#14-540 (170)

Kroh, Karen #3160

From: Mochon, Julie
Sent: Tuesday, December 20, 2016 9:08 AM
To: Kroh, Karen
Subject: FW: KenCrest comments on draft regulations
Attachments: Cover Letter KenCrest comments.doc; KenCrest 2380 regulations comments.docx; KenCrest 2390 regulations comments.docx

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From: Allison Smale [mailto:ASmale@kencrest.org]
Sent: Tuesday, December 20, 2016 9:05 AM
To: Mochon, Julie
Cc: Joan Hanley; Pam Schuessler
Subject: KenCrest comments on draft regulations

Attached, please find our comments for the 2380 and 2390 draft regulations.

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KenCrest
Bringing ability to life

Office of Developmental Programs
Room 502 Health and Welfare Building,
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December 20, 2016

To Whom It May Concern:

Thank you for the opportunity to comment on the draft regulations for both the 2380 and 2390 programs. Please find our comments included as attachments.

Respectfully Submitted by:

Pam Schuessler, Chief Operating Officer
Joan Hanley, Vice President, Community Based Services and Supports
Allison Smale, Director, Program Services

KenCrest
Bringing ability to life

December 19, 2016

Comments from KenCrest Services- Employment and Day Programs

2380 Regulations

§ 2380.3. Definitions.

Discussion 2380.3.

All definitions for these regulations should be included in Chapter 2380.3, and the definitions should be the same across Chapter 6100 and all licensing regulations. Definitions should be consistent and clear with the intent to facilitate communication and understanding. Deleting definitions from the program regulations and including them within Chapter 6100 and the licensing regulations promotes clarity, consistency, and reduces administrative burden across applicable services and programs.

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

Adult—A person 18 years of age or older.

Adult Autism Waiver - An HCBS Federal waiver program approved under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) and designed to provide community-based supports to meet the specific needs of adults with autism spectrum disorders

Adult training facility or facility—A building or portion of a building in which services are provided to four or more individuals, who are 59 years of age or younger and who do not have a dementia-related disease as a primary diagnosis, for part of a 24-hour day, excluding care provided by relatives. Services include the provision of functional activities, assistance in meeting personal needs and assistance in performing basic daily activities.

Aversive Conditioning - The application of startling, painful or noxious stimuli in response to the exhibition of behavior in an effort to modify the behavior.

Autism spectrum disorder (ASD) - A developmental disorder defined and diagnosed in accordance with criteria established in the Diagnostic and Statistical Manual latest edition in effect at time of diagnosis.

Base-funded services: A service funded exclusively by a grant to a county under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B of the Human Services Code.

Based-funded support coordination - A program designed to provide community-based support to locate, coordinate and monitor needed support for individuals who receive support through base-funding.

Chemical restraint - 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 prescribed by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as treatment prior to or following a medical or dental examination or treatment.

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

Corrective action plan - a document prepared by a provider following a written determination by the Department of non-compliance with a provision(s) of this Chapter. The plan establishes timelines, person(s) responsible for the implementation and monitoring of corrective action steps.

Dangerous behavior – A decision, behavior or action by an individual that creates or is highly likely to result in harm or to place the individual and/or other persons at risk of harm.

Department—The Department of Human Services of the Commonwealth.

Direct ~~service~~ support worker—A person whose ~~primary~~ principal job function is to provide services to an individual who attends the provider's facility.

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

Emergency Closure – An event that is unplanned for any reason that results in program closure two days or more.

Family—the person or people who are related to or determined by the individual as family

Fire safety expert—A local fire department, fire protection engineer, State certified fire protection instructor, college instructor in fire science, county or State fire school, volunteer fire person trained by a county or State fire school or an insurance company loss control representative.

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 Medical Assistance State Plan.

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

Incident - A situation or occurrence that has a high likelihood of a negative impact on an individual.

~~—Individual—An adult with disabilities who receives care in an adult training facility and who has developmental needs that require assistance to meet personal needs and to perform basic daily activities. Examples of adults with disabilities include adults who exhibit one or more of the following:~~

~~—(i) A physical disability such as blindness, visual impairment, deafness, hearing impairment, speech or language impairment, or a physical handicap.~~

~~—(ii) A mental illness.~~

~~—(iii) A neurological disability such as cerebral palsy, autism or epilepsy.~~

~~—(iv) An intellectual disability.~~

~~—(v) A traumatic brain injury.~~

Individual—An adult or child who receives a home and community-based intellectual disability or autism support or base-funded services.

Mechanical restraint - a device that restricts the movement or function of an individual or portion of an individual's body in response to the individual's behavior. Mechanical restraints include a geriatric chair (unless prescribed in the individual's PSP), handcuffs, anklets, wristlets, 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) A mechanical restraint does not include a device prescribed by a health care practitioner that is used to provide pre/post-surgical/medical care, proper balance or support for the achievement of functional body position.

(ii) A mechanical restraint does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure or other non-voluntary movements or physical conditions that limit motor control and create the potential for injury.

Natural support—An activity or assistance that is provided by family, friends, or other community members without expectation of payment

Non-conformity - Failure to conform to or meet the expectations outlined within this chapter.

~~[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.~~ Person-Centered Support Plan (PSP): The comprehensive plan for each individual that is developed using a person-centered process and includes HCBS, risks and mitigation of risks, and individual outcomes for a participant.

Physical restraint - A physical (manual) hands-on technique that lasts longer than 30 consecutive seconds and restricts, immobilizes, or reduces an individual's ability to move his/her arms, legs, head, or other body parts freely.

Positive interventions - actions or activities intended to prevent, modify, decrease or eliminate challenging behaviors. These interventions or positive behavior supports include, but are not limited to: environmental adaptations or modifications, identifying and addressing physical and behavioral health symptoms, voluntary physical exercise, health and wellness practices, redirection, praise, modeling, conflict resolution, trauma informed care, de-escalation, and reinforcing desired behavior (contingent and non-contingent rewards).

Pressure point techniques - The application of pain for the purpose of achieving compliance. This technique does not include approved physical intervention techniques in response to aggressive behavior, such as bite release.

Provider—~~An entity or person that enters into an agreement with the Department to deliver a service to an individual.~~ The person, entity or organization that is authorized to deliver services under the Medical Assistance Program.

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.

SC—Supports coordinator—An SCO employee whose primary job functions are to locate, coordinate and monitor services provided to an individual when the individual is receiving services from an SCO.

SCO—Supports coordination organization—A provider that delivers the services of locating, coordinating and monitoring services provided to an individual.

Seclusion - Involuntary confinement of an individual in a room or area from which the individual is physically prevented from leaving.

Services—~~Actions or assistance provided to the individual to support the achievement of an outcome.~~

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 an HCBS, support coordination, TSM, agency with choice, organized health care delivery system, vendor goods and services, and base-funding support, unless specifically exempted in this chapter.

State plan—The Commonwealth's approved Title XIX State Plan.

Support coordination - an HCBS Federal waiver program under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to provide community-based support to locate, coordinate and monitor needed HCBS and other support for individuals.

Vendor - A directly-enrolled provider that sells goods or services to the general public, as well as to an HCBS program.

Voluntary Exclusion - An individual voluntarily or willingly removing himself/herself from his/her immediate environment and placing himself/herself alone to a room or area.

Volunteer - A person who works without compensation and under the supervision of an authorized provider or family member alone with an individual in the performance of a service

GENERAL REQUIREMENTS

§ 2380.17. ~~[Reporting of unusual incidents.]~~ **Incident report and investigation.**

Discussion 2380.17.

Recommended edits promote clarity and specificity.

(f) (9) is a duplicate of (7)

~~[(a) An unusual incident is:~~

~~(1) Abuse or suspected abuse of an individual.~~

~~(2) Injury, trauma or illness requiring inpatient hospitalization, that occurs while the individual is at the facility or under the supervision of the facility.~~

~~(3) A suicide attempt by an individual.~~

~~(4) A violation or alleged violation of an individual's rights.~~

~~(5) An individual whose absence is unaccounted for, and is therefore presumed to be at risk.~~

~~(6) The misuse or alleged misuse of an individual's funds or property.~~

~~(7) An outbreak of a serious communicable disease, as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions) to the extent that confidentiality laws permit reporting.~~

~~(8) An incident requiring the services of a fire department or law enforcement agency.~~

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

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

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

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

~~(2) The funding agency.~~

~~(3) The appropriate regional office of the Department.~~

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

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

~~(2) The funding agency.~~

~~(3) The appropriate regional office of the Department.~~

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

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

~~(2) The funding agency.~~

~~(3) The appropriate regional office of the Department.~~

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

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

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

(a) ~~The~~ A provider shall report the following incidents, ~~and~~ alleged incidents ~~and suspected incidents~~ through the Department's information management system within 24 hours of ~~discovery by a staff person~~ having knowledge of the incident:

(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.~~ 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~~ 13) Theft or misuse of individual funds.

(~~15~~ 14) A violation of individual rights.

(15) Individual to individual incident.

(b) ~~The individual and the persons designated by the individual shall be notified immediately upon discovery of an incident relating to the individual.~~ A provider shall report the following in the Department's information management system within 72 hours of the occurrence or discovery of the incident:

(1) Medication administration error

(2) Use of a restraint outside the parameters of the PSP.

(c) ~~The facility shall keep documentation of the notification in subsection (b).~~ The individual and person(s) designated by the individual shall be notified upon discovery of an incident related to the individual.

(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~~ provider shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or ~~notice~~ identification of an incident, alleged incident and/or suspected incident.

(f) The ~~facility~~ provider shall initiate an investigation of ~~an incident~~ certain incidents within 24 hours of the occurrence or discovery by a staff person of the incident of the following:

(1) Death
(2) Abuse
(3) Neglect
(4) Exploitation
(5) Missing person
(6) Theft or misuse of individual funds
(7) Violations of individuals rights
(8) Unauthorized or inappropriate use of a restraint
(9) Individual to individual sexual abuse and serious bodily injury.

(g) ~~A Department-certified incident investigator shall conduct the incident investigation of the incident listed in subsection (a).~~ The incident investigation shall be conducted by a Department-certified incident investigator.

(h) ~~The~~ A ~~facility~~ provider shall finalize the incident report in the Department's information management system by including additional information about the incident, results of a required investigation and corrective actions taken ~~or on a form specified by the Department~~ within 30 days of the occurrence or discovery of the incident or on a form specified by the Department ~~by a staff person~~ unless an extension is filed.

