conflict resolution.
- (iii) Human development over the lifespan.
- (iv) Family dynamics.
- (v) Cultural diversity.

(2) A support coordinator, targeted support manager, support coordinator supervisor and targeted support manager supervisor shall report incidents, alleged incidents and suspected incidents as specified in §§ 6100.401-6100.403 (relating to types of incidents and timelines for reporting; incident investigation; and individual needs), that the coordinator, manager or supervisor observes directly.

(3) If an individual is authorized for residential habilitation, the support coordinator or targeted support manager shall review and document if the individual continues to need the authorized level of residential habilitation, every 6 months.

(4) If an individual is authorized for residential habilitation and a request for enhanced staffing is received, the support coordinator or targeted support manager shall review and document the following:

- (i) The individual's need, and any change in need, including how the change affects the individual's health, safety and well-being.

- (ii) Assessments used to support the need for enhanced staffing.
- (iii) The specific enhanced staffing that will be provided to address the individual's needs.
- (iv) The plan to reduce the enhanced staffing based on specific outcomes of the individual.
- (v) The time frame and the staff person responsible for monitoring progress on the plan to reduce enhanced staffing.
- (vi) The results of meetings held to re-evaluate the need for continued enhanced staffing.

(5) If a support coordination or TSM provider intends to close, a written notice shall be provided to the Department at least 90 days prior to the planned closure date.

The written notice shall include the following:

- (i) The effective date of closure.
- (ii) The intent to terminate the medical assistance provider agreement and the medical assistance waiver provider agreement.
- (iii) A transition plan for each individual that affords individual choice.
- (iv) A transition plan to transfer the provider's functions.

(6) If a support coordination or TSM provider intends to close, the provider shall complete the following duties:

- (i) Continue to provide support coordination, TSM or base-funded support coordination to individuals in accordance with this chapter until the date of the transfer or until the Department directs otherwise.

(ii) Transfer an individual to the selected provider only after the Department or the designated managing entity approves the individual's transition plan.

(iii) Prepare individual records for transfer to the selected provider within 14 days of the selected provider's accepting the transfer.

(iv) Maintain data and records in accordance with this chapter until the date of the transfer.

**§ 6100.804. Organized health care delivery system.**

(a) An OHCDs is an arrangement in which a provider that renders a HCBS, chooses to offer a different vendor of a HCBS through a subcontract, to facilitate the delivery of vendor goods or services to an individual.

(b) The following requirements of this chapter do not apply to an OHCDs:

(1) Section 6100.571 (relating to fee schedule rates).

(2) Sections 6100.641-6100.711.

(3) Section 6100.806 (relating to vendor goods and services).

(c) In addition to this chapter, the following requirements apply for OHCDs.

(1) The OHCDs shall:

(i) Be an enrolled medical assistance waiver provider.

(ii) Be enrolled in the MMIS.

(iii) Provide at least one medical assistance service.

(iv) Agree to provide the identified vendor goods or services to individuals.

(v) Bill the MMIS for the amount of the vendor goods or services.

(vi) Pay the vendor that provided the vendor goods or services the amount billed for in the MMIS.

(2) An OHCDSD may bill a separate administrative fee under the following:

(i) The administrative fee may not exceed the limit set by Federal requirements.

(ii) The administrative activities must be required to deliver the vendor good or HCBS to an individual and must be documented to support the separate administrative fee.

(3) The OHCDSD shall ensure that each vendor with which it contracts meets the applicable provisions of this chapter and in accordance with the requirements specified in the Department's Federally-approved waivers and waiver amendments, and the state plan, as applicable.

(4) Only vendor goods and services may be subcontracted through the OHCDSD. A provider who subcontracts shall have written agreements specifying the duties, responsibilities and compensation of the subcontractor.

(5) An OHCDSD shall provide the Department with an attestation that the cost of the good or service is the same or less as the cost charged to the general public.

(c) As used in this section:

(1) "OHCDSD" is an organized health care delivery system.

(2) "MMIS" is the Department's Medicaid management information statistics.

**§ 6100.805. Base-funded support.**

(a) A base-funding only support is a state-only funded, county program support provided through the county program, to either an individual who is not eligible for a HCBS or for a support that is not eligible as a HCBS.

(b) The requirements in this chapter do not apply to base-funding only supports, with the exception of the following provisions that do apply.

- (1) General provisions as specified at §§ 6100.1-6100.3.
- (2) General requirements as specified at §§ 6100.41-6100.55.
- (3) Training as specified at §§ 6100.141-6100.144.
- (4) Individual rights as specified at §§ 6100.181-6100.186.
- (5) PSP as specified at §§ 6100.221-6100.225.
- (6) Positive interventions as specified at §§ 6100.341-6100.345.
- (7) Incident management as specified at §§ 6100.401-6100.405.
- (8) Medications administration as specified at §§ 6100.461-6100.470.
- (9) Room and board as specified at §§ 6100.681-6100.694.

**§ 6100.806. Vendor goods and services.**

(a) A vendor is a directly-enrolled provider that sells goods or services to the general public, as well as to a HCBS program.

(b) The requirements in this chapter do not apply to vendor goods and services, with the exception of the following provisions that do apply.

- (1) General provisions as specified at §§ 6100.1-6100.3.
- (2) General requirements as specified at §§ 6100.41-6100.44, 6100.46-6100.51 and 6100.53-6100.55.
- (3) Enrollment as specified at §§ 6100.81-6100.86.
- (4) PSP as specified at §§ 6100.226 (relating to documentation of support delivery).
- (5) Training as specified at §§ 6100.141-6100.144.

(6) Individual rights as specified at §§ 6100.181-6100.186, for respite camps serving 25% or more people with disabilities.

(7) PSP as specified at §§ 6100.221-6100.226, for respite camps serving 25% or more people with disabilities.

(8) Positive interventions as specified at §§ 6100.341-6100.345, for respite camps serving 25% or more people with disabilities.

(9) Incident management as specified at §§ 6100.401-6100.405, for respite camps serving 25% or more people with disabilities.

(10) Medications administration as specified at §§ 6100.461-6100.470, for respite camps serving 25% or more people with disabilities.

(11) General payment provisions as specified at §§ 6100.481-6100.487.

(12) Enforcement as specified at §§ 6100.741-6100.744.

(c) Payment for vendor goods and services will only be made after a good or service is delivered.

(d) The vendor may charge an administrative fee, either as a separate invoice, or as part of the total general invoice.

(e) The administrative fee specified in subsection (d) may not exceed the limit set by Federal requirements.

(f) A vendor shall charge the same fee for a HCBS as the vendor charges to the general public for the same good or service.

(g) A vendor shall document the fee for the good or service charged to the general public and to the HCBS.

(h) A vendor shall ensure that a subcontractor provides the vendor good or service in accordance with this chapter, the Department's Federally-approved waiver and waiver amendments, and the state plan, as applicable.

**[CHAPTER 6200. ROOM AND BOARD CHARGES] (RESERVED).**

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**SUBPART E. RESIDENTIAL AGENCIES/FACILITIES/SERVICES**

**ARTICLE I. LICENSING/APPROVAL**

**CHAPTER 6400. COMMUNITY HOMES FOR  
INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR AUTISM**

**§ 6400.1. Introduction.**

This chapter is based on the principle of normalization which defines the right of the individual with an intellectual disability or autism to live a life which is as close as possible in all aspects to the life which any member of the community might choose. For the individual with an intellectual disability or autism who requires a residential service, the design of the service shall be made with the individual's unique needs in mind so that the service will facilitate the person's ongoing growth and development.

**§ 6400.2. Purpose.**

The purpose of this chapter is to protect the health, safety and well-being of individuals with an intellectual disability or autism, through the formulation, implementation and

enforcement of minimum requirements for the operation of community homes for people with an intellectual disability or autism.

**§ 6400.3. Applicability.**

(a) This chapter applies to community homes for people with an intellectual disability or autism, except as provided in subsection (f).

(b) This chapter contains the minimum requirements that shall be met to [obtain] obtain a certificate of compliance. A certificate of compliance shall be obtained prior to operation of a community home for people with an intellectual disability or autism.

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(f) This chapter does not apply to the following:

(1) Private homes of persons providing care to a relative with an intellectual disability or autism.

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(3) Intermediate care facilities for individuals with an intellectual disability licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) or intermediate care facilities for individuals with other related conditions.

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(7) Residential homes for three or fewer people with an intellectual disability or autism who are 18 years of age or older and who need a yearly average of 30 hours or less direct staff contact per week per home.

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#### **§ 6400.4. Definitions.**

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

*Agency*—A person or legally constituted organization operating one or more community homes for people with an intellectual disability or autism serving eight or fewer individuals.

*Autism*—A developmental disorder defined by the edition of the diagnostic and statistical manual of mental disorders, or its successor, in effect at the time the diagnosis is made. The term includes autistic disorder, Asperger’s disorder and autism spectrum disorder.

*Community home for individuals with an intellectual disability or autism home*—A building or separate dwelling unit in which residential care is provided to one or more individuals with an intellectual disability or autism, except as provided in § 6400.3(f) (relating to applicability). Each apartment unit within an apartment building is considered a separate home. Each part of a duplex, if there is physical separation between the living areas, is considered a separate home.

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*[Content discrepancy—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]*

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*[Documentation—Written statements that accurately record details, substantiate a claim or provide evidence of an event.]*

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*[ISP—Individual Support Plan—The comprehensive document that identifies services and expected outcomes for an individual.]*

*Individual—A person with an intellectual disability or autism who resides, or receives residential respite care, in a home and who is not a relative of the owner of the home.*

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*[Outcomes—Goals the individual and individual's plan team choose for the individual to acquire, maintain or improve.*

*Plan lead—The program specialist, when the individual is not receiving services through an SCO.*

*Plan team—The group that develops the ISP.]*

PSP—Person-centered support plan.

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Restraint - A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the PSP or used on an emergency basis.

### GENERAL REQUIREMENTS

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#### **§ 6400.15. Self-assessment of homes.**

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(b) The agency shall use the Department's licensing inspection instrument for the community homes for people with an intellectual disability or autism regulations to measure and record compliance.

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#### **§ 6400.18. [Reporting of unusual incidents.**

(a) An unusual incident is abuse or suspected abuse of an individual; injury, trauma or illness of an individual requiring inpatient hospitalization; suicide attempt by an individual; violation or alleged violation of an individual's rights; an individual who is missing for more than 24 hours or who could be in jeopardy if missing at all; alleged misuse or misuse of individual funds or property; outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions); an incident requiring the services of a fire

department or law enforcement agency; and any condition that results in closure of the home for more than 1 day.

(b) Written policies and procedures on the prevention, reporting, investigation and management of unusual incidents shall be developed and kept at the home.

(c) The home shall orally notify the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department, within 24 hours after abuse or suspected abuse of an individual or an incident requiring the services of a fire department or law enforcement agency occurs.

(d) The home shall initiate an investigation of the unusual incident and complete and send copies of an unusual incident report on a form specified by the Department to the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department, within 72 hours after an unusual incident occurs.

(e) The home shall send a copy of the final unusual incident report to the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department at the conclusion of the investigation.

(f) A copy of unusual incident reports relating to an individual shall be kept in the individual's record.

(g) A copy of unusual incident reports relating to the home itself, such as those requiring the services of a fire department, shall be kept.

(h) The individual's family or guardian shall be immediately notified in the event of an unusual incident relating to the individual, if appropriate.

**§ 6400.19. Reporting of deaths.**

(a) The home shall complete and send copies of a death report on a form specified by the Department to the county intellectual disability program of the county in which the home is located, the funding agency and the regional office of the Department, within 24 hours after a death of an individual occurs.

(b) The home shall investigate and orally notify the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department within 24 hours after an unusual or unexpected death occurs.

(c) A copy of death reports shall be kept in the individual's record.

(d) The individual's family or guardian shall be immediately notified in the event of a death of an individual.

**§ 6400.20. Record of incidents.**

The home shall maintain a record of individual illnesses, seizures, acute emotional traumas and accidents requiring medical attention but not inpatient hospitalization, that occur at the home.]

**Incident report and investigation.**

(a) The home shall report the following incidents, alleged incidents and suspected incidents in the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) Suicide attempt.

(3) Inpatient admission to a hospital.