(i) ~~The~~ A ~~facility~~ provider shall provide the following information to the Department as part of the final incident report:

(1) Any known additional detail about the incident.

(2) The results of the incident investigation.

(3) A description of the corrective action(s) taken or planned in response to ~~an~~ the incident as necessary.

(4) Additional action(s) 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. **[~~Reporting of deaths.~~] Incident procedures to protect the individual.**

Discussion 2380.18.

We strongly support revising 2380.18 to include the review of serious incidents or the pattern of incidents to ensure the safety and well-being of individuals.

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

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

~~**(2) The funding agency.**~~

~~**(3) The regional office of the Department.**~~

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

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

~~**(2) The funding agency.**~~

~~**(3) The regional office of the Department.**~~

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

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

(a) ~~In investigating an incident, the facility shall review and consider the following needs of the affected individual:~~ In reviewing a serious incident, or pattern of incidents, a provider shall review and consider the following needs of the affected individual(s):

(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~~ provider shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The ~~facility~~ provider shall work cooperatively with the ~~support coordinator or targeted manager and the~~ PSP team to revise the PSP ~~if indicated by the incident investigation.~~ as needed.

§ 2380.19. ~~[Record of incidents.]~~ Incident analysis.

Discussion 2380.19.

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

~~(a) The facility 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 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.~~

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

Discussion 2380.21.

Suggested text is added for clarity and suggested text is redundant or otherwise unnecessary.

~~[(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). An approved PSP shall be deemed consistent with an individual's rights.

(b) ~~An individual shall be continually supported to exercise the individual's rights.~~ An individual shall be provided services, supports, and accommodations to assist the

individual to understand and to actively exercise rights as he/she chooses. The services, supports, and accommodation necessary for the individual to understand and activity exercise rights as he/she chooses shall be funded by the Department as part of the PSP.

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

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

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

~~(f) 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~~)(e) 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.~~ An individual possesses all the civil, legal, and human rights afforded under law.

(k) ~~An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.~~ An individual has the right to be free from abuse, neglect, mistreatment, exploitation, abandonment or be 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.~~ An individual has the right to make informed choices and accept personal risks that do not pose a threat to the individual's and/or another person's health, safety, or well-being.

(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~~ provider's procedures for the individuals to resolve differences and make choices.

(u) The ~~facility~~ provider shall inform and explain individual rights to the individual, and persons designated by the individual, upon admission to the ~~facility~~ program and annually thereafter.

(v) The ~~facility~~ provider 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.

(Editor's Note: The following section is new and printed in regular type to enhance readability.)

§ 2380.26. Applicable laws and regulations.

Discussion 2380.26.

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

STAFFING

§ 2380.33. Program specialist.

Discussion 2380.33.

(a) At least **[~~one~~] 1** program specialist shall be assigned for every 30 individuals, regardless of whether they meet the definition of individual in § 2380.3 (relating to definitions).

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

~~[(1) Coordinating and completing assessments.~~

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

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

~~(4) Attending the ISP meetings.~~

~~(5) Fulfilling the role of plan lead, as applicable, under §§ 2380.182 and 2380.186(f) and (g) (relating to development, annual update and revision of the ISP; and ISP review and revision).~~

~~(6) Reviewing the ISP, annual updates and revisions under § 2380.186 for content accuracy.~~

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

~~(8) Implementing the ISP as written.~~

~~(9) Supervising, monitoring and evaluating services provided to the individual.~~

~~(10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.~~

~~(11) Reporting a change related to the individual's needs to the SC or plan lead, as applicable, and plan team members.~~

~~(12) Reviewing the ISP with the individual as required under § 2380.186.~~

~~(13) Documenting the review of the ISP as required under § 2380.186.~~

~~(14) Providing the documentation of the ISP review to the SC or plan lead, as applicable, and plan team members as required under § 2380.186(d).~~

~~(15) Informing plan team members of the option to decline the ISP Review documentation as required under § 2380.186(e).~~

~~(16) Recommending a revision to a service or outcome in the ISP as provided under § 2380.186(e)(4).~~

~~(17) Coordinating the services provided to an individual.~~

~~(18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each individual.~~

~~(19) Developing and implementing provider services as required under § 2380.188 (relating to provider services).~~]

(1) Coordinating the completion of assessments.

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

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

(4) Coordinating and facilitating the integration of individuals in the community.

(5) Promoting individual communication ~~and involvement with families and friends~~ for the building of relationships.

We feel strongly that Human Services or related field should be included in each education level and across the 2380, 2390 and 6400 regulations; and that the years of experience required at each level be consistent across the 2380, 2390 and 6400 regulations.

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

(1) A master's degree or above from an accredited college or university and 1 year of work experience working directly with persons with disabilities.

(2) A bachelor's degree from an accredited college or university and 2 years of work experience working directly with persons with disabilities.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years of work experience working directly with persons with disabilities.

§ 2380.35. Staffing.

Discussion 2380.35.

(a) A minimum of one direct service worker for every six individuals shall be physically present with the individuals at all times individuals are present at the facility, except while staff persons are attending meetings or training at the facility.

(b) While staff persons are attending meetings or training at the facility, a minimum of one staff person for every ten individuals shall be physically present with the individuals at all times individuals are present at the facility.

(c) A minimum of two staff persons shall be present with the individuals at all times.

(d) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the individual's **[~~ISP~~] PSP**, 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).

(f) An individual may not be left unsupervised solely for the convenience of the facility or the direct service worker.

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

Discussion 2380.36.

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

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

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

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

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

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

[(g)] (c) There shall be at least **[~~one~~] 1** staff person for every 18 individuals, with a minimum of **[~~two~~] 2** staff persons present at the facility at all times who have been trained by an individual

certified as a trainer by a hospital or other recognized health care organization, in first aid, Heimlich techniques and cardio-pulmonary resuscitation within the past year. If a staff person has formal certification from a hospital or other recognized health care organization that is valid for more than 1 year, the training is acceptable for the length of time on the certification.

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

(Editor's Note: Sections 2380.37—2380.39 are new and printed in regular type to enhance readability.)

§ 2380.37. Annual training plan.

Discussion 2380.37.

The purpose of and intent for a training plan is frustrated by a requirement that specific subjects or specific number of hours will address the needs of the clients or the organization. A training plan is created based on an assessment that, by definition, is unique to the individual. As provider organizations analyze the needs of the people they support, evolving best practices and their assessment of performance, a flexible, customized, quality focused plan emerges. The suggested text combines the critical elements of section 37 and 39 into a clear and accountable set of standards that maintain the basics and advance provider services to the next level.

Interns and volunteers should not be required to attend the training process. Such a requirement is unnecessary and costly. The interns and volunteers are time limited, and, additionally, the information they need is included in their orientation. Removing them from the required personnel list will cut down the training cost.

Collapse 2380.37 and 2390.39 into one section.

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

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

(c) The annual training plan ~~must~~ shall include training ~~aimed at~~ intended to improv~~ing~~e the knowledge, skills and core competencies of the staff persons to be trained.

~~(d) The annual training plan must include the following:~~ The plan shall address the need for training in basics such as rights, facilitating community integration, honoring choice and supporting individuals to maintain relationships.

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

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

(e) The plan shall explain how the provider shall assure that staff understand their responsibilities around the promotion of individual rights and the reporting of suspected rights violations, abuse or neglect in accordance with the regulations that define those rights and responsibilities.

(f) The plan shall explain how the provider shall assure that staff understand the safe and appropriate use of positive interventions, including the training in the plans which are unique for any one person served.

(g) The plan shall include paid staff with client contract.

(h) The annual training plan shall include the following

(1) the title of the position to be trained

(2) the required training courses including the training course hours for each position

(i) Records of orientation and training including the training source, content, dates, length of training, copies of certificate receive and persons attending shall be kept.

(j) The provider shall keep a training record for each person trained

§ 2380.38. Orientation program.

Discussion 2380.38.

The proposed edits focus on reducing the need for certain training in different levels and on protecting the individuals. They otherwise refocus the extensive and unecessary training requirements for certain positions.

As noted in discussion section of 2380.37, the provisions included in 2380.37 (e) and (f) should be added to this section to clearly indicate the need for documentation and record of training.

This section is geared towards licensed providers. Accordingly, references to AWC, OHCDS should be deleted. The Department must necessarily adjust payment rates to account for the significant additional costs to be incurred by unlicensed providers and Transportation trip providers if they are expected to comply with this section. This list is not fully inclusive and infers that transportation mile individuals (OHCDS/AWC) who are reimbursed but not household members do not require training. Also, the inclusion of volunteers and management staff is problematic for unlicensed providers, transportation trip, AWC and OHCDS providers. The Department must reconsider this section as it relates to all services, provider types and service delivery models.

PAR supports the wording for 2380.38 (a) (4) and (5)

(a) ~~Prior to working alone with individuals, and within 30 days after hire, the following shall complete the orientation program as described in subsection (b):~~ Within 30 days after hire, and before working directly with or starting to provide service to an individual, the following persons shall complete the orientation program as described in subsection (b):

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

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

(3) Direct ~~service~~ support ~~workers~~ professionals, including full-time and part-time staff persons.

(4) Volunteers who work alone with individuals.

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

(6) Consultants who will work alone with individuals. except for consultants such as clinicians who are licensed by the Commonwealth of PA or other states (i.e. nurses, doctors, psychologists, MSW, etc.).

(b) The orientation program must 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~~)(1) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with sections 701—708 of the Older Adults Protective Services Act (35 P.S. §§ 10225.701—10225.708), 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(~~3~~)(2) Individual rights.

(4)(3) Recognizing and reporting incidents.

~~(5) Job-related knowledge and skills.~~

~~§ 2380.39. Annual training.~~

Discussion 2380.39.

The suggested edits recommend that AWC and OHCDS be removed from the regulations and that Transportation Trip and Unlicensed home and community based providers be excluded

from 2380.37 as written. This list of individuals is geared strictly towards licensed providers and impedes the promotion of family support models of service delivery. A prescribed number of hours for training will not support appropriate training specific for the individual and does not afford the opportunity for families/participants and the unlicensed providers and Transportation trip providers that support them with the type and frequency of training that is needed for the individual. When there are established mandates to hours versus individuality, the service quality and the opportunity to support the values of ODP and Everyday Lives is lost. Further, the current unit rates will not support the increase in training requirements. Optimally, AWC and OHCDS providers will be removed from the regulations and unlicensed providers and transportation trip providers should have separate training requirements that do not include a specific number of hours.