(4) Visit to an emergency room.

(5) Abuse.

(6) Neglect.

(7) Exploitation.

(8) An individual who is missing for more than 24 hours or who could be in jeopardy if missing at all.

(9) Law enforcement activity.

(10) Injury requiring treatment beyond first aid.

(11) Fire requiring the services of the fire department.

(12) Emergency closure.

(13) Use of a restraint.

- (14) Theft or misuse of individual funds.
- (15) A violation of individual rights.
- (b) The individual and the persons designated by the individual shall be notified immediately upon discovery of an incident relating to the individual.
- (c) The home shall keep documentation of the notification in subsection (a).
- (d) The incident report, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual, and persons designated by the individual, upon request.
- (e) The home shall take immediate action to protect the health, safety and well-being of the individual, following the initial knowledge or notice of an incident, alleged incident and suspected incident.
- (f) The home shall initiate an investigation of an incident within 24 hours of discovery by a staff person.
- (g) A Department-certified incident investigator shall conduct the investigation of the incident listed in subsection (a).
- (h) The home shall finalize the incident report in the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person.
- (i) The home shall provide the following information to the Department as part of the final incident report:
- (1) Additional detail about the incident.
  - (2) The results of the incident investigation.
  - (3) A description of the corrective action taken in response to an incident.

(4) Action taken to protect the health, safety and well-being of the individual.

(5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

**§ 6400.19. Incident procedures to protect the individual.**

(a) In investigating an incident, the home shall review and consider the following needs of the affected individual:

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The home shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The home shall work cooperatively with the PSP team, to revise the PSP if indicated by the incident investigation.

**§ 6400.20. Incident analysis.**

(a) The home shall complete the following for each confirmed incident:

(1) Analysis to determine the root cause of the incident.

(2) Corrective action.

(3) A strategy to address the potential risks to the affected individual.

(b) The home shall review and analyze incidents and conduct a trend analysis at least every 3 months.

(c) The home shall identify and implement preventive measures to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of an incident recurring.

(d) The home shall educate staff persons and the individual based on the circumstances of the incident.

(e) The home shall analyze incident data continuously and take actions to mitigate and manage risks.

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**§ 6400.24. Applicable laws and regulations.**

The home shall comply with applicable Federal, State and local laws, regulations and ordinances.

**INDIVIDUAL RIGHTS**

**§ 6400.31. [Informing and encouraging exercise of rights.]**

(a) Each individual, or the individual's parent, guardian or advocate, if appropriate, shall be informed of the individual's rights upon admission and annually thereafter.

(b) Statements signed and dated by the individual, or the individual's parent, guardian or advocate, if appropriate, acknowledging receipt of the information on rights upon admission and annually thereafter, shall be kept.

(c) Each individual shall be encouraged to exercise his rights.

**§ 6400.32. Rights.**

An individual may not be deprived of rights.

**§ 6400.33. Rights of the individual.**

(a) An individual may not be neglected, abused, mistreated or subjected to corporal punishment.

(b) An individual may not be required to participate in research projects.

(c) An individual has the right to manage personal financial affairs.

(d) An individual has the right to participate in program planning that affects the individual.

(e) An individual has the right to privacy in bedrooms, bathrooms and during personal care.

(f) An individual has the right to receive, purchase, have and use personal property.

(g) An individual has the right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with family and persons of the individual's own choice.

(h) An individual has the right to reasonable access to a telephone and the opportunity to receive and make private calls, with assistance when necessary.

(i) An individual has the right to unrestricted mailing privileges.

(j) An individual who is of voting age shall be informed of the right to vote and shall be assisted to register and vote in elections.

(k) An individual has the right to practice the religion or faith of the individual's choice.

(l) An individual has the right to be free from excessive medication.

(m) An individual may not be required to work at the home, except for the upkeep of the individual's personal living areas and the upkeep of common living areas and grounds.

**§ 6400.34. Civil rights.**

(a) An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

(b) The home shall develop and implement civil rights policies and procedures. Civil rights policies and procedures shall include the following:

(1) Nondiscrimination in the provision of services, admissions, placement, use of the home, referrals and communication with non-English speaking and nonverbal individuals.

(2) Physical accessibility and accommodations for individuals with physical disabilities.

(3) The opportunity to lodge civil rights complaints.

(4) Informing individuals of their right to register civil rights complaints.]

**Exercise of rights.**

- (a) An individual may not be deprived of rights, as provided under § 6400.32 (relating to rights of the individual).
- (b) An individual shall be continually supported to exercise the individual's rights.
- (c) An individual shall be provided the support and accommodation necessary to be able to understand and actively exercise the individual's rights.
- (d) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.
- (e) A court's written order that restricts an individual's rights shall be followed.
- (f) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with a court order.
- (g) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in decision-making in accordance with the court order.
- (h) An individual has the right to designate persons to assist in decision-making on behalf of the individual.

**§ 6400.32. Rights of the individual.**

- (a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.
- (b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely and practice the religion of his choice or to practice no religion.

- (c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.
- (d) An individual shall be treated with dignity and respect.
- (e) An individual has the right to make choices and accept risks.
- (f) An individual has the right to refuse to participate in activities and supports.
- (g) An individual has the right to control the individual's own schedule.
- (h) An individual has the right to privacy of person and possessions.
- (i) An individual has the right of access to and security of the individual's possessions.
- (j) An individual has the right to voice concerns about the supports the individual receives.
- (k) An individual has the right to participate in the development and implementation of the PSP.
- (l) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with persons of the individual's choice, at any time.
- (m) An individual has the right to unrestricted access to send and receive mail and other forms of communications, unopened and unread by others.
- (n) An individual has the right to unrestricted and private access to telecommunications.
- (o) An individual has the right to manage and access his own finances.
- (p) An individual has the right to choose persons with whom to share a bedroom.

(q) An individual has the right to furnish and decorate the individual's bedroom and the common areas of the home.

(r) An individual has the right to lock the individual's bedroom door.

(s) An individual has the right to access food at any time.

(t) An individual has the right to make informed health care decisions.

**§ 6400.33. Negotiation of choices.**

(a) An individual's rights shall be exercised so that another individual's rights are not violated.

(b) Choices shall be negotiated by the affected individuals, in accordance with the home's procedures for the individuals to resolve differences and make choices.

**§ 6400.34. Informing of rights.**

(a) The home shall inform and explain individual rights to the individual and persons designated by the individual, upon admission to the home and annually thereafter.

(b) The home shall keep a copy of the statement signed by the individual, or the individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

**STAFFING**

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**§ 6400.44. Program specialist.**

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(b) The program specialist shall be responsible for the following:

- (1) [Coordinating and completing assessments.
- (2) Providing the assessment as required under § 6400.181(f) (relating to assessment).
- (3) Participating in the development of the ISP, ISP annual update and ISP revision.
- (4) Attending the ISP meetings.
- (5) Fulfilling the role of plan lead, as applicable, under § § 6400.182 and 6400.186(f) and (g) (relating to development, annual update and revision of the ISP; and ISP review and revision).
- (6) Reviewing the ISP, annual updates and revisions under § 6400.186 for content accuracy.
- (7) Reporting content discrepancy to the SC, as applicable, and plan team members.
- (8) Implementing the ISP as written.
- (9) Supervising, monitoring and evaluating services provided to the individual.
- (10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.
- (11) Reporting a change related to the individual's needs to the SC, as applicable, and plan team members.

(12) Reviewing the ISP with the individual as required under § 6400.186.

(13) Documenting the review of the ISP as required under § 6400.186.

(14) Providing the documentation of the ISP review to the SC, as applicable, and plan team members as required under § 6400.186(d).

(15) Informing plan team members of the option to decline the ISP review documentation as required under § 6400.186(e).

(16) Recommending a revision to a service or outcome in the ISP as provided under § 6400.186(c)(4).

(17) Coordinating the services provided to an individual.

(18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each individual.

(19) Developing and implementing provider services as required under § 6400.188 (relating to provider services).]

Coordinating the completion of assessments.

(2) Participating in the PSP process, PSP development, PSP team reviews and the implementation of the PSP in accordance with this chapter.

(3) Providing and supervising activities for the individuals in accordance with the PSPs.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and involvement with families and friends.

(c) A program specialist shall have one of the following groups of qualifications:

(1) A master's degree or above from an accredited college or university and 1 year work experience working directly with individuals with an intellectual disability or autism.

(2) A bachelor's degree from an accredited college or university and 2 years work experience working directly with individuals with an intellectual disability or autism.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years work experience working directly with individuals with an intellectual disability or autism.

**§ 6400.45. Staffing.**

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(c) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the individual's [ISP] PSP, as an outcome which requires the achievement of a higher level of independence.

(d) The staff qualifications and staff ratio as specified in the [ISP] PSP shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

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**§ 6400.46. [Staff] Emergency training.**

[(a) The home shall provide orientation for staff persons relevant to their responsibilities, the daily operation of the home and policies and procedures of the home before working with individuals or in their appointed positions.

(b) The home shall have a training syllabus describing the orientation specified in subsection (a).

(c) The chief executive officer shall have at least 24 hours of training relevant to human services or administration annually.

(d) Program specialists and direct service workers who are employed for more than 40 hours per month shall have at least 24 hours of training relevant to human services annually.

(e) Program specialists and direct service workers shall have training in the areas of intellectual disability, the principles of integration, rights and program planning and implementation, within 30 calendar days after the day of initial employment or within 12 months prior to initial employment.]

[(f)] (a) Program specialists and direct service workers shall be trained before working with individuals in general fire safety, evacuation procedures, responsibilities during fire drills, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures if individuals or staff persons

smoke at the home, the use of fire extinguishers, smoke detectors and fire alarms, and notification of the local fire department as soon as possible after a fire is discovered.

[(g)] (b) Program specialists and direct service workers shall be trained annually by a fire safety expert in the training areas specified in subsection [(f)] (a).

[(h)] (c) Program specialists and direct service workers and at least one person in a vehicle while individuals are being transported by the home, shall be trained before working with individuals in first aid techniques.

[(i)] (d) Program specialists, direct service workers and drivers of and aides in vehicles shall be trained within 6 months after the day of initial employment and annually thereafter, by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid, Heimlich techniques and cardio-pulmonary resuscitation.

[(j) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and staff persons attending, shall be kept.]

**§ 6400.47. Annual training plan.**

(a) The home shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs and other data and analysis indicating staff person training needs and as required under § 6400.46 (relating to staff training) and § 6400.49 (relating to annual training).

(b) The annual training plan shall include an orientation program as specified in § 6400.48 (relating to orientation program).

(c) The annual training plan shall include training aimed at improving the knowledge, skills and core competencies of the staff persons to be trained.

(d) The annual training plan shall include the following:

(1) The title of the position to be trained.

(2) The required training courses, including training course hours, for each position.

**§ 6400.48. Orientation program.**

(a) Prior to working alone with individuals and within 30 days after hire the following shall complete an orientation program as described in subsection (b):

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons.

(3) Direct service workers, including full and part time staff persons.

(4) Volunteers who will work alone with individuals.

(5) Paid and unpaid interns who will work alone with individuals.

(6) Consultants who will work alone with individuals.

(b) The orientation program shall encompass the following areas:

(1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. § 10225.701-10225.708

(relating to older adult protective services), 23 Pa.C.S. §§ 6301-6386

(relating to child protective services), 35 P.S. §§ 10210.101–10210.704

(relating to adult protective services) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) Job-related knowledge and skills.

**§ 6400.49. Annual training.**

(a) The following staff persons shall complete 24 hours of training each year.

(1) Direct service workers.

(2) Direct supervisors of direct service workers.

(3) Program specialists.

(b) The following staff persons shall complete 12 hours of training each year.

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons.

(3) Consultants who work alone with individuals.

(4) Volunteers who work alone with individuals.

(5) Paid and unpaid interns who work alone with individuals.

(c) A minimum of 8 of the annual training hours specified in subsections (a) and (b) shall encompass the following areas:

(1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. § 10225.701-708 (relating to older adult protective services), 23 Pa.C.S. §§ 6301-6385 (relating to child protective services), Chapter 3490 (relating to protective services), 35 P.S. §§ 10210.101–10210.704 (relating to adult protective services) and applicable adult protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of positive interventions, if the staff person will provide a support to an individual with a dangerous behavior.