See prior comment under 2380.37.

~~(a) The following staff persons shall complete 24 hours of training each year:~~

~~(1) Direct service workers, including full-time and part-time staff persons.~~

~~(2) Direct supervisors of direct service workers.~~

~~(3) Positions required by this chapter.~~

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

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

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

~~(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 hours of the annual training hours specified in subsections (a) and (b) must encompass the following areas:~~

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

~~(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with sections 701—708 of the Older Adults Protective Services Act (35 P.S. §§ 10225.701—10225.708), 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.~~

~~(3) Individual rights.~~

~~(4) Recognizing and reporting incidents.~~

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

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

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

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

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

MEDICATIONS

Discussion MEDICATIONS

Comment and Suggestion: Medication Administration

There are two extremely important issues concerning the proposed new regulations pertaining to medication administration. These issues must be carefully reconsidered by the Department.

1. Codifying content that requires modifications over time into regulations will lock a crucial component of service provision into temporal practices which will become obsolete as new information, prevailing practices and technology emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally - accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.

2. Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contrast to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.

As a ready example of the problem with codifying material which requires change over time, an area has been identified in which the proposed regulations are at odds with prevailing practices as detailed by Title 49 of the State Nursing Board. 49 PA. CODE CH. 21 explicitly provides for Licensed Practical Nurses to accept oral orders for administering medication. The proposed 6100.465 provision only allows this practice for Registered Nurses.

This discrepancy is instructive both to the specific issue regarding LPN's and to the process issue of codifying Nursing Practices content which changes from time to time according to authorities outside of the Department. It is noted that the provider system needs LPN's to be able to do all that state law provides for them to do. In the second case, we need regulations which do not lock providers to standards which may soon become obsolete due to new and emerging best practices and advances.

A second example of the problem with trying to maintain this content in multiple places is that there are already discrepancies between the proposed 6100's and the Department's Approved Medication Administration Training. The training's required checklist for medication self-administration has discrepancies with the proposed regulation. There is also a notable practice discrepancy regarding pre-pouring of medications. The Department can avoid unnecessary confusion by requiring compliance with the most current version of the Department's approved Medication Administration Training module.

§

§ 2380.121. **[~~Storage of medications.~~] Self-administration.**

Discussion 2380.121.

1. Codifying content that requires modifications over time into regulations will lock a crucial component of service provision into temporal practices which will become obsolete as new information, prevailing practices and technologies emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally - accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.
2. Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contract to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.

These points as further described in Discussion for 6100.461 persuade us to recommend that 6100 regulations pertaining to Medication Administration should refer to the Departments Approved Medication Training for the 2380, 2390 and 6400 services and should cite existing 6500 regulations for the 6500 services. The 6100.470 Exception for Family Members should be retained.

Prescription Medications shall be stored and disposed of according to the Office of Developmental Programs' Approved Medication Administration Training.

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

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

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

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

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

(a) The ~~facility~~ 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~~ may include helping the individual to ~~remember~~ adhere to 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~~ PSP team shall ~~provide or arrange for~~ facilitate the utilization of assistive technology to support the individual's self-administration of medications.

(d) The PSP must identify if the individual is ~~unable~~ able to self-administer medications with necessary training, prompts and natural supports.

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

~~(1) Be able to recognize and distinguish the individual's his/her medication~~

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

~~(3) Know and understand the purpose for taking the medication.~~

~~(3)(4) 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)(5) Be able to take or apply the ~~individual's~~ his/her own medication with or without the use of assistive technology.

§ 2380.122. **[~~Labeling of medications.~~] Medication administration.**

Discussion 2380.122.

It appears that there was an inadvertent problem created by the inclusion of standardized medications content across these four program areas that includes the 6500 regulations. If the 6500 LifeSharing programs are included in this requirement, significant unintended consequence are likely to arise and cause severe negative impact on the viability and expansion of this program – a program that the Department has repeatedly stated it desires to expand. A consequence as well for the inclusion of this provision for 6500 programs will be more institutional style program expectations in a program which should increasingly exemplify the ideals of Everyday Lives principals in an integrated and typical family fashion to the retest degree. LifeSharing (6500) service providers are not currently required to complete the ODP Medication Training Module. The Module is necessarily a very detailed training requiring at least two full days of training plus four subsequent observations. This level of intensive training is possible in 2380, 2390 and 6400 programs because they have staff who are employees with employer-controlled schedules and they have centralized access to administrative supports, in perhaps a less intrusive way than entering a family's home. These conditions do not exist and are not desirable for LifeSharing. LifeSharing is provided in people's homes.

LifeSharing providers are not employees who spend regular time at training locations, nor should they – they are typical families who work and live in the community. These families work their own independent jobs in the community and would be challenged just to have the physical access to go through this process. There is already a shortage of certified medication administration trainers contributing to this access problem. Requiring this additional training would necessarily result in losing some providers who are unable to connect with the available training times and places, and potentially separating an already established shared life situation with an individual. It would also add a new barrier for new family-providers at a time when the Department is trying to expand this service and providers trying to find and recruit willing families.

Another problem with this expansion of the Training Module into the 6500's involves the respite services which are crucial to helping LifeSharing providers to support individuals over the long-haul. Respite providers are often potential LifeSharing providers who are interested in gaining experience with the service and with individuals. These new/potential providers have not gone through full process as providers yet – adding this considerable step when they are not yet committed to the service would be destructive to the service.

Further concerns with requiring specific detailed training that can only come from service agencies to the 6500's is the necessity that we maintain LifeSharing providers' relationship as contracted supports rather than employees. The level of training specificity, the fact that it would be the "presumed employer" providing the training and the likelihood that LifeSharing providers would be taking the training alongside employees with no differentiation from the employees all implies an employee relationship which needs to be avoided if LifeSharing is

going to continue to be an efficient, community-based model. Clear expectations are established by the IRS and DOL which providers must explicitly follow to maintain explicit differences between independent contractors and employees.

Finally, there is also a simple matter of proportionality. LifeSharing providers generally only serve one individual and the individuals in Life Sharing are typically able to take more responsibility for themselves than individuals in the other licensure groups. LifeSharing providers are able to focus-in on the needs of their lifesharer. They do not need days of general information. To require the Medication Administration Module of them would be disproportionate to their task – in fact, it would change the nature of the service from family-like supports to medical-model "administration" of medical care.

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

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

(a) ~~A facility whose staff persons are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer his prescribed medication.~~ **Persons who administer prescription medication or insulin injections to individuals shall receive training by the individual's source of healthcare or satisfactorily complete the Department's/ODP's most current Medication Training Module.**

~~(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. ~~[Use of prescription medications.]~~ **Storage and disposal of medications.**

Discussion 2380.123.

As written, this section is far too prescriptive and subjective given the training that provider staff must complete. The suggested edits reflect clarity and brevity and are adapted from Chapter 6500.

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

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

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

(b) ~~**A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.**~~ **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) ~~**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.~~ **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 medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.~~ **Prescription and nonprescription medications of individuals shall be stored under proper conditions of sanitation, temperature, moisture and light.**

(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.~~ **Discontinued prescription medications of individuals shall be disposed of in a safe manner.**

~~(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) - (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. **[~~Medication log.~~] Labeling of medications.**

Discussion 2380.124.

Edits are adapted from suggested edits to Chapter 6500. Also, as with section 123, the proposed regulatory text is much too prescriptive, subjective and unnecessary given applicable training requirements.

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

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

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

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

~~(1) The individual's name.~~

~~(2) The name of the medication.~~

~~(3) The date the prescription was issued.~~

~~(4) The prescribed dosage and instructions for administration.~~

~~(5) The name and title of the prescriber.~~

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

(b) Nonprescription medications used by individuals shall be labeled with the original label.

§ 2380.125. [~~Medication errors.~~] **Prescription ~~medications.~~ Use of a prescription.**

Discussion 2380.125.

Adapted from Chapter 6500.

Why is subsection (c) necessary? Individuals who attend licensed 2380 and 2390 programs come from home. Family members and residential programs are responsible for the healthcare needs of the individuals. The review contemplated in (c) is a matter between the family members and/or provider staff.

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

~~(a) A prescription medication shall be prescribed in writing by an authorized prescriber.~~

~~(b) A prescription order shall be kept current.~~

~~(c) A prescription medication shall be administered as prescribed.~~

~~(d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.~~

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

(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 PSP 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 or a certified nurse practitioner at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.

§ 2380.126. **[~~Adverse reaction.~~] Medication record.**

Discussion 2380.126.
Suggested edits are adapted from edits to Chapter 6500

[~~If an individual has a suspected adverse reaction to a medication, the facility shall notify the prescribing physician and the family or residential program immediately. Documentation of adverse reactions shall be kept.~~]

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

~~(1) Individual's name.~~

~~(2) Name and title of the prescriber.~~

~~(3) Drug allergies.~~

~~(4) Name of medication.~~

~~(5) Strength of medication.~~

~~(6) Dosage form.~~

~~(7) Dose of medication.~~

~~(8) Route of administration.~~

~~(9) Frequency of administration.~~

~~(10) Administration times.~~

~~(11) Diagnosis or purpose for the medication, including pro re nata.~~

~~(12) Date and time of medication administration.~~

~~(13) Name and initials of the person administering the medication.~~

~~(14) Duration of treatment, if applicable.~~

~~(15) Special precautions, if applicable.~~

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

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

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

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

(a) A medication log that lists the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered. 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 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 maintained for each individual who self-administers medication.

§ 2380.127. **[~~Administration of medications.~~] Medication errors.**

Discussion 2380.127.

Adapted from Chapter 6500

Medications errors must be addressed according to the Office of Developmental Programs' Approved Medication Administration Training Manual.

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

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

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

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

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

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

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong amount 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~~,~~ and follow-up action taken ~~and the prescriber's response~~ shall be kept ~~in the individual's record~~.

§ 2380.128. **[~~Medication administration training~~.] Adverse reaction.**

Discussion 2380.128.

See comment above.