(d) The balance of the annual training hours shall be in areas identified by the home in the home's annual training plan in § 6400.47 (relating to annual training plan).

(e) All training, including those training courses identified in subsection (c) and (d), shall be included in the provider's annual training plan.

(f) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and staff persons attending, shall be kept.

(g) A training record for each person trained shall be kept.

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## MEDICATIONS

**§ 6400.161. [Storage of medications.]**

(a) Prescription and nonprescription medications shall be kept in their original containers, except for medications of individuals who self-administer medications and keep the medications in personal daily or weekly dispensing containers.

(b) Prescription and potentially toxic nonprescription medications shall be kept in an area or container that is locked, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(c) Prescription and potentially toxic nonprescription medications stored in a refrigerator shall be kept in a separate locked container, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(d) Prescription and nonprescription medications shall be stored under proper conditions of sanitation, temperature, moisture and light.

(e) Discontinued prescription medications shall be disposed of in a safe manner.

**§ 6400.162. Labeling of medications.**

(a) The original container for prescription medications shall be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

(b) Nonprescription medications shall be labeled with the original label.

**§ 6400.163. Use of prescription medications.**

(a) Prescription medications shall only be used by the individual for whom the medication was prescribed.

(b) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a written protocol as part of the ISP to address the social, emotional and environmental needs of the individual related to the symptoms of the diagnosed psychiatric illness.

(c) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a review with documentation by a licensed physician at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.

**§ 6400.164. Medication log.**

(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered and the name of the person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer medication.

(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication.

(c) A list of prescription medications, the prescribed dosage and the name of the prescribing physician shall be kept for each individual who self-administers medication.

**§ 6400.165. Medication errors.**

Documentation of medication errors and follow-up action taken shall be kept.

**§ 6400.166. Adverse reaction.**

If an individual has a suspected adverse reaction to a medication, the home shall notify the prescribing physician immediately. Documentation of adverse reactions shall be kept.

**§ 6400.167. Administration of prescription medications and injections.**

(a) Prescription medications and injections of a substance not self-administered by individuals shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse or licensed practical nurse.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.

(4) A staff person who meets the criteria specified in § 6400.168 (relating to medications administration training) for the administration of oral, topical and eye and ear drop prescriptions and insulin injections.

(b) Prescription medications and injections shall be administered according to the directions specified by a licensed physician, certified nurse practitioner or licensed physician's assistant.

**§ 6400.168. Medications administration training.**

(a) In a home serving eight or fewer individuals, a staff person who has completed and passed the Department's Medications Administration Course is permitted to administer oral, topical and eye and ear drop prescription medications.

(b) In a home serving eight or fewer individuals, a staff person who has completed and passed the Department's Medications Administration Course and who has completed and passed a diabetes patient education program within the past 12 months that meets the National Standards for Diabetes Patient Education Programs of the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Bethesda, Maryland 20205, is permitted to administer insulin injections to an individual who is under the care of a licensed physician who is monitoring the diabetes, if insulin is premeasured by licensed or certified medical personnel.

(c) Medications administration training of a staff person shall be conducted by an instructor who has completed the Department's Medications Administration Course for trainers and is certified by the Department to train staff.

(d) A staff person who administers prescription medications and insulin injections to an individual shall complete and pass the Medications Administration Course Practicum annually.

(e) Documentation of the dates and locations of medications administration training for trainers and staff persons and the annual practicum for staff persons shall be kept.

**§ 6400.169. Self-administration of medications.**

(a) To be considered capable of self-administration of medications an individual shall:

(1) Be able to recognize and distinguish the individual's medication.

(2) Know how much medication is to be taken.

(3) Know when medication is to be taken.

(b) Insulin that is self-administered by an individual shall be measured by the individual or by licensed or certified medical personnel.]

**Self-administration.**

(a) A home shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

- (c) The provider shall provide or arrange for assistive technology to support the individual's self-administration of medications.
- (d) The PSP shall identify if the individual is unable to self-administer medications.
- (e) To be considered able to self-administer medications, an individual shall do all of the following:
  - (1) Recognize and distinguish the individual's medication.
  - (2) Know how much medication is to be taken.
  - (3) Know when the medication is to be taken. This knowledge may include reminders of the schedule and offering the medication at the prescribed times, as specified in subsection (b).
  - (4) Take or apply his own medication with or without the use of assistive technology.

**§ 6400.162. Medication administration.**

- (a) A home whose staff persons or others are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer the individual's prescribed medication.
- (b) A prescription medication that is not self-administered shall be administered by one of the following:
  - (1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A person who has completed the medication administration training as specified in § 6400.169 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

(3) Crush or split the medication as ordered by the prescriber.

(4) Place the medication in a medication cup or other appropriate container, or in the individual's hand, mouth or other route as ordered by the prescriber.

(5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin or epinephrine in accordance with this chapter.

**§ 6400.163. Storage and disposal of medications.**

(a) Prescription and nonprescription medications shall be kept in their original labeled containers.

(b) A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.

- (c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.
- (d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.
- (e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.
- (f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.
- (g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.
- (h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to the Department of Environmental Protection and applicable Federal and State regulations.
- (i) Subsections (a), (b), (c), (d) and (f) do not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom.

**§ 6400.164. Labeling of medications.**

The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- (1) The individual's name.

- (2) The name of the medication.
- (3) The date the prescription was issued.
- (4) The prescribed dosage and instructions for administration.
- (5) The name and title of the prescriber.

**§ 6400.165. Prescription medications.**

- (a) A prescription medication shall be prescribed in writing by an authorized prescriber.
- (b) A prescription order shall be kept current.
- (c) A prescription medication shall be administered as prescribed.
- (d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.
- (e) Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a registered nurse in accordance with regulations of the Department of State. The individual's medication record shall be updated as soon as a written notice of the change is received.

**§ 6400.166. Medication record.**

- (a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:
  - (1) Individual's name.
  - (2) Name and title of the prescriber.
  - (3) Drug allergies.
  - (4) Name of medication.

- (5) Strength of medication.
  - (6) Dosage form.
  - (7) Dose of medication.
  - (8) Route of administration.
  - (9) Frequency of administration.
  - (10) Administration times.
  - (11) Diagnosis or purpose for the medication, including pro re nata.
  - (12) Date and time of medication administration.
  - (13) Name and initials of the person administering the medication.
  - (14) Duration of treatment, if applicable.
  - (15) Special precautions, if applicable.
  - (16) Side effects of the medication, if applicable.
- (b) The information in subsection (a)(12) and (13) shall be recorded at the time the medication is administered.
- (c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.
- (d) The directions of the prescriber shall be followed.

**§ 6400.167. Medication errors.**

- (a) Medication errors include the following:
- (1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong amount of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(b) Documentation of medication errors, follow-up action taken and the prescriber's response shall be kept in the individual's record.

**§ 6400.168. Adverse reaction.**

(a) If an individual has a suspected adverse reaction to a medication, the home shall immediately consult a health care practitioner or seek emergency medical treatment.

(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction, and the action taken shall be documented.

**§ 6400.169. Medication administration training.**

(a) A staff person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer the following:

(1) Oral medications.

(2) Topical medications.

(3) Eye, nose and ear drop medications.

(b) A staff person may administer insulin injections following:

(1) Successful completion of the course specified in subsection (a).

(2) Successful completion of a Department-approved diabetes patient education program within the past 12 months.

(c) A staff person may administer an epinephrine injection via an auto-injection device in response to anaphylaxis or another serious allergic reaction following:

(1) Successful completion of the course specified in subsection (a).

(2) Successful completion of training relating to the use of an auto-injection epinephrine injection device provided by a licensed, registered or certified health care professional within the past 12 months.

(d) A record of the training shall be kept including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

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## PROGRAM

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### **§ 6400.181. Assessment.**

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(b) If the program specialist is making a recommendation to revise a service or outcome in the [ISP as provided under § 6400.186(c)(4) (relating to ISP review and revision)] PSP, the individual shall have an assessment completed as required under this section.

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(f) The program specialist shall provide the assessment to the SC, as applicable, and [plan] PSP team members at least 30 calendar days prior to [an ISP] a PSP meeting [for the development, annual update and revision of the ISP under § § 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP)].

**§ 6400.182. [Development, annual update and revision of the ISP.**

(a) An individual shall have one ISP.

(b) When an individual is not receiving services through an SCO, the residential program specialist shall be the plan lead when one of the following applies:

(1) The individual resides at a residential home licensed under this chapter.

(2) The individual resides at a residential home licensed under this chapter and attends a facility licensed under Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities).

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the individual's current assessment as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the individual's admission date to the facility.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) and also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 6400.186 (relating to ISP review and revision), shall be provided as required under § 6400.187 (relating to copies).

**§ 6400.183. Content of the ISP.**

The ISP, including annual updates and revisions under § 6400.186 (relating to ISP review and revision), must include the following:

(1) Services provided to the individual and expected outcomes chosen by the individual and individual's plan team.

(2) Services provided to the individual to increase community involvement, including volunteer or civic-minded opportunities and membership in National or local organizations as required under § 6400.188 (relating to provider services).

(3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.

(4) A protocol and schedule outlining specified periods of time for the individual to be without direct supervision, if the individual's current assessment states the individual may be without direct supervision and if the individual's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve the higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the individual, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.

(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

- (iii) The method and timeline for eliminating the use of restrictive procedures.
- (iv) A protocol for intervention or redirection without utilizing restrictive procedures.

(7) Assessment of the individual's potential to advance in the following:

- (i) Residential independence.
- (ii) Community involvement.
- (iii) Vocational programming.
- (iv) Competitive community-integrated employment.

**§ 6400.184. Plan team participation.**

(a) The plan team shall participate in the development of the ISP, including the annual updates and revisions under § 6400.186 (relating to ISP review and revision).

(1) A plan team must include as its members the following:

- (i) The individual.
- (ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the individual.
- (iii) A direct service worker who works with the individual from each provider delivering services to the individual.
- (iv) Any other person the individual chooses to invite.

(2) If the following have a role in the individual's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the individual from each provider delivering services to the individual.

(iii) The individual's parent, guardian or advocate.

(b) At least three plan team members, in addition to the individual, if the individual chooses to attend, shall be present for an ISP, annual update and ISP revision meeting.

(c) A plan team member who attends a meeting under subsection (b) shall sign and date the signature sheet.

**§ 6400.185. Implementation of the ISP.**

(a) The ISP shall be implemented by the ISP's start date.

(b) The ISP shall be implemented as written.

**§ 6400.186. ISP review and revision.**

(a) The program specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the residential home licensed under this chapter with the

individual every 3 months or more frequently if the individual's needs change which impacts the services as specified in the current ISP.

(b) The program specialist and individual shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of an individual's participation and progress during the prior 3 months toward ISP outcomes supported by services provided by the residential home licensed under this chapter.

(2) A review of each section of the ISP specific to the residential home licensed under this chapter.

(3) The program specialist shall document a change in the individual's needs, if applicable.

(4) The program specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the program specialist shall complete a revised assessment as required under § 6400.181(b) (relating to assessments).

(d) The program specialist shall provide the ISP review documentation, including recommendations, if applicable, to the SC, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The program specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead as applicable, under §§ 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.

**§ 6400.187. Copies.**

A copy of the ISP, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP, annual update and ISP revision meetings.

**§ 6400.188. Provider services.**

(a) The residential home shall provide services including assistance, training and support for the acquisition, maintenance or improvement of functional skills, personal needs, communication and personal adjustment.

(b) The residential home shall provide opportunities and support to the individual for participation in community life, including volunteer or civic-minded opportunities and membership in National or local organizations.

(c) The residential home shall provide services to the individual as specified in the individual's ISP.

(d) The residential home shall provide services that are age and functionally appropriate to the individual.]

**Development of the PSP.**

(a) An individual shall have one, approved and authorized PSP at a given time.

(b) An individual's service implementation plan shall be consistent with the PSP in subsection (a).

(c) The support coordinator, targeted support manager or program specialist shall coordinate the development of the PSP, including revisions, in cooperation with the individual and the individual's PSP team.

(d) The initial PSP shall be developed based on the individual assessment within 60 days of the individual's date of admission to the home.

(e) The PSP shall be initially developed, revised annually and revised when an individual's needs change, based upon a current assessment.