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

~~(b) A staff person who has completed and passed the Department's Medications Administration Course and who has completed and passed a diabetes patient education program within the past 12 months that meets the National Standards for Diabetes Patient Education Programs of the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Bethesda, Maryland 20205, is permitted to administer insulin injections to an individual who is under the care of a licensed physician who is monitoring the diabetes.~~

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

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

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

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

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

If an individual has a suspected adverse reaction to a medication, the healthcare provider shall be contacted immediately. Documentation of adverse reactions shall be kept in the individual's record.

§ 2380.129. **[~~Self-administration of medications.~~] Medication administration training.**

Discussion 2380.129.

Epi-pen mandatory training will add a significant cost to providers. This resource, such as HCQU, will be difficult to meet the needs of the agencies. There are some agencies that have had a video regarding this training.

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

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

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

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

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

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

~~(1) Oral medications.~~

~~(2) Topical medications.~~

~~(3) Eye, nose and ear drop medications.~~

~~(b) A staff person may administer insulin injections following successful completion of both:~~

~~(1) The course specified in subsection (a).~~

~~(2) A Department-approved diabetes patient education program within the past 12 months.~~

~~(c) A staff person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:~~

~~(1) The course specified in subsection (a).~~

~~(2) 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.~~

[~~RESTRICTIVE PROCEDURES~~] POSITIVE INTERVENTION

§ 2380.151. [~~Definition of restrictive procedures.~~] **Use of a positive intervention.**

Discussion 2380.151.

All definitions have been moved to 2380.3 for clarity and ease of reference.

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

~~(1) Limits an individual's movement, activity or function.~~

~~(2) Interferes with an individual's ability to acquire positive reinforcement.~~

~~(3) Results in the loss of objects or activities that an individual values.~~

~~(4) Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.~~]

(a) A positive intervention shall be used ~~to prevent, modify and eliminate a dangerous behavior~~ when ~~the~~ challenging behaviors ~~is~~ are anticipated and/or ~~occurring~~ in response to challenging behaviors to prevent escalation of behaviors, or in attempts to modify, decrease or eliminate behaviors.

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

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

~~Dangerous behavior—An action with a high likelihood of resulting in harm to the individual or others.~~

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

§ 2380.152. [~~Written policy.~~] PSP.

Discussion 2380.152.

It is recommended that this section be deleted and content rolled to 2380.153 as specified in the comment.

[~~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.~~]

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

~~(1) The specific dangerous behavior to be addressed.~~

~~(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.~~

~~(3) The outcome desired.~~

~~(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.~~

~~(5) A target date to achieve the outcome.~~

~~(6) Health conditions that require special attention.~~

§ 2380.153. **[~~Appropriate use of restrictive procedures.~~] Prohibition of restraints.**

Discussion 2380.153.

All definitions have been moved to 2380.3

"Camisole" has been deleted, upon the advice of experts in the field of Intellectual Disability Services, from the definition of "mechanical restraint" because they do not restrict movement. The definition notes that the use of geriatric chairs is sometimes prescribed by an individual's PSP.

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

~~(b) For each incident requiring a restrictive procedure:~~

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

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

The following procedures are prohibited:

(1) Seclusion~~, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented 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~~ physical restraint~~, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a nonemergency basis, or for more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to a support as specified in the individual's PSP.~~

(7) A prone position ~~manual~~ physical restraint.

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

(9) A physical restraint may not be used as a substitute for positive behavioral interventions, or as retribution, punishment, noncompliance, or for the convenience of staff persons.

§ 2380.154. **[~~Restrictive procedure review committee.~~] Permitted interventions.**

Discussion 2380.154.

(h) has been incorporated into (e)

Text added and deleted for clarity

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

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

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

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

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

(b) The least intrusive intervention shall be used to deescalate the dangerous behaviors when the behavior is occurring.

(c) A physical restraint may be used in the case of a dangerous behavior to prevent an individual from injuring the individual's self or others.

(d) If the individual has a known dangerous behavior, it must be identified and addressed in the PSP, or if a new dangerous behavior is identified it should be added to the PSP through a revision.

~~(b) A physical protective restraint may be used only in accordance with § 2380.153(6)—(8) (relating to prohibition of restraints).~~

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

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

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

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

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

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

§ 2380.155. **[~~Restrictive procedure plan.~~] Access to or the use of an individual's personal property.**

Discussion 2380.155.

There are some individuals who understand the consequences of making restitution for damages to others' property. In these cases, there should be a mechanism for this natural consequence to occur, such as a team approved proposed plan, restrictive procedure committee review and approval, etc.

Regulation must take into account legal orders secondary to adjudication of conviction of a crime that results in the need for some type of restitution.

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

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

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

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

~~(e) The restrictive procedure plan shall include:~~

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

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

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

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

~~(5) A target date for achieving the outcome.~~

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

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

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

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

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

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

(b) An individual's personal funds or property may not be used as payment for damages unless legally ordered or 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 with the support of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.

(3) There may not be coercion in obtaining the consent of an individual.

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

§ 2380.156. **[~~Staff training~~.] ~~Rights team~~.**

Discussion 2380.156.

PAR is very encouraged by the enhanced focus on individual rights and protections throughout these regulations and in associated licensing regulations. We believe that the values represented in Everyday Lives are the core elements of encouraging increased individual participation in community, and exercising their choice, control, and rights.

This section, however, as written, merely adds an unnecessary bureaucratic layer to providers and families.

The concept of evaluating the potential and actual violation of rights is essential and, in fact, is already appropriately covered in the Incident Management process which includes a thorough investigation by an investigator who has been certified in the Department-approved training. As part of the already well-established and robust Incident Management system, all

allegations of rights violations must be investigated. If a violation of rights is confirmed, the existing process has established corrective action follow-up. PAR supports the clear and currently existing requirements that thoroughly address any rights violations. The proposed additional administrative duties and their associated costs are unnecessary, inefficient and uneconomical.

According to the regulations, the "rights team" is to meet every three months, regardless of whether any actual rights violations occurred during that quarter. Why?

A second stated purpose of the "rights team" is that it reviews any and all uses of restraint through the convening of the entire rights team, including the use of techniques which are used for emergency scenarios in dangerous situation and those that are part of a PSP.

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

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

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

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

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

~~(b) The role of the rights team is to:~~

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

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

~~(i) Analyze systemic concerns.~~

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

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

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

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

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

~~(f) The rights team shall meet at least once every 3 months.~~

~~(g) The rights team shall report its recommendations to the individual's PSP team.~~

~~(h) The facility shall keep documentation of the rights team meetings and the decisions made at the meetings.~~

(Editor's Note: As part of this proposed rulemaking, the Department is proposing to rescind §§ 2380.157—2380.165 which appear in 55 Pa. Code pages 2380-37—2380-40, serial pages (352107)—(352110).)

§§ 2380.157—2380.165. (Reserved).

Discussion 2380.157.

RECORDS

§ 2380.173. Content of records.

Discussion 2380.173.

Each individual's record must include the following information:

(1) Personal information including:

(i) The name, sex, admission date, birthdate and **[social security] Social Security** number.

(ii) The race, height, weight, color of hair, color of eyes and identifying marks.

(iii) The language or means of communication spoken or understood by the individual and the primary language used in the individual's natural home, if other than English.

(iv) Religious affiliation.

(v) A current, dated photograph.

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

(3) Physical examinations.

(4) Assessments as required under § 2380.181 (relating to assessment).

[~~(5) A copy of the invitation to:~~

~~(i) The initial ISP meeting.~~

~~(ii) The annual update meeting.~~

~~(iii) The ISP revision meeting.~~

~~(6) A copy of the signature sheet for:~~

~~(i) The initial ISP meeting.~~

~~(ii) The annual update meeting.~~

~~(iii) The ISP revision meeting.~~

~~(7) A copy of the current ISP.~~

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

~~(i) ISP review signature sheets.~~

~~(ii) Recommendations to revise the ISP.~~

~~(iii) ISP revisions.~~

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

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

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

(5) PSP 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.

Discussion 2380.181.

The recommended language in 2380.181 (b) is intended to distinguish between the need for a full assessment and a partial assessment.

2390.181 (f) has been amended to provide additional time to enable a program specialist to better prepare an informed assessment.

* * * * *

(b) If the program specialist ~~is making~~ makes 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 specific to that recommendation completed as required under this section.

* * * * *

(f) The program specialist shall provide the assessment to the SC **[~~or plan lead~~]**, as applicable, and **[~~plan~~] PSP** team members at least ~~30~~ 15 calendar days prior to **[~~an ISP meeting for the development, annual update and revision of the ISP under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP~~)] a PSP meeting**.

§ 2380.182. Development **[, ~~annual update and revision of the ISP~~] and revisions of the PSP**.

Discussion 2380.182.

PAR is pleased to see the inclusion of an expectation that there is one plan for the individual as included in 2380.182 (a) and supports this provision.

New text is proposed to add clarity.

6100.221(g) delete as it is redundant now. 2380.182(f) delete as it is redundant now.

~~[(a) An individual shall have one ISP.~~

~~(b) When an individual is not receiving services through an SCO and does not reside in a home licensed under Chapter 6400 or 6500 (relating to community homes for individuals with an intellectual disability; and family living homes), the adult training facility program specialist shall be the plan lead when one of the following applies:~~

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

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

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

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

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

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

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

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

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

(a) An individual shall have one approved and authorized PSP ~~at a given time~~ that identifies the need for supports, the supports to be provided and the expected outcomes. The PSP is intended to ensure that services are delivered in a manner reflecting individual preferences consistent with an individual's health, safety, well-being and personal preferences as agreed upon by the PSP team so as to promote an individual's opportunity for an Everyday Life.

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

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

manager shall be responsible for the development of the PSP, including revisions, in collaboration 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 completion of the individual's assessment ~~of the individual's date of admission to the facility~~.

(e) ~~The PSP shall will be initially developed, revised annually and revised when an individual's needs change based upon a current assessment.~~ The PSP shall be revised when an individual's needs or support system changes and upon the request of an individual or the individual's family.

(f) The PSP and PSP revisions are to be correlated with a current valid assessment and the individual and PSP team input.

~~(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. **[~~Content of the ISP.~~] The PSP team.**

Discussion 2380.183.
Delete this section and add essential content to 2380.182 and 2380.285 as noted.