(f) The individual and persons designated by the individual shall be involved in and supported in the development and revisions of the PSP.

(g) The PSP, including revisions, shall be documented on a form specified by the Department.

**§ 6400.183. The PSP team.**

(a) The PSP shall be developed by an interdisciplinary team including the following:

(1) The individual.

(2) Persons designated by the individual.

(3) The individual's direct care staff persons.

(4) The program specialist.

(5) The support coordinator, targeted support manager or a program representative from the funding source, if applicable.

(6) The program specialist for the individual's day program, if applicable.

(7) Other specialists such as health care, behavior management, speech, occupational, physical therapy, as appropriate for the individual needs.

(b) At least three members of the PSP team, in addition to the individual and persons designated by the individual, shall be present at a PSP meeting at which the PSP is developed or revised.

(c) Members of the PSP team who attend the meeting shall sign and date the PSP.

**§ 6400.184. The PSP process.**

The PSP process shall:

- (1) Provide necessary information and support to ensure that the individual directs the PSP process to the maximum extent possible.
- (2) Enable the individual to make informed choices and decisions.
- (3) Be conducted to reflect what is important to the individual to ensure that supports are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.
- (4) Be timely in relation to the needs of the individual and occur at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.
- (5) Be communicated in clear and understandable language.
- (6) Reflect cultural considerations of the individual
- (7) Include guidelines for solving disagreements among the PSP team members.
- (8) Include a method for the individual to request updates to the PSP.

**§ 6400.185. Content of the PSP.**

The PSP, including revisions, shall include the following:

- (1) The individual's strengths and functional abilities.
- (2) The individual's individualized clinical and support needs.
- (3) The individual's goals and preferences related to relationships, community participation, employment, income and savings, health care, wellness and education.
- (4) Individually identified, person-centered desired outcomes.
- (5) Supports to assist the individual to achieve desired outcomes.

- (6) The type, amount, duration and frequency for the support, specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.
- (7) Communication mode, abilities and needs.
- (8) Opportunities for new or continued community participation.
- (9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.
- (10) Modification of individual rights as necessary to mitigate risks, if applicable.
- (11) Health care information, including a health care history.
- (12) Financial information including how the individual chooses to use personal funds.
- (13) The person responsible for monitoring the implementation of the PSP.

**§ 6400.186. Implementation of the PSP.**

The home shall implement the PSP, including revisions.

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**[RESTRICTIVE PROCEDURES] POSITIVE INTERVENTION**

**§ 6400.191.[Definition of restrictive procedures.**

A restrictive procedure is a practice that limits an individual's movement, activity or function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in

**§ 6400.192. Written policy.**

A written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which restrictive procedures may be used, the persons who may authorize the use of restrictive procedures, a mechanism to monitor and control the use of restrictive procedures and a process for the individual and family to review the use of restrictive procedures shall be kept at the home.

**§ 6400.193. Appropriate use of restrictive procedures.**

(a) A restrictive procedure may not be used as retribution, for the convenience of staff persons, as a substitute for the program or in a way that interferes with the individual's developmental program.

(b) For each incident requiring restrictive procedures:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

**§ 6400.194. Restrictive procedure review committee.**

(a) If a restrictive procedure is used, there shall be a restrictive procedure review committee.

(b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.

(c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.

(d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.

**§ 6400.195. Restrictive procedure plan.**

(a) For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written prior to use of restrictive procedures.

(b) The restrictive procedure plan shall be developed and revised with the participation of the program specialist, the individual's direct care staff, the interdisciplinary team as appropriate and other professionals as appropriate.

(c) The restrictive procedure plan shall be reviewed, and revised, if necessary, according to the time frame established by the restrictive procedure review committee, not to exceed 6 months.

(d) The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the restrictive procedure review committee and the program specialist, prior to the use of a restrictive procedure, whenever the restrictive procedure plan is revised and at least every 6 months.

(e) The restrictive procedure plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.

(2) The single behavioral outcome desired stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.

(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(5) A target date for achieving the outcome.

(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in this chapter.

(7) Physical problems that require special attention during the use of restrictive procedures.

(8) The name of the staff person responsible for monitoring and documenting progress with the plan.

(f) The restrictive procedure plan shall be implemented as written.

(g) Copies of the restrictive procedure plan shall be kept in the individual's record.

**§ 6400.196. Staff training.**

(a) If restrictive procedures are used, there shall be at least one staff person available when restrictive procedures are used who has completed training within the past 12 months in the use of and ethics of using restrictive procedures including the use of alternate positive approaches.

(b) A staff person responsible for developing, implementing or managing a restrictive procedure plan shall be trained in the use of the specific techniques or procedures that are used.

(c) If manual restraint or exclusion is used, a staff person responsible for developing, implementing or managing a restrictive procedure plan shall have experienced use of the specific techniques or procedures directly on themselves.

(d) Documentation of the training program provided, including the staff persons trained, dates of training, description of training and training source shall be kept.

**§ 6400.197. Seclusion.**

Seclusion, defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

**§ 6400.198. Aversive conditioning.**

The use of aversive conditioning, defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli, is prohibited.

**§ 6400.199. Chemical restraints.**

(a) A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual.

(b) Administration of a chemical restraint is prohibited except for the administration of drugs ordered by a licensed physician on an emergency basis.

(c) If a chemical restraint is administered as specified in subsection (b), the following apply:

(1) Prior to each incidence of administering a drug on an emergency basis, a licensed physician shall have examined the individual and given a written order to administer the drug.

(2) Prior to each readministration of a drug on an emergency basis, a licensed physician shall have examined the individual and ordered readministration of the drug.

(d) If a chemical restraint is administered as specified in subsection (c), the following apply:

(1) The individual's vital signs shall be monitored at least once each hour.

(2) The physical needs of the individual shall be met promptly.

(e) A Pro Re Nata (PRN) order for controlling acute, episodic behavior is prohibited.

(f) A drug ordered by a licensed physician as part of an ongoing program of medication is not a chemical restraint.

(g) A drug ordered by a licensed physician for a specific, time-limited stressful event or situation to assist the individual to control the individual's own behavior, is not a chemical restraint.

(h) A drug ordered by a licensed physician as pretreatment prior to medical or dental examination or treatment is not a chemical restraint.

(i) A drug self-administered by an individual is not a chemical restraint.

(j) If a drug is administered in accordance with subsection (b), (f), (g) or (h) there shall be training for the individual aimed at eliminating or reducing the need for the drug in the future.

(k) Documentation of compliance with subsections (b)—(i) shall be kept.

**§ 6400.200. Mechanical restraints.**

(a) A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with

fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices.

(b) The use of a mechanical restraint is prohibited except for use of helmets, mitts and muffs to prevent self-injury on an interim basis not to exceed 3 months after an individual is admitted to the home.

(c) If a mechanical restraint is used as specified in subsection (b), the following apply:

(1) The use of a mechanical restraint may not exceed 2 hours, unless a licensed physician examines the individual and gives written orders to continue use of the restraint. Reexamination and new orders by a licensed physician are required for each 2-hour period the restraint is continued. If a restraint is removed for any purpose other than for movement and reused within 24 hours after the initial use of the restraint, it is considered continuation of the initial restraint.

(2) A licensed physician shall be notified immediately after a mechanical restraint is used.

(3) The restraint shall be checked for proper fit by a staff person at least every 15 minutes.

(4) The physical needs of the individual shall be met promptly.

(5) The restraint shall be removed completely for at least 10 minutes during every 2 hours the restraint is used, unless the individual is sleeping.

(6) There shall be training for the individual aimed at eliminating or reducing the need for the restraint in the future.

(7) Documentation of compliance with subsection (b) and paragraphs (1)—(6) shall be kept.

(d) A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

**§ 6400.201. Use of personal funds and property.**

(a) An individual's personal funds or property may not be used as reward or punishment.

(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages.

**§ 6400.202. Manual restraints.**

(a) Manual restraint is a physical hands-on technique that lasts more than 30 seconds, and is used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body, such as basket holds and prone or supine containment.

(b) Manual restraint shall be used only when necessary to protect the individual from injuring himself or others.

(c) Manual restraint shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from injuring himself or others.

(d) An individual shall be released from the manual restraint within the time specified in the restrictive procedure plan not to exceed 30 minutes within a 2-hour period.

**§ 6400.203. Exclusion.**

(a) Exclusion is the removal of an individual from the individual's immediate environment and restricting the individual alone to a room or area. If a staff person remains with the individual, it is not exclusion.

(b) Exclusion shall be used only when necessary to protect the individual from self-injury or injury to others.

(c) Exclusion shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from self-injury or injury to others.

(d) An individual shall be permitted to return to routine activity within the time specified in the restrictive procedure plan not to exceed 60 minutes within a 2-hour period.

(e) Exclusion may not be used for an individual more than 4 times within a 24-hour period.

(f) An individual in exclusion shall be monitored continually by a staff person.

(g) A room or area used for exclusion shall have at least 40 square feet of indoor floor space, with a minimum ceiling height of 7 feet.

(h) A room or area used for exclusion shall have an open door or a window for staff observation of the individual.

(i) A room or area used for exclusion shall be well lighted and ventilated.

**§ 6400.204. Emergency use of exclusion and manual restraints.**

If exclusion or manual restraint is used on an unanticipated, emergency basis, §§ 6400.194 and 6400.195 (relating to restrictive procedure review committee; and restrictive procedure plan) do not apply until after the exclusion or manual restraint is used for the same individual twice in a 6-month period.

**§ 6400.205. Restrictive procedure records.**

A record of each use of a restrictive procedure documenting the specific behavior addressed, methods of intervention used to address the behavior, the date and time the restrictive procedure was used, the specific procedures followed, the staff person who used the restrictive procedure, the duration of the restrictive procedure, the staff person

who observed the individual if exclusion was used and the individual's condition following the removal of the restrictive procedure shall be kept in the individual's record.

**§ 6400.206. Notification.**

The individual's day service facility shall be sent copies of the restrictive procedure plan and revisions of the plan. Documentation of transmittal of the restrictive procedure plan shall be kept.]

**Use of a positive intervention.**

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

“Dangerous behavior” is an action with a high likelihood of resulting in harm to the individual or others.

“Positive intervention” is an action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and

other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.

**§ 6400.192. PSP.**

If the individual has a dangerous behavior as identified in the PSP, the PSP shall include the following:

- (1) The specific dangerous behavior to be addressed.
- (2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.
- (3) The outcome desired.
- (4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.
- (5) A target date to achieve the outcome.
- (6) Health conditions that require special attention.

**§ 6400.193. Prohibition of restraints.**

The following procedures are prohibited:

- (1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.
- (2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.
- (3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.

- (4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
- (5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.
- (i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.
- (ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.
- (6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a non-emergency basis, or, for a period of more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor.

**§ 6400.194. Permitted interventions.**

(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.

(b) A physical protective restraint may be used only in accordance with § 6400.193 (6) - (8) (relating to prohibition of restraints).

(c) A physical protective restraint shall not be used until § 6400.49(c)(5) (relating to annual training) and § 6400.185(9) (relating to content of PSP) are met.

(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.

(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.

(f) A physical protective restraint may not be used for a period of more than 15 minutes within a 2-hour period.

(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 6400.49 (relating to annual training).

(h) As used in this section, a “physical protective restraint” is a hands-on hold of an individual.

**§ 6400.195. Access to or the use of an individual’s personal property.**

(a) Access to or the use of an individual’s personal funds or property shall not be used as a reward or punishment.

(b) An individual’s personal funds or property shall not be used as payment for damages unless the individual consents to make restitution for the damages as follows:

(1) A separate written consent by an individual is required for each incidence of restitution.

(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.

(3) There shall be no coercion in obtaining the consent of an individual.

(4) The home shall keep a copy of the individual’s written consent.

**§ 6400.196. Rights team.**

(a) The home shall have a rights team. The home may use a county mental health and intellectual disability program rights team that meets the requirements of this section.

(b) The role of the rights team shall be to:

(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified at § 6400.31-6400.34 (relating to individual rights).

(2) Review each incidence of the use of a restraint as specified at §§ 6400.191-6400.194 (relating to positive intervention) to:

- (i) Analyze systemic concerns.
- (ii) Design positive supports as an alternative to the use of a restraint.
- (iii) Discover and resolve the reason for an individual's behavior.
- (c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for himself, the individual's support coordinator, a representative from the funding agency and a home representative.
- (d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.
- (e) If a restraint was used, the individual's health care practitioner shall be consulted.
- (f) The rights team shall meet at least once every 3 months.
- (g) The rights team shall report its recommendations to the individual's PSP team.
- (h) The home shall keep documentation of the rights team meetings and the decisions made at the meetings.

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## INDIVIDUAL RECORDS

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### **§ 6400.213. Content of records.**

Each individual's record must include the following information:

(1) Personal information including:

(i) The name, sex, admission date, birthdate and social security number.

- (ii) The race, height, weight, color of hair, color of eyes and identifying marks.
- (iii) The language or means of communication spoken or understood by the individual and the primary language used in the individual's natural home, if other than English.
- (iv) The religious affiliation.
- (v) The next of kin.
- (vi) A current, dated photograph.
- (2) [Unusual incident] Incident reports relating to the individual.
- (3) Physical examinations.
- (4) Dental examinations.
- (5) Dental hygiene plans.
- (6) Assessments as required under § 6400.181 (relating to assessment).
- (7) [A copy of the invitation to:
  - (i) The initial ISP meeting.
  - (ii) The annual update meeting.
  - (iii) The ISP revision meeting.
- (8) A copy of the signature sheets for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(9) A copy of the current ISP.

(10) Documentation of ISP reviews and revisions under § 6400.186 (relating to ISP review and revision), including the following:

(i) ISP review signature sheets.

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(11) Content discrepancy in the ISP, The annual update or revision under § 6400.186.]

PSP documents as required by this chapter.

[(12) Restrictive procedure protocols and] (8) Positive intervention records related to the individual.

[(13)] (9) Copies of psychological evaluations, if applicable.

[(14)] (10) Recreational and social activities provided to the individual.

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## CHAPTER 6500. [FAMILY LIVING HOMES] LIFE SHARING

### § 6500.1. Introduction.

[Family living] Life sharing is based on the importance of enduring and permanent relationships as the foundation for learning life skills, developing self-esteem and learning to exist in interdependence with others; the opportunity for each individual with an intellectual disability or autism to grow and develop to their fullest potential; the provision of individualized attention based on the needs of the individual with an intellectual disability or autism; and the participation of the individual with an intellectual disability or autism in everyday community activities. [Family living] Life sharing offers an opportunity for an individual with an intellectual disability or autism and a family to share their lives together.

### § 6500.2. Purpose.

The purpose of this chapter is to protect the health, safety and well-being of individuals with an intellectual disability or autism, through the formulation, implementation and enforcement of minimum requirements for [family living homes] life sharing.

### § 6500.3. Applicability.

(a) This chapter applies to [family living] life sharing homes, except as provided in subsection (f).

(b) This chapter contains the minimum requirements that shall be met to obtain a certificate of compliance. A certificate of compliance shall be obtained prior to an individual with an intellectual disability or autism living or receiving respite care in a [family living] life sharing home.

(c) This chapter applies to profit, nonprofit, publicly funded and privately funded [family living] life sharing homes.

(d) Each agency administering one or more [family living] life sharing homes shall have at least a sample of their homes inspected by the Department each year. Each new [family living] life sharing home administered by an agency shall be inspected by the Department prior to an individual with an intellectual disability or autism living or receiving respite care in the home. The certificate of compliance issued to an agency shall specify the location and maximum capacity of each [family living] life sharing home.

(e) A [family living] life sharing home that is not administered by an agency will be inspected by the Department each year.

(f) This chapter does not apply to the following:

(1) Private homes of persons providing care to a relative with an intellectual disability or autism.

(2) A community home for individuals with an intellectual disability or autism licensed by the Department in accordance with Chapter 6400 (relating to community homes for individuals with an intellectual disability or autism).

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(5) A home providing room and board for one or two people with an intellectual disability or autism who are 18 years of age or older and who need a yearly average of 30 hours or less direct training and assistance per week per home, from the agency, the county intellectual disability program or the family.

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#### § 6500.4. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

*Agency*—A person or legally constituted organization administering one or more [family living] life sharing homes.

*Autism*—A developmental disorder defined by the edition of the diagnostic and statistical manual of mental disorders, or its successor, in effect at the time the diagnosis is made. The term includes autistic disorder, Asperger's disorder and autism spectrum disorder.

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*[Content discrepancy]*—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]

*Direct service worker*—A person whose primary job function is to provide services to an individual who resides in the provider's [family living] life sharing home.

*[Documentation—*Written statements that accurately record details, substantiate a claim or provide evidence of an event.]

*[Family living] Life sharing home or home—*

(i) The private home of an individual or a family in which residential care is provided to one or two individuals with an intellectual disability or autism, except as provided in § 6500.3(f) (relating to applicability).

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*[ISP—Individual Support Plan—*The comprehensive document that identifies services and expected outcomes for an individual.]

*Individual—*

(i) A person with an intellectual disability or autism who resides, or receives residential respite care, in a [family living] life sharing home and who is not a relative of the owner of the family members.

(ii) The term does not include family members.

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*[Outcomes—*Goals the individual and individual's plan team choose for the individual to acquire, maintain or improve.

*Plan lead—*The family living specialist, when the individual is not receiving services

through an SCO.

*Plan team*—The group that develops the ISP.]

PSP—Person-centered support plan.

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*Respite care*—Temporary [family living] care not to exceed 31 calendar days for an individual in a calendar year.

Restraint - A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the PSP or used on an emergency basis.

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#### **§ 6500.15. Responsibility for compliance.**

(a) If an agency is the legal entity administering the [family living] home, the agency is responsible for compliance with this chapter.

(b) If the [family living] life sharing home is the legal entity, the [family living] home is responsible for compliance with this chapter.

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#### **§ 6500.17. Self-assessment of homes.**

(a) If an agency is the legal entity for the [family living] home, the agency shall complete a self-assessment of each home the agency is licensed to operate within 3 to 6 months

prior to the expiration date of the agency's certificate of compliance, to measure and record compliance with this chapter.

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**§ 6500.20.[ Reporting of unusual incidents.**

(a) An unusual incident is abuse or suspected abuse of an individual; injury, trauma or illness of an individual requiring inpatient hospitalization; suicide attempt by an individual; violation or alleged violation of an individual's rights; an individual who is missing for more than 24 hours or could be in jeopardy if missing at all; misuse or alleged misuse of individual funds or property; outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to reportable diseases); or an incident requiring the services of a fire department or law enforcement agency.

(b) Written policies and procedures on the prevention, reporting, investigation and management of unusual incidents shall be kept.

(c) Oral notification of the county intellectual disability program of the county in which the home is located, the funding agency if applicable, and the appropriate regional office of the Department shall be given within 24 hours after abuse or suspected abuse of an individual or an incident requiring the services of a fire department or law enforcement agency occurs.

(d) An investigation of the unusual incident shall be initiated and an unusual incident report shall be completed on a form specified by the Department. Copies of the unusual

incident report shall be sent to the county intellectual disability program of the county in which the home is located, the funding agency if applicable, and the appropriate regional office of the Department, within 72 hours after an unusual incident occurs.

(e) A copy of the final unusual incident report shall be sent to the county intellectual disability program of the county in which the home is located, the funding agency if applicable, and the appropriate regional office of the Department at the conclusion of the investigation.

(f) A copy of unusual incident reports relating to an individual shall be kept in the individual's record.

(g) A copy of unusual incident reports relating to the home itself, such as those requiring the services of a fire department, shall be kept.

(h) The individual's family or guardian shall be immediately notified in the event of an unusual incident relating to the individual, if appropriate.

**§ 6500.21. Reporting of deaths.**

(a) A death report shall be completed on a form specified by the Department and sent to the county intellectual disability program of the county in which the home is located, the funding agency and the regional office of the Department, within 24 hours after a death of an individual occurs.

(b) An investigation shall be initiated and oral notification of the county intellectual disability program of the county in which the facility is located, the funding agency and

the appropriate regional office of the Department shall be given within 24 hours after an unusual or unexpected death occurs.

(c) A copy of death reports shall be kept.

(d) The individual's family or guardian shall be immediately notified of the death of an individual.

#### **§ 6500.22. Incident record.**

A record shall be kept of individual illnesses, seizures, acute emotional traumas and accidents requiring medical attention but not inpatient hospitalization, that occur at the home.]

#### **Incident report and investigation.**

(a) The agency and the home shall report the following incidents, alleged incidents and suspected incidents in the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) Suicide attempt.

(3) Inpatient admission to a hospital.

(4) Visit to an emergency room.

(5) Abuse.

(6) Neglect.

(7) Exploitation.

- (8) An individual who is missing for more than 24 hours or who could be in jeopardy if missing at all.
- (9) Law enforcement activity.
- (10) Injury requiring treatment beyond first aid.
- (11) Fire requiring the services of the fire department.
- (12) Emergency closure.
- (13) Use of a restraint.
- (14) Theft or misuse of individual funds.
- (15) A violation of individual rights.
- (b) The individual and the persons designated by the individual shall be notified immediately upon discovery of an incident relating to the individual.
- (c) The agency and the home shall keep documentation of the notification in subsection (b).
- (d) The incident report, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual and persons designated by the individual, upon request.
- (e) The agency shall take immediate action to protect the health, safety and well-being of the individual, following the initial knowledge or notice of an incident, alleged incident and suspected incident.
- (f) The home shall initiate an investigation of an incident within 24 hours of discovery by a staff person.
- (g) A Department-certified incident investigator shall conduct the incident investigation of the incident listed in subsection (a).

(h) The agency shall finalize the incident report in the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person.

(i) The agency shall provide the following information to the Department as part of the final incident report:

- (1) Additional detail about the incident.
- (2) The results of the incident investigation.
- (3) A description of the corrective action taken in response to an incident.
- (4) Action taken to protect the health, safety and well-being of the individual.
- (5) The person responsible for implementing the corrective action.
- (6) The date the corrective action was implemented or is to be implemented.

**§ 6500.21. Incident procedures to protect the individual.**

(a) In investigating an incident, the agency shall review and consider the following needs of the affected individual:

- (1) Potential risks.
- (2) Health care information.
- (3) Medication history and current medication.
- (4) Behavioral health history.
- (5) Incident history.
- (6) Social needs.
- (7) Environmental needs.
- (8) Personal safety.

- (b) The agency shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.
- (c) The agency shall work cooperatively with the PSP team, to revise the PSP if indicated by the incident investigation.

**§ 6500.22. Incident analysis.**

- (a) The agency shall complete the following for each confirmed incident:
  - (1) Analysis to determine the root cause of the incident.
  - (2) Corrective action.
  - (3) A strategy to address the potential risks to the affected individual.
- (b) The agency shall review and analyze incidents and conduct a trend analysis at least every 3 months.
- (c) The agency shall identify and implement preventive measures to reduce:
  - (1) The number of incidents.
  - (2) The severity of the risks associated with the incident.
  - (3) The likelihood of an incident recurring.
- (d) The agency shall educate staff persons and the individual based on the circumstances of the incident.
- (e) The agency shall analyze incident data continuously and take actions to mitigate and manage risks.

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**§ 6500.25. Applicable laws and regulations.**

The home and agency shall comply with applicable Federal, State and local laws, regulations and ordinances.

**INDIVIDUAL RIGHTS**

**§ [6500.31. Informing and encouraging exercise of rights.**

(a) Each individual, or the individual's parent, guardian or advocate if appropriate, shall be informed of the individual's rights upon admission and annually thereafter.

(b) A statement signed and dated by the individual, or the individual's parent, guardian or advocate if appropriate, acknowledging receipt of the information on individual rights upon admission and annually thereafter, shall be kept.

(c) Each individual shall be encouraged to exercise the individual's rights.

**§ 6500.32. Rights.**

An individual may not be deprived of rights.

**§ 6500.33. Rights of the individual.**

(a) An individual may not be neglected, abused, mistreated or subjected to corporal punishment.

(b) An individual may not be required to participate in research projects.

(c) An individual has the right to manage the individual's personal financial affairs.

(d) An individual has the right to participate in program planning that affects the individual.

(e) An individual has the right to privacy in bedrooms, bathrooms and during personal care.