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

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

~~(2) Services provided to the individual to increase community involvement, including work opportunities as required under § 2380.188 (relating to provider services).~~

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

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

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

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

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

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

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

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

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

~~(i) Vocational programming.~~

~~(ii) Community involvement.~~

~~(iii) Competitive community integrated employment.~~]

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

~~(1) The individual.~~

~~(2) Persons designated by the individual.~~

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

~~(4) The program specialist.~~

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

~~(6) Other specialists such as health care, behavior management, speech, occupational and physical therapy as appropriate for the individual 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. [~~Plan team participation.~~] **The PSP process.**

Discussion 2380.184.

Delete section and add essential content to 2380.182 and 2380.185 as noted.

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

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

~~(i) The individual.~~

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

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

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

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

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

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

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

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

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

~~The PSP 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. **[~~Implementation of the ISP.~~] Content of the PSP.**

Discussion 2380.185.

Text is proposed to be added or deleted to enhance clarity and avoid confusion.

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

~~(b) The ISP shall be implemented as written.~~]

The PSP, including revisions, must include the following elements:

(1) The individual's strengths, preferences and functional abilities.

(2) The individual's ~~individualized~~ assessed diagnoses, clinical and support needs.

(3) The individual's goals and preferences such as those related to relationships, community participation, self-determination, employment, income and savings, health care, wellness, quality and education.

(4) Individually identified, person-centered desired outcomes.

(5) Supports to assist the individual to achieve desired outcomes.

(6) The type, amount of units, 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) The individual's communication mode, abilities and needs.

~~(8) Opportunities for new or continued community participation.~~

~~(9)~~(8) The level of needed support, risk factors, dangerous behaviors and risk mitigation strategies, if applicable.

(~~10~~)(9) Modification of individual rights as necessary to mitigate risks, if applicable. The PSP as approved by the PSP team is presumed to be consistent with an individual's rights and is the governing document for rights purposes.

(~~11~~)(10) Health care information, including a health care history.

(~~12~~)(11) Financial information including how the individual ~~chooses~~ may choose to use personal funds based on history and communicated interest.

(~~13~~)(12) The person or entity responsible for monitoring the implementation of the PSP.

(13) If the individual has a known behavioral support need, it must be identified in the PSP, or if a new behavior is identified, it must be added to the PSP through a revision.

§ 2380.186. [~~ISP review and revision.~~] Implementation of the PSP.

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

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

~~(c) The ISP review must include the following:~~

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

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

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

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

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

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

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

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

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

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

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

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

The ~~facility~~ provider shall implement the PSP, including any revisions.

§ 2380.187. [~~Copies.~~] (Reserved).

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

§ 2380.188. [~~Provider services.~~] (Reserved).

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

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

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

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

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2390 Regulations

CHAPTER 2390. VOCATIONAL FACILITIES

GENERAL PROVISIONS

§ 2390.5. Definitions.

Discussion 2390.5.

All definitions for these regulations should be included in Chapter 2390.5, and the definitions should be the same across Chapter 6100 and all licensing regulations. Definitions should be consistent and clear with the intent to facilitate communication and understanding. Deleting definitions from the program regulations and including them within Chapter 6100 and the licensing regulations promotes clarity, consistency, and reduces administrative burden across applicable services and programs.

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

~~*Abusive act* – An act or omission of an act that willfully deprives a client of rights or which may cause or causes actual physical injury or emotional harm to a client.~~

Adult Autism Waiver - An HCBS Federal waiver program approved under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) and designed to provide community-based supports to meet the specific needs of adults with autism spectrum disorders

Aversive Conditioning - The application of startling, painful or noxious stimuli in response to the exhibition of behavior in an effort to modify the behavior.

Autism spectrum disorder (ASD) - A developmental disorder defined and diagnosed in accordance with criteria established in the Diagnostic and Statistical Manual latest edition in effect at time of diagnosis.

Base-funded services: A service funded exclusively by a grant to a county under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B of the Human Services Code.

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Based-funded support coordination - A program designed to provide community-based support to locate, coordinate and monitor needed support for individuals who receive support through base-funding.

Certificate of compliance—A document issued to a legal entity permitting it to operate a vocational facility at a given location, for a specific period of time, according to appropriate regulations of the Commonwealth.

Chemical restraint - 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 prescribed by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as treatment prior to or following a medical or dental examination or treatment.

Chief executive officer—The staff person responsible for the general management of the facility. Other terms such as "program director" or "administrator" may be used as long as the qualifications specified in § 2390.32 (relating to chief executive officer) are met.

~~*Client*—A disabled adult receiving services in a vocational facility.~~

Competitive employment—A job in a regular work setting with an employee-employer relationship, in which an ~~disabled~~ adult with a disability is hired to do a job that other ~~nondisabled~~ employees who do not have a disability also do.

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

Corrective action plan - a document prepared by a provider following a written determination by the Department of non-compliance with a provision(s) of this Chapter. The plan establishes timelines, person(s) responsible for the implementation and monitoring of corrective action steps.

Criminal abuse—Crimes against the person such as assault and crimes against the property of the ~~client~~ individual such as theft or embezzlement.

Dangerous behavior – A decision, behavior or action by an individual that creates or is highly likely to result in harm or to place the individual and/or other persons at risk of harm.

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Dignity of risk - Respecting an individual's expression of self-determination, even when it may adversely impact his/her health, safety, or well-being.

Department—The Department of Human Services of the Commonwealth.

Direct ~~service~~ support ~~worker~~ professional—A person whose ~~primary~~ principal job function is to provide services to an individual who attends the provider's facility.

~~*Disabled adult*—~~

~~(i) A person who because of a disability requires special help or special services on a regular basis to function vocationally.~~

~~(ii) The term includes persons who exhibit any of the following characteristics:~~

~~(A) A physical disability, such as visual impairment, hearing impairment, speech or language impairment, or other physical handicap.~~

~~(B) Social or emotional maladjustment.~~

~~(C) A neurologically based condition such as cerebral palsy, autism or epilepsy.~~

~~(D) An intellectual disability.~~

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

Emergency Closure – An event that is unplanned for any reason that results in program closure two days or more.

Family—the person or people who are related to or determined by the individual as family

Handicapped employment—A vocational program in which the individual ~~client~~ individual does not require rehabilitation, habilitation or ongoing training to work at the facility.

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

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

~~*Outcomes*—Goals the client individual and client individual plan team choose for the client individual to acquire, maintain or improve.~~

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

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

Incident - A situation or occurrence that has a high likelihood of a negative impact on an individual.

Individual—An adult or child who receives a home and community-based intellectual disability or autism support or base-funded services.

Mechanical restraint - a device that restricts the movement or function of an individual or portion of an individual's body in response to the individual's behavior. Mechanical restraints include a geriatric chair (unless prescribed in the individual's PSP), handcuffs, anklets, wristlets, 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) A mechanical restraint does not include a device prescribed by a health care practitioner that is used to provide pre/post-surgical/medical care, proper balance or support for the achievement of functional body position.

(ii) A mechanical restraint does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure or other non-voluntary movements or physical conditions that limit motor control and create the potential for injury.

Natural support—An activity or assistance that is provided by family, friends, or other community members without expectation of payment

Non-conformity - Failure to conform to or meet the expectations outlined within this chapter.

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***PSP*—Person-centered support plan.** Person-Centered Support Plan (PSP): The comprehensive plan for each individual that is developed using a person-centered process and includes HCBS, risks and mitigation of risks, and individual outcomes for a participant.

Provider—~~An entity or person that enters into an agreement with the Department to deliver a service to a client individual.~~ The person, entity or organization that is authorized to deliver services under the Medical Assistance Program.

Physical restraint - A physical (manual) hands-on technique that lasts longer than 30 consecutive seconds and restricts, immobilizes, or reduces an individual's ability to move his/her arms, legs, head, or other body parts freely.

Positive interventions - actions or activities intended to prevent, modify, decrease or eliminate challenging behaviors. These interventions or positive behavior supports include, but are not limited to: environmental adaptations or modifications, identifying and addressing physical and behavioral health symptoms, voluntary physical exercise, health and wellness practices, redirection, praise, modeling, conflict resolution, trauma informed care, de-escalation, and reinforcing desired behavior (contingent and non-contingent rewards).

Pressure point techniques - The application of pain for the purpose of achieving compliance. This technique does not include approved physical intervention techniques in response to aggressive behavior, such as bite release.

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

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

SCO—Supports coordination organization—A provider that delivers the services of locating, coordinating and monitoring services provided to an individual.

SC—Supports coordinator—An SCO employee whose primary job functions are to locate, coordinate and monitor services provided to a ~~client~~ individual when the ~~client~~ individual is receiving services from an SCO.

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Seclusion - Involuntary confinement of an individual in a room or area from which the individual is physically prevented from leaving.

Support— An activity, assistance or product provided to an individual that is funded through a federally approved waiver program, the State plan, or base funding. A service includes HCBS, supports coordination, targeted support management, agency with choice, an organized health care delivery system, vendor goods and services, base-funding service, uncles specifically exempted otherwise within this chapter.

State plan—The Commonwealth's approved Title XIX State Plan.

Support coordination - an HCBS Federal waiver program under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to provide community-based support to locate, coordinate and monitor needed HCBS and other support for individuals.

Vendor - A directly-enrolled provider that sells goods or services to the general public, as well as to an HCBS program.

Voluntary Exclusion - An individual voluntarily or willingly removing himself/herself from his/her immediate environment and placing himself/herself alone to a room or area.

Volunteer - A person who works without compensation and under the supervision of an authorized provider or family member alone with an individual in the performance of a service

* * * * *

GENERAL REQUIREMENTS

§ 2390.18. **[Unusual incident report.] Incident report and investigation.**

Discussion 2390.18.

Recommended edits promote clarity and specificity.

(f) (9) is a duplicate of (7)

~~**[(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.**~~

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~~The facility shall send copies of the report to the regional office of the Department and the funding agency within 24 hours after the event occurs. A copy of unusual incident reports shall be kept on file by the facility.~~

~~(b) If an unusual incident occurs during a weekend, the regional office of the Department and the funding agency shall be notified within 24 hours after the event occurs and the unusual incident report shall be sent on the first business day following the event.]~~

(a) ~~The~~ A provider shall report the following incidents~~,~~ and alleged incidents ~~and suspected incidents~~ through the Department's information management system within 24 hours of ~~discovery by a staff person~~ having knowledge of the incident:

(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.~~ 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.