(f) An individual has the right to receive, purchase, have and use personal property.

(g) An individual has the right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with the individual's family and persons of the individual's own choice.

(h) An individual has the right to reasonable access to a telephone and the opportunity to receive and make private calls, with assistance when necessary.

(i) An individual has the right to unrestricted mailing privileges.

(j) An individual who is of voting age shall be informed of the right to vote and shall be assisted to register and vote in elections.

(k) An individual has the right to practice the religion or faith of the individual's choice.

(l) An individual has the right to be free from excessive medication.

(m) An individual may not be required to work at the home except for the upkeep of the individual's bedrooms and in the upkeep of family areas and yard.

**§ 6500.34. Civil rights.**

- (a) An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.
- (b) Civil rights policies and procedures shall be developed and implemented. Civil rights policies and procedures shall include the following:
  - (1) Nondiscrimination in the provision of services, admissions, placement, referrals and communication with non-English speaking and nonverbal individuals.
  - (2) Physical accessibility and accommodation for individuals with physical disabilities.
  - (3) The opportunity to lodge civil rights complaints.
  - (4) Informing individuals of their right to register civil rights complaints. ]

**Exercise of rights.**

- (a) An individual may not be deprived of rights, as provided under § 6500.32 (relating to rights of the individual).
- (b) An individual shall be continually supported to exercise the individual's rights.
- (c) An individual shall be provided the support and accommodation necessary to be able to understand and actively exercise the individual's rights.
- (d) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.
- (e) A court's written order that restricts an individual's rights shall be followed.
- (f) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with a court order.

- (g) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in decision-making in accordance with the court order.
- (h) An individual has the right to designate persons to assist in decision-making on behalf of the individual.

**§ 6500.32. Rights of the individual.**

- (a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.
- (b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely and practice the religion of his choice or to practice no religion.
- (c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.
- (d) An individual shall be treated with dignity and respect.
- (e) An individual has the right to make choices and accept risks.
- (f) An individual has the right to refuse to participate in activities and supports.
- (g) An individual has the right to control the individual's own schedule.
- (h) An individual has the right to privacy of person and possessions.
- (i) An individual has the right of access to and security of the individual's possessions.

- (j) An individual has the right to voice concerns about the supports the individual receives.
- (k) An individual has the right to participate in the development and implementation of the PSP.
- (l) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with persons of the individual's choice, at any time.
- (m) An individual has the right to unrestricted access to send and receive mail and other forms of communications, unopened and unread by others.
- (n) An individual has the right to unrestricted and private access to telecommunications.
- (o) An individual has the right to manage and access the individual's own finances.
- (p) An individual has the right to choose persons with whom to share a bedroom.
- (q) An individual has the right to furnish and decorate the individual's bedroom and the common areas of the home.
- (r) An individual has the right to lock the individual's bedroom door.
- (s) An individual has the right to access food at any time.
- (t) An individual has the right to make informed health care decisions.

**§ 6500.33. Negotiation of choices.**

- (a) An individual's rights shall be exercised so that another individual's rights are not violated.
- (b) Choices shall be negotiated by the affected individuals, in accordance with the home's procedures for the individuals to resolve differences and make choices.

**§ 6500.34. Informing of rights.**

(a) The agency shall inform and explain individual rights to the individual, and persons designated by the individual, upon admission to the home and annually thereafter.

(b) The home shall keep a copy of the statement signed by the individual, or an individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

**STAFFING**

**§ 6500.41. Effective date of staff qualifications.**

(a) Sections 6500.42(c) and 6500.43(c) (relating to chief executive officer; and [family living] life sharing specialist) apply to chief executive officers and [family living] lifesharing specialists hired or promoted after November 8, 1991.

(b) Sections 6400.43(c) and 6400.44(c) as published as Chapter 9054 at 12 Pa.B. 384 (January 23, 1982) and which appeared in this title of the *Pennsylvania Code* at serial pages (133677) to (133678) apply to chief executive officers and [family living] life sharing specialists hired or promoted prior to November 8, 1991.

**§ 6500.42. Chief executive officer.**

(a) If an agency is the legal entity administering the home, there shall be one chief executive officer responsible for the [family living] life sharing program or agency.

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**§ 6500.43. [Family living specialist] Life sharing specialist.**

(a) There shall be a [family living specialist] life sharing specialist for each individual.

(b) A [family living specialist] life sharing specialist shall be assigned to no more than 8 homes.

(c) A [family living specialist] life sharing specialist shall be responsible for a maximum of 16 people, including people served in other types of services.

(d) The [family living specialist] life sharing specialist shall be responsible for the following:

(1) [Coordinating and completing assessments.

(2) Providing the assessment as required under § 6500.151(f) (relating to assessment).

(3) Participating in the development of the ISP, including annual updates and revisions of the ISP.

(4) Attending the ISP meetings.

(5) Fulfilling the role of plan lead, as applicable, under § § 6500.152 and 6500.156(f)

and (g) (relating to development, annual update and revision of the ISP; and ISP review and revision).

(6) Reviewing the ISP, annual updates and revisions for content accuracy.

(7) Reporting content discrepancy to the SC, as applicable, and plan team members.

- (8) Implementing the ISP as written.
- (9) Supervising, monitoring and evaluating services provided to the individual.
- (10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.
- (11) Reporting a change related to the individual's needs to the SC, as applicable, and plan team members.
- (12) Reviewing the ISP with the individual as required under § 6500.156.
- (13) Documenting the review of the ISP as required under § 6500.156.
- (14) Providing the documentation of the ISP review to the SC, as applicable, and plan team members as required under § 6500.156(d).
- (15) Informing plan team members of the option to decline the ISP review documentation as required under § 6500.156(e).
- (16) Recommending a revision to a service or outcome in the ISP as provided under § 6500.156(c)(4).
- (17) Coordinating the services provided to an individual.
- (18) Coordinating the support services for the family.
- (19) Coordinating the training of direct service workers and the family in the content of health and safety needs relevant to each individual.

(20) Developing and implementing provider services as required under § 6500.158 (relating to provider services). ]

Coordinating the completion of assessments.

(2) Participating in the PSP process, PSP development, PSP team reviews and the implementation of the PSP in accordance with this chapter.

(3) Providing and supervising activities for the individuals in accordance with the PSPs.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and involvement with families and friends.

(e) A [family living specialist] life sharing specialist shall have one of the following groups of qualifications:

(1) A master's degree or above from an accredited college or university and 1 year work experience working directly with persons with an intellectual disability or autism.

(2) A bachelor's degree from an accredited college or university and 2 years work experience working directly with persons with an intellectual disability or autism.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years work experience working directly with persons with an intellectual disability or autism.

(4) A high school diploma or general education development certificate and 6 years work experience working directly with persons with an intellectual disability or autism.

**§ 6500.44. Supervision.**

(a) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the individual's [ISP] PSP, as an outcome which requires the achievement of a higher level of independence.

(b) An individual requiring direct supervision may not be left under the supervision of a person under the age of 18.

(c) There shall be a [family living] life sharing specialist or designee accessible when the individual is in the home.

(d) Supervision as specified in the [ISP] PSP shall be implemented as written when the supervision specified in the [ISP] PSP is greater than required under subsections (a), (b) and (c).

(e) The staff qualifications and staff ratio as specified in the [ISP] PSP shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

(f) An individual may not be left unsupervised solely for the convenience of the family or direct service worker.

**§ 6500.45. CPR, first aid and Heimlich Maneuver training.**

(a) [The adult family member who will have primary responsibility for caring for and providing services to the individual shall have at least 24 hours of training related to intellectual disability, family dynamics, community participation, individual service planning and delivery, relationship building and the requirements specified in this chapter, prior to an individual living in the home.

(b)] The primary caregiver shall be trained by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid and Heimlich techniques prior to an individual living in the home and annually thereafter.

[(c)] (b) The primary caregiver shall be trained and certified by an individual certified as a trainer by a hospital or other recognized health care organization, in cardiopulmonary resuscitation, if indicated by the medical needs of the individual, prior to the individual living in the home and annually thereafter.

**[§ 6500.46. Annual training.**

(a) The adult family member who will have primary responsibility for caring for and providing services to the individual shall have at least 24 hours of training in the human services field annually.

(b) A family living specialist who is employed by an agency for more than 40 hours per month shall have at least 24 hours of training related to intellectual disability and the requirements specified in this chapter annually.

**§ 6500.47. Record of training.**

Records of preservice and annual training, including the training source, content, dates, length of training, copies of certificates received and persons attending shall be kept.]

**§ 6500.46. Annual training plan.**

(a) The agency shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, other data and analysis indicating person's training needs and as required under §§ 6500.45 and 6500.48 (relating to CPR, first aid and Heimlich maneuver training and annual training).

(b) The annual training plan shall include an orientation program as specified in § 6100.47 (relating to orientation program).

(c) The annual training plan shall include training aimed at improving the knowledge, skills and core competencies of the person to be trained.

**§ 6500.47. Orientation program.**

(a) Prior to an individual living in the home, the primary caregiver and the life sharing specialist shall complete an orientation program as described in subsection (b).

(b) The orientation program shall encompass the following areas:

- (1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.

- (2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. § 10225.701-10225.708 (relating to older adult protective services), 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101-10210.704 (relating to adult protective services) and applicable protective services regulations.
- (3) Individual rights.
- (4) Recognizing and reporting incidents.
- (5) Job-related knowledge and skills.

**§ 6500.48. Annual training.**

- (a) The primary caregiver and the life sharing specialist shall complete 24 hours of training each year.
- (b) A minimum of 8 of the annual training hours specified in subsection (a) shall encompass the following areas:
  - (1) The application of person-centered practices, including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships.
  - (2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. § 10225.701-10225.708 (relating to older adult protective services), 23 Pa.C.S. §§ 6301-6386 (relating to child protective services), 35 P.S. §§ 10210.101–10210.704

(relating to adult protective services) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of positive interventions, if the primary caregiver will provide a support to an individual with a dangerous behavior.

(c) The balance of the annual training hours shall be in areas identified by the agency in the agency's annual training plan in § 6500.46 (relating to annual training plan).

(d) All training, including those training courses identified in subsections (b) and (c), shall be included in the agency's annual training plan.

**§ 6500. 49. Training records.**

(a) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.

(b) A training record for each person trained shall be kept.

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**PHYSICAL SITE**

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**§ 6500.69. Indoor temperature.**

(a) The indoor temperature in individual bedrooms and [family living] life sharing areas may not be less than 62°F during nonsleeping hours while individuals are present in the home.

(b) The indoor temperature in individual bedrooms and [family living] life sharing areas may not be less than 55°F during sleeping hours.

(c) When the indoor temperature in individual bedrooms or [family living] life sharing areas exceeds 85°F, mechanical ventilation such as fans shall be used.

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**§ 6500.76. Furniture.**

Furniture in individual bedrooms and [family living] life sharing areas shall be nonhazardous, clean and sturdy.

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**MEDICATIONS**

**§ 6500.131. [Storage of medications.]**

(a) Prescription and nonprescription medications of individuals shall be kept in their original containers, except for medications of individuals who self-administer

medications and keep their medications in personal daily or weekly dispensing containers.

(b) Prescription and potentially toxic nonprescription medications shall be kept in an area or container that is locked or made inaccessible to the individuals, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(c) Prescription and potentially toxic nonprescription medications stored in a refrigerator shall be kept in a separate locked container or made inaccessible to the individuals, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(d) Prescription and nonprescription medications of individuals shall be stored under proper conditions of sanitation, temperature, moisture and light.

(e) Discontinued prescription medications of individuals shall be disposed of in a safe manner.

**§ 6500.132. Labeling of medications.**

(a) The original container for prescription medications of individuals shall be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

(b) Nonprescription medications used by individuals shall be labeled with the original label.

**§ 6500.133. Use of prescription medications.**

(a) A prescription medication shall only be used by the individual for whom the medication was prescribed.

(b) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a written protocol as part of the ISP to address the social, emotional and environmental needs of the individual related to the symptoms of the diagnosed psychiatric illness.

(c) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a review with documentation by a licensed physician at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.

**§ 6500.134. Medication log.**

(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered, and the name of the person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer medication.

(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication.

(c) A list of prescription medications, the prescribed dosage and the name of the prescribing physician shall be kept for each individual who self-administers medication.

**§ 6500.135. Medication errors.**

Documentation of medication errors and follow-up action taken shall be kept.

**§ 6500.136. Adverse reaction.**

If an individual has a suspected adverse reaction to a medication, the family shall notify the prescribing physician immediately. Documentation of adverse reactions shall be kept in the individual's record.

**§ 6500.137. Administration of prescription medications and insulin injections.**

(a) Prescription medications and insulin injections shall be administered according to the directions specified by a licensed physician, certified nurse practitioner or licensed physician's assistant.

(b) An insulin injection administered by an individual or another person shall be premeasured by the individual or licensed medical personnel.

**§ 6500.138. Medications training.**

(a) Family members who administer prescription medications or insulin injections to individuals shall receive training by the individual's source of health care about the administration, side effects and contraindications of the specific medication or insulin.

(b) Family members who administer insulin injections to individuals shall have completed and passed a diabetes patient education program that meets the National Standards for Diabetes Patient Education Programs of the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Bethesda, Maryland 20205.

(c) Documentation of the training specified in subsections (a) and (b) shall be kept. ]

**Self-administration.**

(a) An agency shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

(c) The agency shall provide or arrange for assistive technology to support the individual's self-administration of medications.

(d) The PSP shall identify if the individual is unable to self-administer medications.

(e) To be considered able to self-administer medications, an individual shall do all of the following:

(1) Recognize and distinguish his medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken. This knowledge may include reminders of the schedule and offering the medication at the prescribed times, as specified in subsection (b).

(4) Take or apply the individual's own medication with or without the use of assistive technology.

**§ 6500.132. Medication administration.**

(a) An agency whose staff persons or others are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer the individual's prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A person who has completed the medication administration training as specified in § 6500.139 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

- (3) Crush or split the medication as ordered by the prescriber.
- (4) Place the medication in a medication cup or other appropriate container, or in the individual's hand, mouth or other route as ordered by the prescriber.
- (5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.
- (6) Injection of insulin or epinephrine in accordance with this chapter.

**§ 6500.133. Storage and disposal of medications.**

- (a) Prescription and nonprescription medications shall be kept in their original labeled containers.
- (b) A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.
- (c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.
- (d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.
- (e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.
- (f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

- (g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.
- (h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to the Department of Environmental Protection and applicable Federal and State regulations.
- (i) Subsections (a), (b), (c), (d) and (f) do not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom.

**§ 6500.134. Labeling of medications.**

The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- (1) The individual's name.
- (2) The name of the medication.
- (3) The date the prescription was issued.
- (4) The prescribed dosage and instructions for administration.
- (5) The name and title of the prescriber.

**§ 6500.135. Prescription medications.**

- (a) A prescription medication shall be prescribed in writing by an authorized prescriber.
- (b) A prescription order shall be kept current.
- (c) A prescription medication shall be administered as prescribed.
- (d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a registered nurse in accordance with regulations of the Department of State. The individual's medication record shall be updated as soon as a written notice of the change is received.

**§ 6500.136. Medication record.**

(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:

(1) Individual's name.

(2) Name and title of the prescriber.

(3) Drug allergies.

(4) Name of medication.

(5) Strength of medication.

(6) Dosage form.

(7) Dose of medication.

(8) Route of administration.

(9) Frequency of administration.

(10) Administration times.

(11) Diagnosis or purpose for the medication, including pro re nata.

(12) Date and time of medication administration.

(13) Name and initials of the person administering the medication.

(14) Duration of treatment, if applicable.

(15) Special precautions, if applicable.

- (16) Side effects of the medication, if applicable.
- (b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.
- (c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.
- (d) The directions of the prescriber shall be followed.

**§ 6500.137. Medication errors.**

- (a) Medication errors include the following:
  - (1) Failure to administer a medication.
  - (2) Administration of the wrong medication.
  - (3) Administration of the wrong amount of medication.
  - (4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.
  - (5) Administration to the wrong person.
  - (6) Administration through the wrong route.
- (b) Documentation of medication errors, follow-up action taken and the prescriber's response shall be kept in the individual's record.

**§ 6500.138. Adverse reaction.**

- (a) If an individual has a suspected adverse reaction to a medication, the home shall immediately consult a health care practitioner or seek emergency medical treatment.
- (b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction and the action taken shall be documented.

**§ 6500.139. Medication administration training.**

- (a) A person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer the following:

  - (1) Oral medications.
  - (2) Topical medications.
  - (3) Eye, nose and ear drop medications.
- (b) A person may administer insulin injections following:

  - (1) Successful completion of the course specified in subsection (a).
  - (2) Successful completion of a Department-approved diabetes patient education program within the past 12 months.
- (c) A person may administer an epinephrine injection via an auto-injection device in response to anaphylaxis or another serious allergic reaction following:

  - (1) Successful completion of the course specified in subsection (a).
  - (2) Successful completion of training relating to the use of an auto-injection epinephrine injection device provided by a licensed, registered or certified health care professional within the past 12 months.

(d) A record of the training shall be kept including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

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## PROGRAM

### **§ 6500.151. Assessment.**

(a) Each individual shall have an initial assessment within 1 year prior to or 60 calendar days after admission to the [family living] home and an updated assessment annually thereafter. The initial assessment must include an assessment of adaptive behavior and level of skills completed within 6 months prior to admission to the [family living] home.

(b) If the [program specialist] life sharing specialist is making a recommendation to revise a service or outcome in the [ISP as required under § 6500.156(c)(4) (relating to ISP review and revision)] PSP, the individual shall have an assessment completed as required under this section.

(c) The assessment shall be based on assessment instruments, interviews, progress notes and observations.

(d) The [family living specialist] life sharing specialist shall sign and date the assessment.

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(f) The [program specialist] life sharing specialist shall provide the assessment to the SC, as applicable, and [plan] PSP team members at least 30 calendar days prior to [an ISP] a PSP meeting [for the development of the ISP, the annual update, and revision of the ISP under § § 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP)].

**§ 6500.152. [Development, annual update and revision of the ISP.**

(a) An individual shall have one ISP.

(b) When an individual is not receiving services through an SCO, the family living program specialist shall be the plan lead when one of the following applies:

(1) The individual resides at a family living home licensed under this chapter.

(2) The individual resides at a family living home licensed under this chapter and attends a facility licensed under Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities).

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the individual's current assessments as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the individual's admission date to the family living home.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) and also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 6500.156 (relating to ISP review and revision), shall be sent as required under § 6500.157 (relating to copies).

**§ 6500.153. Content of the ISP.**

The ISP, including annual updates and revisions under § 6500.156 (relating to ISP review and revision) must include the following:

(1) Services provided to the individual and expected outcomes chosen by the individual and individual's plan team.

(2) Services provided to the individual to increase community involvement, including volunteer or civic-minded opportunities and membership in National or local organizations as required under § 6500.158 (relating to provider services).

(3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.

(4) A protocol and schedule outlining specified periods of time for the individual to be without direct supervision, if the individual's current assessment states the individual may be without direct supervision and if the individual's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve the higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the individual, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.

(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

- (iii) The method and time line for eliminating the use of restrictive procedures.
  - (iv) A protocol for intervention or redirection without utilizing restrictive procedures.
- (7) Assessment of the individual's potential to advance in the following:
- (i) Residential independence.
  - (ii) Community involvement.
  - (iii) Vocational programming.
  - (iv) Competitive community-integrated employment.

**§ 6500.154. Plan team participation.**

(a) The plan team shall participate in the development of the ISP, including the annual updates and revision under § 6500.156 (relating to ISP review and revision).

(1) A plan team shall include as its members the following:

- (i) The individual.
- (ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the individual.
- (iii) A direct service worker who works with the individual from each provider delivering services to the individual.
- (iv) Any other person the individual chooses to invite.

(2) If the following have a role in the individual's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the individual from each provider delivering a service to the individual.

(iii) The individual's parent, guardian or advocate.

(b) At least three plan team members, in addition to the individual, if the individual chooses to attend, shall be present for the ISP, annual update and ISP revision meeting.

(c) Plan team members who attend a meeting under subsection (b) shall sign and date the signature sheet.

#### **§ 6500.155. Implementation of the ISP.**

(a) The ISP shall be implemented by the ISP's start date.

(b) The ISP shall be implemented as written.

#### **§ 6500.156. ISP review and revision.**

(a) The family living specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the family living home licensed under this

chapter with the individual every 3 months or more frequently if the individual's needs change, which impacts the services as specified in the current ISP.

(b) The family living specialist and individual shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of an individual's participation and progress during the prior 3 months toward ISP outcomes supported by services provided by the family living home licensed under this chapter.

(2) A review of each section of the ISP specific to the family living home licensed under this chapter.

(3) The family living specialist shall document a change in the individual's needs, if applicable.

(4) The family living specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the family living specialist shall complete a revised assessment as required under § 6500.151(b) (relating to assessment).

(d) The family living specialist shall provide the ISP review documentation, including recommendations if applicable, to the SC, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The family living specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead as applicable, under §§ 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.

**§ 6500.157. Copies.**

A copy of the ISP, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP, annual update and ISP revision meetings.

**§ 6500.158. Provider services.**

(a) The family living home shall provide services including assistance, training and support for the acquisition, maintenance or improvement of functional skills, personal needs, communication and personal adjustment.

(b) The family living home shall provide opportunities to the individual for participation in community life, including volunteer or civic-minded opportunities and membership in National or local organizations.

(c) The family living home shall provide services to the individual as specified in the individual's ISP.

(d) The family living home shall provide services that are age and functionally appropriate to the individual.]

**Development of the PSP.**

(a) An individual shall have one, approved and authorized PSP at a given time.

(b) An individual's service implementation plan shall be consistent with the PSP in subsection (a).

(c) The support coordinator, targeted support manager or life sharing specialist shall coordinate the development of the PSP, including revisions, in cooperation with the individual and the individual's PSP team.

(d) The initial PSP shall be developed based on the individual assessment within 60 days of the individual's date of admission to the home.

- (e) The PSP shall be initially developed, revised annually and revised when an individual's needs change, based upon a current assessment.
- (f) The individual and persons designated by the individual shall be involved in and supported in the development and revisions of the PSP.
- (g) The PSP, including revisions, shall be documented on a form specified by the Department.

**§ 6500.153. The PSP team.**

- (a) The PSP shall be developed by an interdisciplinary team including the following:
  - (1) The individual.
  - (2) Persons designated by the individual.
  - (3) The individual's direct care staff persons.
  - (4) The program specialist.
  - (5) The support coordinator, targeted support manager or a program representative from the funding source, if applicable.
  - (6) The program specialist for the individual's day program, if applicable.
  - (7) Other specialists such as health care, behavior management, speech, occupational, physical therapy, as appropriate for the individual needs.
- (b) At least three members of the PSP team, in addition to the individual and persons designated by the individual, shall be present at a PSP meeting at which the PSP is developed or revised.
- (c) Members of the PSP team who attend the meeting shall sign and date the PSP.

**§ 6500.154. The PSP process.**

The PSP process shall:

- (1) Provide necessary information and support to ensure that the individual directs the PSP process to the maximum extent possible.
- (2) Enable the individual to make informed choices and decisions.
- (3) Be conducted to reflect what is important to the individual to ensure that supports are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.
- (4) Be timely in relation to the individual's needs and occur at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.
- (5) Be communicated in clear and understandable language.
- (6) Reflect cultural considerations of the individual
- (7) Include guidelines for solving disagreements among the PSP team members.
- (8) Include a method for the individual to request updates to the PSP.

**§ 6500.155. Content of the PSP.**

The PSP, including revisions, shall include the following:

- (1) The individual's strengths and functional abilities.
- (2) The individual's individualized clinical and support needs.
- (3) The individual's goals and preferences related to relationships, community participation, employment, income and savings, health care, wellness and education.
- (4) Individually identified, person-centered desired outcomes.

- (5) Supports to assist the individual to achieve desired outcomes.
- (6) The type, amount, duration and frequency for the support, specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.
- (7) Communication mode, abilities and needs.
- (8) Opportunities for new or continued community participation.
- (9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.
- (10) Modification of individual rights as necessary to mitigate risks, if applicable.
- (11) Health care information, including a health care history.
- (12) Financial information including how the individual chooses to use personal funds.
- (13) The person responsible for monitoring the implementation of the PSP.