(12) Emergency closure.

~~(13) Use of a restraint.~~

(~~14~~ 13) Theft or misuse of individual funds.

(~~15~~ 14) A violation of individual rights.

(15) Individual to individual incident.

(b) ~~The individual and the persons designated by the individual shall be notified immediately upon discovery of an incident relating to the individual.~~ A provider shall report the following in the Department's information management system within 72 hours of the occurrence or discovery of the incident:

(1) Medication administration error

(2) Use of a restraint outside the parameters of the PSP.

(c) ~~The facility shall keep documentation of the notification in subsection (b).~~ The individual and person(s) designated by the individual shall be notified upon discovery of an incident related to the individual.

(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~~ provider shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or ~~notice~~ identification of an incident, alleged incident and/or suspected incident.

(f) The ~~facility~~ provider shall initiate an investigation of ~~an incident~~ certain incidents within 24 hours of the occurrence or discovery by a staff person of the incident of the following:

(1) Death
(2) Abuse
(3) Neglect
(4) Exploitation
(5) Missing person
(6) Theft or misuse of individual funds

(7) Violations of individuals rights
(8) Unauthorized or inappropriate use of a restraint
(9) Individual to individual sexual abuse and serious bodily injury.

(g) ~~A Department-certified incident investigator shall conduct the incident investigation of the incident listed in subsection (a).~~ The incident investigation shall be conducted by a Department-certified incident investigator.

(h) ~~The A facility~~ provider 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, unless an extension is filed.

(i) ~~The A facility~~ provider shall provide the following information to the Department as part of the final incident report:

(1) Any known additional detail about the incident.

(2) The results of the incident investigation.

(3) A description of the corrective action(s) taken or planned in response to ~~an~~ the incident as necessary.

(4) Additional action(s) 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. **[~~Abuse.~~] Incident procedures to protect the individual.**

Discussion 2390.19.

~~[(a) Abusive acts against clients are prohibited.~~

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

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

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

(a) ~~In investigating an incident, the facility shall review and consider the following needs of the affected individual:~~ In reviewing a serious incident, or pattern of incidents, a provider shall review and consider the following needs of the affected individual(s):

(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~~ provider shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

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

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

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~~(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.~~

~~(c) 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.

Discussion 2390.21.

Suggested text is added for clarity and suggested text is redundant or otherwise unnecessary.

~~[(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.~~

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~~(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). An approved PSP shall be deemed consistent with an individual's rights.

(b) An individual shall be continually supported to exercise the individual's rights. An individual shall be provided services, supports, and accommodations to assist the individual to understand and to actively exercise rights as he/she chooses. The services, supports, and accommodation necessary for the individual to understand and activity exercise rights as they choose shall be funded by the Department as part of the PSP.

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

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

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

~~(f) 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~~)(e) 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.~~ An individual possesses all the civil, legal, and human rights afforded under law.

(k) ~~An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.~~ An individual has the right to be free from abuse, neglect, mistreatment, exploitation, abandonment or be 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.~~ An individual has the right to make informed choices and accept personal risks that do not pose a threat to the individual's and/or another person's health, safety, or well-being.

(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~~ provider shall inform and explain individual rights to the individual, and persons designated by the individual, upon admission to the ~~facility~~ program and annually thereafter.

(v) The ~~facility~~ provider 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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(*Editor's Note*: The following section is new and printed in regular type to enhance readability.)

§ 2390.24. Applicable laws and regulations.

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

STAFFING

§ 2390.33. Program specialist.

Discussion 2390.33.

(a) A minimum of **[one] 1** program specialist for every 45 ~~clients~~ individuals shall be available when ~~clients~~ individuals are present at the facility.

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

[~~(1) Coordinating and completing assessments.~~

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

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

~~(4) Attending the ISP meetings.~~

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

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

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

~~(8) Implementing the ISP as written.~~

~~(9) Supervising, monitoring and evaluating services provided to the client.~~

~~(10) Reviewing, signing and dating the monthly documentation of a client's participation and progress toward outcomes.~~

~~(11) Reporting a change related to the client's needs to the SC or plan lead, as applicable, and plan team members.~~

~~(12) Reviewing the ISP with the client as required under § 2390.156.~~

~~(13) Documenting the review of the ISP as required under § 2390.156.~~

~~(14) Providing documentation of the ISP review to the SC or plan lead, as applicable, and plan team members as required under § 2390.156(d).~~

~~(15) Informing plan team members of the option to decline the ISP review documentation as required under § 2390.156(e).~~

~~(16) Recommending a revision to a service or out- come in the ISP as provided under § 2390.156(c)(4).~~

~~(17) Coordinating the services provided to a client.~~

~~(18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each client.~~

~~(19) Developing and implementing provider services as required under § 2390.158 (relating to provider services).]~~

(1) Coordinating the completion of assessments.

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

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

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

(5) ~~Supporting~~ Promoting individual communication for the building ~~and involvement~~ of relationships with families and friends.

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

KenCrest feels strongly that Human Services or related field should be included in each education level and across the 2380, 2390 and 6400 regulations; and that the years of experience required at each level be consistent across the 2380, 2390 and 6400 regulations.

(1) A master's degree or above from an accredited college or university and 1 year of work experience working directly with persons with disabilities.

(2) A bachelor's degree from an accredited college or university and 2 years of work experience working directly with persons with disabilities.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years of work experience working directly with persons with disabilities.

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

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

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

(4) Possess a license or certification by the State Board of Nurse Examiners, the State Board of Physical Therapists Examiners, or the Committee on Rehabilitation Counselor Certification or

be a licensed psychologist or registered occupational therapist; and 1 year experience working directly with disabled persons.

§ 2390.39. Staffing.

Discussion 2390.39.

(a) A minimum of two staff shall be present at the facility when **[10] ten** or more ~~clients~~ individuals are present at the facility.

(b) A minimum of one staff shall be present at the facility when fewer than **[10] ten** ~~clients~~ individuals are present at the facility.

(c) If 20 or more ~~clients~~ individuals are present at the facility, there shall be at least **[one] 1** staff present at the facility who meets the qualifications of program specialist.

(d) A ~~client~~ individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the ~~client's~~ individual's assessment and is part of the ~~client's~~ 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).

(f) ~~A client~~ An individual may not be left unsupervised solely for the convenience of the facility or the direct service worker.

§ 2390.40. **[~~Staff training.~~] Annual training plan.**

Discussion 2390.40.

The purpose for a training plan is defeated by the idea that specific subjects or specific number of hours will address the needs of the clients or the organization. The training plan must be created based on an assessment that is by definition unique. As agencies analyze the needs of the people they support, the knowledge created in the field and their assessment of performance, a flexible, customized, quality focused plan will emerge. This new section

collapses the critical elements of section 40 and 49 into one streamlined and accountable set of standards to not only maintain the basics, but to advance our work to the next level.

Interns and volunteers should not be included as required to go through the training process. The interns and volunteers are time limited, and, additionally, the information they need should already be included in the orientation. Removing them from the required personnel list will cut down the training cost.

Collapse 2390.40 and 2390.49 into one section.

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

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

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

(a) The ~~facility~~ provider shall design an annual training plan based on the needs of the individuals as specified in the ~~individuals' PSPs~~ individual's PSP~~, other data and analysis indicating staff person training needs and as required under § 2390.49 (relating to annual training).~~ and the provider's quality improvement strategy.

(b) The annual training plan ~~must~~ shall include the orientation program as specified in § 2390.48 (relating to orientation program).

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

(d) ~~The annual training plan must include the following:~~ The plan shall address the need for training in basics such as rights, facilitating community integration, honoring choice and supporting individuals to maintain relationships

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

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

(e) The plan shall explain how the provider shall assure that staff understand their responsibilities around the promotion of individual rights and the reporting of suspected rights violations, abuse or neglect in accordance with the regulations that define those rights and responsibilities.

(f) The plan shall explain how the provider shall assure that staff understand the safe and appropriate use of positive interventions, including the training in the plans which are unique for any one person served.

(g) The plan shall include paid staff with client contract.

(h) The annual training plan shall include the following

(1) the title of the position to be trained

(2) the required training courses including the training course hours for each position

(i) Records of orientation and training including the training source, content, dates, length of training, copies of certificate receive and persons attending shall be kept.

(j) The provider shall keep a training record for each person trained

(*Editor's Note*: Sections 2390.48 and 2390.49 are new and printed in regular type to enhance readability.)

§ 2390.48. Orientation program.

Discussion 2390.48.

Focus on reducing the need for certain training in different levels. Open up the training of the basics to those who interact with individuals. Focus on protecting the individuals and limiting the extensive training requirements for certain positions.

This section is geared towards licensed providers. Remove AWC, OHCDS from the regulations and modify this section for unlicensed providers and transportation trip providers. Payment rates must be increased significantly for unlicensed providers and Transportation trip providers if they are expected to comply fully with this section. This list is not fully inclusive and infers that transportation mile individuals (OHCDS/AWC) who are reimbursed but not household members do not need training. Also, the inclusion of volunteers, management staff is problematic for unlicensed providers, transportation trip, AWC and OHCDS providers. The

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department must reconsider this section as it relates to all services, provider types and service delivery models. We support the wording for 2390.48 (a) (4) and (5)

(a) ~~Prior to working alone with individuals, and within 30 days after hire, the following shall complete the orientation program as described in subsection (b):~~ Within 30 days after hire, and before working directly with or starting to provide service to an individual, the following persons shall complete the orientation program as described in subsection (b):

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

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

(3) Direct ~~service~~ support ~~workers~~ professionals, including full-time and part-time staff persons.

(4) Volunteers who will work alone with individuals.

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

(6) Consultants who will work alone with individuals, except for consultants such as clinicians who are licensed by the Commonwealth of PA or other states (i.e. nurses, doctors, psychologists, MSW, etc.).

(b) The orientation program must 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~~)(1) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with sections 701—708 of the Older Adults Protective Services Act (35 P.S. §§ 10225.701—10225.708), 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(~~3~~)(2) Individual rights.

(4)(3) Recognizing and reporting incidents.

~~(5) Job-related knowledge and skills.~~

~~§ 2390.49. Annual training.~~

Discussion 2390.49.

We recommend that AWC and OHCDS be removed from the regulations and that Transportation Trip and Unlicensed home and community based providers be excluded from 2390.40 as written. This list of training is geared strictly towards licensed providers and impedes the promotion of family support models of service delivery. A prescribed number of hours for training will not support appropriate training specific for the individual and does not afford the opportunity for families/participants and the unlicensed providers and Transportation trip providers that support them with the type and frequency of training that is needed for the individual. When there are established mandates to hours versus individuality, the service quality and the opportunity to support the values of ODP and Everyday Lives is lost. The current unit rates will not support the increase in training requirements. Optimally, AWC and OHCDS providers will be removed from the regulations and unlicensed providers and transportation trip providers should have separate training requirements that do not include a specific number of hours.

See prior comment under 2390.40.

~~(a) The following staff persons, including full-time 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 hours of the annual training hours specified in subsections (a) and (b) must encompass the following areas:~~

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

~~(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with sections 701—708 of the Older Adults Protective Services Act (35 P.S. §§ 10225.701—10225.708), 23 Pa.C.S. §§ 6301—6386 (relating to Child Protective Services Law), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.~~

~~(3) Individual rights.~~

~~(4) Recognizing and reporting incidents.~~

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

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

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

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

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

CLIENT RECORDS

§ 2390.124. Content of records.

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Discussion 2390.124.

Each ~~client's~~ individual's record must include the following information:

(1) The name, sex, admission date, birthdate and place, **[~~social security~~] Social Security** number and dates of entry, transfer and discharge.

(2) The name, address and telephone number of parents, legal guardian and a designated person to be contacted in case of an emergency.

(3) The name and telephone number of a physician or source of health care.

(4) Written consent from the ~~client~~ individual, parent or guardian for emergency medical treatment.

(5) Physical examinations.

(6) Assessments as required under § 2390.151 (relating to assessment).

(7) A copy of the vocational evaluations, if applicable.

~~**[(8) A copy of the invitation to:**~~

~~**(i) The initial ISP meeting.**~~

~~**(ii) The annual update meeting.**~~

~~**(iii) The ISP revision meeting.**~~

~~**(9) A copy of the signature sheet for:**~~

~~**(i) The initial ISP meeting.**~~

~~**(ii) The annual update meeting.**~~

~~**(iii) The ISP revision meeting.**~~

~~(10) A copy of the current ISP.~~

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

~~(i) ISP Review signature sheets.~~

~~(ii) Recommendations to revise the ISP.~~

~~(iii) ISP revisions.~~

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

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

~~(12) Content discrepancy in the ISP, the annual update or revision under § 2390.156.]~~

(8) PSP 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).

PROGRAM

§ 2390.151. Assessment.

Discussion 2390.151.

The recommended language in 2380.181 (b) is intended to distinguish between the need for a full assessment and a partial assessment.

2390.181 (f) has been amended to provide additional time to enable a program specialist to

better prepare an informed assessment.

* * * * *

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

* * * * *

(f) The program specialist shall provide the assessment to the SC or plan lead, as applicable, and plan team members at least ~~30~~ 15 calendar days prior to **[~~an ISP~~] a PSP** meeting for the development, annual update and revision of the **[~~ISP~~]PSP** under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development**[~~, annual update and revision of the ISP~~] of the PSP**).

§ 2390.152. Development **[~~, annual update and revision of the ISP~~] and revisions of the PSP**.

Discussion 2390.152.

We are pleased to see the inclusion of an expectation that there is one plan for the individual as included in 2380.182 (a) and supports this provision.

New text is proposed to add clarity.

Delete (g) and (f) as they are redundant now.

[~~(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.~~

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

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

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

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

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

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

(a) An individual shall have one approved and authorized PSP ~~at a given time~~ that identifies the need for supports, the supports to be provided and the expected outcomes. The PSP is intended to ensure that services are delivered in a manner reflecting individual preferences consistent with an individual's health, safety, well-being and personal preferences as agreed upon by the PSP team so as to promote an individual's opportunity for an Everyday Life.

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

(c) ~~The support coordinator, targeted support manager or program specialist shall coordinate the development of the PSP, including revisions, in cooperation with the individual and the individual's PSP team.~~ The support coordinator or targeted support manager shall be responsible for the development of the PSP, including revisions, in collaboration 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 completion of the individual's assessment ~~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.~~ **The PSP shall be revised when an individual's needs or support system changes and upon the request of an individual or the individual's family.**

~~(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. **[~~Content of the ISP.~~] The PSP team.**

Discussion 2390.153.
Delete this section and roll into other sections as noted

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

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

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

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

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

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

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

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

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

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

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

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

~~(i) Vocational programming.~~

~~(ii) Competitive community-integrated employment.~~]

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

~~(1) The individual.~~

~~(2) Persons designated by the individual.~~

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

~~(4) The program specialist.~~

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

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

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§ 2390.154. **[~~Plan team participation.~~] The PSP process.**

Discussion 2390.154.
Delete this section and add content elsewhere as noted.

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

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

~~(i) The client.~~

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

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

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

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

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

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

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

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

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

~~The PSP 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. **[~~Implementation of the ISP~~.] Content of the PSP.**

Discussion 2390.155.

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

~~(b) The ISP shall be implemented as written~~.]

The PSP, including revisions, must include the following elements:

(1) The individual's strengths, preferences and functional abilities.

(2) The individual's ~~individualized~~ assessed diagnoses, clinical and support needs.

(3) The individual's goals and preferences such as those related to relationships, community participation, self-determination, employment, income and savings, health care, wellness, quality and education.

(4) Individually identified, person-centered desired outcomes.

(5) Supports to assist the individual to achieve desired outcomes.

(6) The type, amount of units, 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) The individual's communication mode, abilities and needs.

~~**(8) Opportunities for new or continued community participation.**~~

(~~9~~)(8) The level of needed support, risk factors, dangerous behaviors and risk mitigation strategies, if applicable.

(~~10~~)(9) Modification of individual rights as necessary to mitigate risks, if applicable. The PSP as approved by the PSP team is presumed to be consistent with an individual's rights and is the governing document for rights purposes.

(~~11~~)(10) Health care information, including a health care history.

(~~12~~)(11) Financial information including how the individual ~~chooses~~ may choose to use personal funds based on history and communicated interest.

(~~13~~)(12) The person or entity responsible for monitoring the implementation of the PSP.

(13) If the individual has a known behavioral support need, it must be identified in the PSP, or if a new behavior is identified, it must be added to the PSP through a revision.

(14) the individual's participation in community employment and other integrated services will be based on the PSP process and the individual's choices shall be honored.

§ 2390.156. **[~~ISP review and revision.~~] Implementation of the PSP.**

Discussion 2390.156.

[~~(a) The program specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the facility licensed under this chapter with the client every~~

~~3 months or more frequently if the client's needs change which impacts the services as specified in the current ISP.~~

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

~~(c) The ISP review must include the following:~~

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

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

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

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

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

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

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

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

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

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

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

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

The ~~facility~~ provider shall implement the PSP, including any revisions.

§ 2390.157. **[~~Copies.~~] (Reserved).**

Discussion 2390.157.

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

§ 2390.158. **[~~Provider services.~~] (Reserved).**

Discussion 2390.158.

[~~(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.~~]

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(*Editor's Note*: Sections 2390.171—2390.176 and 2390.191—2930.199 are new and printed in regular type to enhance readability.)

POSITIVE INTERVENTION

§ 2390.171. Use of a positive intervention.

Discussion 2390.171.

Definitions have been moved to 2390.5

~~(a)~~ A positive intervention shall be used ~~to prevent, modify and eliminate a dangerous behavior~~ when ~~the~~ challenging behaviors ~~is~~ are anticipated and/or ~~occurring~~ in response to challenging behaviors to prevent escalation of behaviors, or in attempts to modify, decrease or eliminate behaviors.

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

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

~~*Dangerous behavior*—An action with a high likelihood of resulting in harm to the individual or others.~~

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

~~**§ 2390.172. PSP.**~~

Discussion 2390.172.

It is recommended that this section be deleted and content rolled to 2390.73 as specified in the comment.

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

~~(1) The specific dangerous behavior to be addressed.~~

~~(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.~~

~~(3) The outcome desired.~~

~~(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.~~

~~(5) A target date to achieve the outcome.~~

~~(6) Health conditions that require special attention.~~

§ 2390.173. Prohibition of restraints.

Discussion 2390.173.

All definitions have been moved to 2380.3

"Camisole" has been deleted, upon the advice of experts in the field of Intellectual Disability Services, from the definition of "mechanical restraint" because they do not restrict movement. The definition notes that the use of geriatric chairs is sometimes prescribed by an individual's PSP.

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 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.~~

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

(7) A prone position ~~manual~~ physical restraint.

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

(9) A physical restraint may not be used as a substitute for positive behavioral interventions, or as retribution, punishment, noncompliance, or for the convenience of staff persons.

§ 2390.174. Permitted interventions.

Discussion 2390.174.

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(h) has been incorporated into (e) Text added and deleted for clarity

(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) The least intrusive intervention shall be used to deescalate the dangerous behaviors when the behavior is occurring.

(c) A physical restraint may be used in the case of a dangerous behavior to prevent an individual from injuring the individual's self or others.

(d) If the individual has a known dangerous behavior, it must be identified and addressed in the PSP, or if a new dangerous behavior is identified it should be added to the PSP through a revision.

~~(b) A physical protective restraint may be used § 2390.173(6) (8) (relating to prohibition of restraints).~~

~~(c) A physical protective restraint may not be used until §§ 2390.49(c)(5) and 2390.155(9) (relating to annual training; and content of the PSP) are met.~~

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

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

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

~~(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 2390.49.~~

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~~(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.

Discussion 2390.175.

There are some individuals who understand the consequences of making restitution for damages to others' property. In these cases, there should be a mechanism for this natural consequence to occur, such as a team approved proposed plan, restrictive procedure committee review and approval, etc.

Regulation must take into account legal orders secondary to adjudication of conviction of a crime that results in the need for some type of restitution.

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

(b) An individual's personal funds or property may not be used as payment for damages unless legally ordered or 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~~ with the support of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.

(3) There may not be coercion in obtaining the consent of an individual.

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

~~§ 2390.176. Rights team.~~

Discussion 2390.176.

We are very encouraged by the enhanced focus on individual rights and protections throughout these regulations and in associated licensing regulations. We believe that the values represented in Everyday Lives are the core elements of encouraging increased

individual participation in community, and exercising their choice, control, and rights.