**§ 6500.156. Implementation of the PSP.**

The home and the agency shall implement the PSP including revisions.

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**§ 6500.159. Day services.**

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(b) Day services and activities shall be provided at a location other than the [family living] home where the individual lives, unless one of the following exists:

- (1) There is written annual documentation by a licensed physician that it is medically necessary for the individual to complete day services at the [family living] home.

(2) There is written annual documentation by the plan team that it is in the best interest of the individual to complete day services at the [family living] home.

**§ 6500.160. Recreational and social activities.**

(a) The [family living] home shall provide recreational and social activities, including volunteer or civic-minded opportunities and membership in National or local organizations at the following locations:

(1) The [family living] home.

(2) Away from the [family living] home.

(b) Time away from the [family living] home may not be limited to time in school, work or vocational, developmental and volunteer facilities.

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**[RESTRICTIVE PROCEDURES] POSITIVE INTERVENTION**

**§ 6500.161. [Definition of restrictive procedures.**

A restrictive procedure is a practice that limits an individual's movement, activity of function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.

**§ 6500.162. Written policy.**

A written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which restrictive procedures may be used, the persons who may authorize the use of restrictive procedures, a mechanism to monitor and control the use of restrictive procedures, and a process for the individual and family to review the use of restrictive procedures shall be kept.

**§ 6500.163. Appropriate use of restrictive procedures.**

(a) A restrictive procedure may not be used as retribution, for the convenience of the family, as a substitute for the program or in a way that interferes with the individual's developmental program.

(b) For each incident requiring restrictive procedures:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

**§ 6500.164. Restrictive procedure review committee.**

(a) If restrictive procedures are used, there shall be a restrictive procedure review committee.

(b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.

(c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.

(d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.

**§ 6500.165. Restrictive procedure plan.**

(a) For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written prior to the use of restrictive procedures.

(b) The restrictive procedure plan shall be developed and revised with the participation of the family living specialist, the family, the interdisciplinary team as appropriate and other professionals as appropriate.

(c) The restrictive procedure plan shall be reviewed, and revised if necessary, according to the time frame established by the restrictive procedure review committee, not to exceed 6 months.

(d) The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the restrictive procedure review committee and the family living specialist, prior to the use of a restrictive procedure, whenever the restrictive procedure plan is revised and at least every 6 months.

(e) The restrictive procedure plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.

(2) The single behavioral outcome desired stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.

(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(5) A target date for achieving the outcome.

(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in this chapter.

(7) Physical problems that require special attention during the use of restrictive procedures.

(8) The name of the person responsible for monitoring and documenting progress with the plan.

(f) The restrictive procedure plan shall be implemented as written.

(g) Copies of the restrictive procedure plan shall be kept in the individual's record.

**§ 6500.166. Training.**

(a) If a restrictive procedure is used, there shall be at least one person available when restrictive procedures are used who has completed training within the past 12 months in the use of and ethics of using restrictive procedures including the use of alternate positive approaches.

(b) Persons responsible for developing, implementing or managing a restrictive procedure plan shall be trained in the use of the specific techniques or procedures that are used.

(c) If manual restraint or exclusion is used, persons responsible for developing, implementing or managing a restrictive procedure plan shall have experienced the use of the specific techniques or procedures directly on themselves.

(d) Documentation of the training program provided, including the persons trained, dates of training, description of training and training source shall be kept.

**§ 6500.167. Seclusion.**

Seclusion, defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.

**§ 6500.168. Aversive conditioning.**

The use of aversive conditioning, defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli, is prohibited.

**§ 6500.169. Chemical restraints.**

(a) A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual.

(b) Administration of a chemical restraint is prohibited except for the administration of drugs ordered by a licensed physician on an emergency basis.

(c) If a chemical restraint is administered as specified in subsection (b) the following apply:

(1) Prior to each incidence of administering a drug on an emergency basis, a licensed physician has examined the individual and has given a written order to administer the drug.

(2) Prior to each readministration of a drug on an emergency basis, a licensed physician has examined the individual and has ordered readministration of the drug.

(d) If a chemical restraint is administered as specified in subsection (c) the following apply:

(1) The individual's vital signs shall be monitored at least once each hour.

(2) The physical needs of the individual shall be met promptly.

(3) A Pro Re Nata (PRN) order for controlling acute, episodic behavior is prohibited.

(e) A drug ordered by a licensed physician as part of an ongoing program of medication is not a chemical restraint.

(f) A drug ordered by a licensed physician for a specific, time-limited stressful event or situation to assist the individual to control the individual's behavior, is not a chemical restraint.

(g) A drug ordered by a licensed physician as pretreatment prior to medical or dental examination or treatment is not a chemical restraint.

(h) A drug self-administered by an individual is not a chemical restraint.

(i) If a drug is administered in accordance with subsection (b), (e), (f) or (g), there shall be training for the individual aimed at eliminating or reducing the need for the drug in the future.

(j) Documentation of compliance with subsections (b)—(h) shall be kept.

**§ 6500.170. Mechanical restraints.**

(a) A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with

fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices.

(b) The use of a mechanical restraint is prohibited except for use of helmets, mitts and muffs to prevent self-injury on an interim basis not to exceed 3 months after an individual is admitted to the home.

(c) If a mechanical restraint is used as specified in subsection (b), the following apply:

(1) The use of a mechanical restraint may not exceed 2 hours, unless a licensed physician examines the individual and gives written orders to continue use of the restraint. Reexamination and new orders by a licensed physician are required for each 2-hour period the restraint is continued. If a restraint is removed for a purpose other than for movement and reused within 24 hours after the initial use of the restraint, it is considered continuation of the initial restraint.

(2) A licensed physician shall be notified immediately after a mechanical restraint is used.

(3) The restraint shall be checked for proper fit at least every 15 minutes.

(4) The physical needs of the individual shall be met promptly.

(5) The restraint shall be removed completely for at least 10 minutes during every 2 hours the restraint is used, unless the individual is sleeping.

(6) There shall be training for the individual aimed at eliminating or reducing the need for the restraint in the future.

(7) Documentation of compliance with subsections (b) and paragraphs (1)—(6) shall be kept.

(d) A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

**§ 6500.171. Use of personal funds and property.**

(a) An individual's personal funds or property may not be used as reward or punishment.

(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages.

**§ 6500.172. Manual restraints.**

(a) Manual restraint is defined as a physical hands-on technique that lasts more than 30 seconds, used to control acute, episodic behavior that restricts the movement or functions of an individual or portion of an individual's body such as basket holds and prone or supine containment.

(b) Manual restraint shall be used only when necessary to protect the individual from injuring himself or others.

(c) Manual restraint shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from injuring himself or others.

(d) An individual shall be released from the manual restraint within the time specified in the restrictive procedure plan not to exceed 30 minutes within any 2 hour period.

**§ 6500.173. Exclusion.**

(a) Exclusion is the removal of an individual from the individual's immediate environment and restricting the individual alone to a room or area. If a family member remains with the individual it is not exclusion.

(b) Exclusion shall be used only when necessary to protect the individual from self-injury or injury to others.

(c) Exclusion shall only occur when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from self-injury or injury to others.

(d) An individual shall be permitted to return to routine activity within the time specified in the restrictive procedure plan not to exceed 60 minutes within a 2-hour period.

(e) Exclusion may not be used for an individual more than 4 times within a 24-hour period.

(f) An individual in exclusion shall be monitored continually.

(g) A room or area used for exclusion shall be a routine living space with at least 40 square feet of indoor floor space.

**§ 6500.174. Emergency use of exclusion and manual restraints.**

If exclusion or manual restraints are used on an unanticipated, emergency basis, §§ 6500.164 and 6500.165 (relating to restrictive procedure review committee; and restrictive procedure plan) do not apply until after the exclusion or manual restraint is used for the same individual twice in a 6-month period.

**§ 6500.175. Restrictive procedure records.**

A record of each use of a restrictive procedure documenting the specific behavior addressed, methods of intervention used to address the behavior, the date and time the restrictive procedure was used, the specific procedures followed, the person who used the restrictive procedure, the duration of the restrictive procedure and the individual's condition following the removal from the restrictive procedure shall be kept in the individual's record.

**§ 6500.176. Notification.**

The individual's day service facility shall be sent copies of the restrictive procedure plan and revisions of the plan. Documentation of transmittal of the restrictive procedure plan shall be kept.]

**Use of a positive intervention.**

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

A "dangerous behavior" is an action with a high likelihood of resulting in harm to the individual or others.

"positive intervention" is an action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.

**§ 6500.162. PSP.**

If the individual has a dangerous behavior as identified in the PSP, the PSP shall include the following:

- (1) The specific dangerous behavior to be addressed.
- (2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.
- (3) The outcome desired.
- (4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.
- (5) A target date to achieve the outcome.
- (6) Health conditions that require special attention.

**§ 6500.163. Prohibition of restraints.**

The following procedures are prohibited:

- (1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.
- (2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.
- (3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.
- (4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A

chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.

(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a non-emergency basis, or, for a period of more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor.

**§ 6500.164. Permitted interventions.**

(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.

(b) A physical protective restraint may be used only in accordance with § 6500.163 (6) - (8) (relating to prohibition of restraints).

(c) A physical protective restraint shall not be used until § 6500.48(b)(5) (relating to annual training) and § 6500.155(9) (relating to content of PSP) are met.

(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.

(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.

(f) A physical protective restraint may not be used for a period of more than 15 minutes within a 2-hour period.

(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 6500.48 (relating to annual training).

(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.

**§ 6500.165. Access to or the use of an individual's personal property.**

- (a) Access to or the use of an individual's personal funds or property shall not be used as a reward or punishment.
- (b) An individual's personal funds or property shall not be used as payment for damages unless the individual consents to make restitution for the damages as follows:
- (1) A separate written consent is required for each incidence of restitution.
  - (2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.
  - (3) There shall be no coercion in obtaining the consent of an individual.
  - (4) The agency shall keep a copy of the individual's written consent.

**§ 6500.166. Rights team.**

- (a) The agency shall have a rights team. The agency may use a county mental health and intellectual disability program rights team that meets the requirements of this section.
- (b) The role of the rights team shall be to:
- (1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified at § 6500.31-34 (relating to individual rights).
  - (2) Review each incidence of the use of a restraint as specified at § 6500.161-164 (relating to positive intervention) to:
    - (i) Analyze systemic concerns.
    - (ii) Design positive supports as an alternative to the use of a restraint.
    - (iii) Discover and resolve the reason for an individual's behavior.

- (c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for himself, the individual's support coordinator, a representative from the funding agency and an agency representative.
- (d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.
- (e) If a restraint was used, the individual's health care practitioner shall be consulted.
- (f) The rights team shall meet at least once every 3 months.
- (g) The rights team shall report its recommendations to the individual's PSP team.
- (h) The agency shall keep documentation of the rights team meetings and the decisions made at the meetings.

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## RECORDS

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### § 6500.182. Content of records.

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- (c) Each individual's record must include the following information:

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- (6) [A copy of the invitation to:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(7) A copy of the signature sheet for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting

(8) A copy of the current ISP.

(9) Documentation of ISP reviews and revisions under § 6500.156 (relating to ISP review and revision), including the following:

(i) ISP review signature sheets

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(10) Content discrepancy in the ISP, the annual updates or revisions under § 6500.156.

] PSP documents as required by this chapter.

[(11) Restrictive procedure protocols] (7) Positive intervention records related to the individual.

[(12) Restrictive procedure records related to the individual. ]

[(13)] (8) Recreational and social activities provided to the individual.

[(14)] (9) Copies of psychological evaluations and assessments of adaptive behavior, as necessary.

**§ 6500.183. Record location.**

Copies of the most current record information required in § 6500.182(c)(1)—(9) (relating to individual records) shall be kept in the [family living] home.

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**§ 6500.185. Access.**

The individual, and the individual's parent, guardian or advocate, shall have access to the records and to information in the records. If the [family living] life sharing specialist documents, in writing, that disclosure of specific information constitutes a substantial detriment to the individual or that disclosure of specific information will reveal the identity of another individual or breach the confidentiality of persons who have provided

information upon an agreement to maintain their confidentiality, that specific information identified may be withheld.

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