This section, however, as written, merely adds an unnecessary bureaucratic layer to providers and families.

The concept of evaluating the potential and actual violation of rights is essential and, in fact, is already appropriately covered in the Incident Management process which includes a thorough investigation by an investigator who has been certified in the Department-approved training. As part of the already well-established and robust Incident Management system, all allegations of rights violations must be investigated. If a violation of rights is confirmed, the existing process has established corrective action follow-up. We support the clear and currently existing requirements that thoroughly address any rights violations. The proposed additional administrative duties and their associated costs are unnecessary, inefficient and uneconomical.

According to the regulations, the "rights team" is to meet every three months, regardless of whether any actual rights violations occurred during that quarter. Why?

A second stated purpose of the "rights team" is that it reviews any and all uses of restraint through the convening of the entire rights team, including the use of techniques which are used for emergency scenarios in dangerous situation and those that are part of a PSP.

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

~~(b) The role of the rights team is to:~~

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

~~(2) Review each incidence of the use of a restraint as specified in §§ 2390.171 2390.174 to:~~

~~(i) Analyze systemic concerns.~~

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

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

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

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

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

~~(f) The rights team shall meet at least once every 3 months.~~

~~(g) The rights team shall report its recommendations to the affected PSP.~~

~~(h) The facility shall keep documentation of the rights team meetings and the decisions made at the meetings.~~

MEDICATION ADMINISTRATION

Comment and Suggestion: Medication Administration

There are two extremely important issues concerning the proposed new regulations pertaining to medication administration. These issues must be carefully reconsidered by the Department.

1. Codifying content that requires modifications over time into regulations will lock a crucial component of service provision into temporal practices which will become obsolete as new information, prevailing practices and technology emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally - accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.

2. Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contrast to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.

As a ready example of the problem with codifying material which requires change over time, an area has been identified in which the proposed regulations are at odds with prevailing

practices as detailed by Title 49 of the State Nursing Board. 49 PA. CODE CH. 21 explicitly provides for Licensed Practical Nurses to accept oral orders for administering medication. The proposed 6100.465 provision only allows this practice for Registered Nurses.

This discrepancy is instructive both to the specific issue regarding LPN's and to the process issue of codifying Nursing Practices content which changes from time to time according to authorities outside of the Department. It is noted that the provider system needs LPN's to be able to do all that state law provides for them to do. In the second case, we need regulations which do not lock providers to standards which may soon become obsolete due to new and emerging best practices and advances.

A second example of the problem with trying to maintain this content in multiple places is that there are already discrepancies between the proposed 6100's and the Department's Approved Medication Administration Training. The training's required checklist for medication self-administration has discrepancies with the proposed regulation. There is also a notable practice discrepancy regarding pre-pouring of medications. We should avoid such confusion by requiring compliance with the most current version of the Department's approved Medication Administration Training module.

§ 2390.191. Self-administration.

Discussion 2390.191.

1. Codifying content that requires modifications over time into regulations will lock a crucial component of service provision into temporal practices which will become obsolete as new information, prevailing practices and technologies emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally - accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.
2. Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contract to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.

These points as further described in Discussion for 6100.461 persuade us to recommend that 6100 regulations pertaining to Medication Administration should refer to the Departments

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Approved Medication Training for the 2380, 2390 and 6400 services and should cite existing 6500 regulations for the 6500 services. The 6100.470 Exception for Family Members should be retained.

Prescription Medications shall be stored and disposed of according to the Office of Developmental Programs' Approved Medication Administration Training.

(a) The ~~facility~~ 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~~ may include helping the individual to ~~remember~~ adhere to 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~~ PSP team shall ~~provide or arrange for~~ facilitate the utilization of assistive technology to support the individual's self-administration of medications.

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

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

~~(1) Be able to recognize and distinguish the individual's his/her medication.~~

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

~~(3) Know and understand the purpose for taking the medication.~~

~~(3)(4) 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)(5) Be able to take or apply the individual's his/her own medication with or without the use of assistive technology.~~

In place of (e) please refer to (d) below.

(d) The PSP must identify if the individual is ~~unable~~ able to self-administer medications with necessary training, prompts and natural supports.

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§ 2390.192. Medication administration.

(a) ~~A facility whose staff persons are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer his prescribed medication.~~ Persons who administer prescription medication or insulin injections to individuals shall receive training by the individual's source of healthcare or satisfactorily complete the Department's/ODP's most current Medication Training Module.

~~(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.~~

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~~(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.~~

It appears that there was an inadvertent problem created by the inclusion of standardized medications content across these four program areas that includes the 6500 regulations. If the 6500 LifeSharing programs are included in this requirement, significant unintended consequence are likely to arise and cause severe negative impact on the viability and expansion of this program – a program that the Department has repeatedly stated it desires to expand. A consequence as well for the inclusion of this provision for 6500 programs will be more institutional style program expectations in a program which should increasingly exemplify the ideals of Everyday Lives principals in an integrated and typical family fashion to the retest degree. LifeSharing (6500) service providers are not currently required to complete the ODP Medication Training Module. The Module is necessarily a very detailed training requiring at least two full days of training plus four subsequent observations. This level of intensive training is possible in 2380, 2390 and 6400 programs because they have staff who are employees with employer-controlled schedules and they have centralized access to administrative supports, in perhaps a less intrusive way than entering a family's home. These conditions do not exist and are not desirable for LifeSharing. LifeSharing is provided in people's homes.

LifeSharing providers are not employees who spend regular time at training locations, nor should they – they are typical families who work and live in the community. These families work their own independent jobs in the community and would be challenged just to have the physical access to go through this process. There is already a shortage of certified medication administration trainers contributing to this access problem. Requiring this additional training would necessarily result in losing some providers who are unable to connect with the available training times and places, and potentially separating an already established shared life situation with an individual. It would also add a new barrier for new family-providers at a time when the Department is trying to expand this service and providers trying to find and recruit willing families.

Another problem with this expansion of the Training Module into the 6500's involves the respite services which are crucial to helping LifeSharing providers to support individuals over

the long-haul. Respite providers are often potential LifeSharing providers who are interested in gaining experience with the service and with individuals. These new/potential providers have not gone through full process as providers yet – adding this considerable step when they are not yet committed to the service would be destructive to the service.

Further concerns with requiring specific detailed training that can only come from service agencies to the 6500's is the necessity that we maintain LifeSharing providers' relationship as contracted supports rather than employees. The level of training specificity, the fact that it would be the "presumed employer" providing the training and the likelihood that LifeSharing providers would be taking the training alongside employees with no differentiation from the employees all implies an employee relationship which needs to be avoided if LifeSharing is going to continue to be an efficient, community-based model. Clear expectations are established by the IRS and DOL which providers must explicitly follow to maintain explicit differences between independent contractors and employees.

Finally, there is also a simple matter of proportionality. LifeSharing providers generally only serve one individual and the individuals in Life Sharing are typically able to take more responsibility for themselves than individuals in the other licensure groups. LifeSharing providers are able to focus-in on the needs of their lifesharer. They do not need days of general information. To require the Medication Administration Module of them would be disproportionate to their task – in fact, it would change the nature of the service from family-like supports to medical-model "administration" of medical care.

§ 2390.193. Storage and disposal of medications.

Discussion 2390.193.

As written, this section is far too prescriptive and subjective given the training that provider staff must complete. The suggested edits reflect clarity and brevity and are adapted from Chapter 6500.

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

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(b) ~~A prescription medication may not be removed from its original labeled container more than 2 hours in advance of the scheduled administration.~~ 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) ~~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.~~ 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 medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.~~ Prescription and nonprescription medications of individuals shall be stored under proper conditions of sanitation, temperature, moisture and light.

(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.~~ Discontinued prescription medications of individuals shall be disposed of in a safe manner.

~~(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) (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.~~

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§ 2390.194. Labeling of medications.

Discussion 2390.194.

Edits are adapted from suggested edits to Chapter 6500. Also, as with section 123, the proposed regulatory text is much too prescriptive, subjective and unnecessary given applicable training requirements.

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

~~(1) The individual's name.~~

~~(2) The name of the medication.~~

~~(3) The date the prescription was issued.~~

~~(4) The prescribed dosage and instructions for administration.~~

~~(5) The name and title of the prescriber.~~

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

(b) Nonprescription medications used by individuals shall be labeled with the original label.

§ 2390.195. ~~Prescription medications.~~ Use of a prescription.

Discussion 2390.195.

Adapted from Chapter 6500.

Why is subsection (c) necessary? Individuals who attend licensed 2380 and 2390 programs come from home. Family members and residential programs are responsible for the healthcare needs of the individuals. The review contemplated in (c) is a matter between the family members and/or provider staff.

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~~(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.~~

(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 PSP 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 or a certified nurse practitioner at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.

§ 2390.196. Medication record.

Discussion 2390.196.

Suggested edits are adapted from edits to Chapter 6500

~~(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.~~

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~~(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.~~

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(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.

§ 2390.197. Medication errors.

Discussion 2390.197.

Adapted from Chapter 6500

Medications errors must be addressed according to the Office of Developmental Programs' Approved Medication Administration Training Manual.

(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~~,~~ and follow-up action taken ~~and the prescriber's response~~ shall be kept ~~in the individual's record~~.

§ 2390.198. Adverse reaction.

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Discussion 2390.198.

Adapted from Chapter 6500

Adverse reactions shall be handled according to the Office of Developmental Programs' Approved Medication Administration Training.

~~(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.~~

If an individual has a suspected adverse reaction to a medication, the healthcare provider shall be contacted immediately. Documentation of adverse reactions shall be kept in the individual's record.

§ 2390.199. Medication administration training.

Discussion 2390.199.

Epi-pen mandatory training will add a significant cost to providers. This resource, such as HCQU, will be difficult to meet the needs of the agencies. There are some agencies that have had a video regarding this training.

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

~~(1) Oral medications.~~

~~(2) Topical medications.~~

~~(3) Eye, nose and ear drop medications.~~

(b) A ~~staff~~ person may administer insulin injections following successful completion of both:

(1) The course specified in subsection (a).

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(2) A Department-approved diabetes patient education program within the past 12 months.

(c) A ~~staff~~ person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:

(1) The course specified in subsection (a).

(2) 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.