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Nursing Assessment
POLICY: It is the policy of RHG to require a history and physical not more than sixty days old prior to admission, and to utilize community service providers for the purpose of admission history, physicals, and routine health care needs, when needed.

PROCEDURE:

1. The facility Administrator or Admissions staff will coordinate with any prospective resident, resident’s family and resident’s referral source to ensure that a history and physical shall be completed no more than sixty days prior to admission. In the event that the resident is a direct transfer from another hospital indicating a continuum of care, the history and physical contained within the previous treatment records is acceptable IF the Attending Physician attests to its appropriateness and affixes his signature and date to the form.

2. In the event that a resident is admitted without a previous history and physical approved by the attending physician, the nurse or designee will schedule a history and physical appointment with the service provider upon receipt of admission notification. The history and physical shall be initiated within 24 hours of admission and shall be completed within thirty days (30) of admission. The physical shall be completed by a physician. The physical shall include the following: medical history, including responses to medication, physical diseases and physical handicaps; date of last physical examination; description of physical status, including diagnosis of any functional limitations; recommendations for care, including medication, diet and therapy; and to the extent possible, a determination of the presence of a communicable disease.

3. During the admission procedure, the admitting psychiatrist will assess the physical health status of the resident.

4. The Nursing Assessment shall include the Medical History Form.

5. The Medical History form is completed by the parent/guardian. A copy of the Medical History is sent with the resident to the medical service provider at the time of history and physical appointment. A consult form is also sent for comments and recommendations.

6. All recommendations regarding medications and/or treatment made by the medical service provider must be legally ordered on the resident record by the attending physician.

7. The complete physical exam shall be returned to facility within thirty days and shall be included in the
resident’s clinical records.
POLICY: It is the policy of RHG to provide pharmaceutical, physical and dental health services 24 hours a day, 365 days a year through contractual arrangement with service providers in the community. Physical and dental health services are provided by licensed physicians, dentists, and accredited hospitals and approved by RHG Professional Staff. All residents shall have access to medical treatment as often as necessary to ensure optimum medical care.

PROCEDURE:

1. A routine physical examination shall be initiated within 24 hours of admission if the resident does not come directly from another hospital with records containing history and physical, and shall be completed within 30 days of admission.

2. The physical health assessment shall include evaluations of motor development and functioning, sensorimotor functioning, visual functioning, Tanner Scale, and immunization status. If immunizations are incomplete or records are unavailable, they shall be completed on recommendation of the health service provider and require a written order by the resident’s Attending Physician. The family is financially responsible for these charges.

3. Routine laboratory and clinical tests, as determined by the Professional Staff, shall be performed on all new admissions and as required thereafter.

4. Records of referrals, examinations and/or treatments shall be filed in the resident’s chart.

5. Staff shall have a basic knowledge of and receive training in the health needs and problems of residents.

6. A full range of health services will be provided through contracts with outside providers for the treatment of illnesses and maintenance of general health.
POLICY: It is the policy of RHG to assess the nursing needs, goals, and interventions of every resident admitted to the facility. The nursing assessment is conducted on the day of the admission and includes information from both resident and parent/guardian.

PROCEDURE:

1. The Admission staff will notify the Clinical Services Manager, therapist, and nurse of the date and time of scheduled admission. Previous treatment records will be made available to the nurse as a data base for the Nursing Assessment.

2. At time of admission, an appointment will be made with the nurse, who is to obtain the assessment.

3. The nurse will interview the parent/guardian regarding the resident’s past and current medical history and, where appropriate, interview the resident privately regarding other areas of the assessment such as thoughts, feelings, family dynamics, and other areas touching on personal or sensitive areas.

4. Upon completion of the interview, the nurse will formulate a summarization of nursing findings; identify problems, goals and objectives.

5. Included in the Nursing Assessment are weight, height, vital signs, apparent state of nutrition, allergies, past illnesses, medications, mental status, nursing review of systems, and a suicide potential assessment.
POLICY: It is the policy of Pasadena Villa that all staff and consultants are required and expected to attend Treatment Team meetings when individual resident cases are scheduled for formal review.

PROCEDURE:

1. The Administrator or designee will prepare a schedule, the last week of each month, of treatment reviews for the upcoming month.

2. The schedule must ensure that each resident is reviewed every 60 days.

3. The Administrator or designee will distribute the schedule to all physicians, clinical staff, and residents.
POLICY: It is the policy of RHG to provide radiology, pathology and laboratory services to aid in the assessment, diagnosis, and treatment of its residents.

RHG provides these services through a contractual agreement with community providers and laboratory. Services for residents are ordered by physicians.

PROCEDURE:

1. Services are provided by local emergent and other professionals. RHG staff shall contact providers regarding services to be rendered, the resident(s) to be served, and financial responsibility for payment.

2. Laboratory test results are returned by a courier from Quest Diagnostics or LabCorp, or by fax, as appropriate. It is the responsibility of the nurse to follow-up on results of all lab work done. There should be no more than four days between the time the specimen is obtained and laboratory results are returned.

3. The nurse is to notify the physician immediately of any abnormal results.

4. The nurse shall follow-up with healthcare providers to obtain any history and physical, or other diagnostic treatment summary, and is responsible to make sure these documents are placed in the resident record.
POLICY: The purpose of this policy is to define the program's philosophy and intervention techniques for assessment/supervision of residents at risk for dangerous behavior, including suicidal potential.

PROCEDURE:

Any talk (particularly expressions of suicidal ideation) or behavior patterns identified by the Attending Psychiatrist from the resident's history which indicates potential dangerous behavior is taken seriously. Staff shall react in a calm and confident manner and increase the amount of supervision. This includes:

1. Placing the resident on "visuels" or one-on-one supervision.
2. Sleeping them under the direct observation of a staff member in resident's own bed.
3. Notifying and apprising the Attending Psychiatrist of the situation.
5. The Attending Psychiatrist may decide no other interventions are necessary or may order the resident hospitalized if assessed to be acutely at risk for dangerous behavior.
6. When the resident is able to therapeutically maintain their behavior, staff shall document such and the treatment team will determine if any further interventions are required.
7. The Risk Assessment shall include an assessment of suicidal and/or homicidal ideation, aggressive behavior, self-harm behavior and level of social functioning.
POLICY: All residents will receive a comprehensive psychosocial evaluation upon admission to the system by a therapist and documented in the medical record (Best Notes) within 21 days of admission. Reassessments and updates are conducted following any significant life or status changes of the person served.

PROCEDURE:

The Psychosocial Assessment will include the following:

Name
Date of Birth
Date of Admission
Location
Marital Status
Date of Interview
Gender
Religion
Attending Physician
Guardian (if applicable)
Address and telephone
Source of information
Admitting Diagnosis (Axis I-V)
Reason for enrollment; including precipitating events.
History of prior treatment and psychiatric problems
Developmental and Family history: including legal, sexual and medical history
Substance abuse history and pattern of use
Prior treatment history
Education and independent living assessment
Family interviews and goals
Cultural assessment
Issues and goals identified by patient
Therapist formulation, recommendations and individual assessment
Initial Discharge plan
POLICY:
Recreation interests and needs will be addressed by recreation therapy staff within 7 days of admission.

PROCEDURE:
Assessments and inventories will become part of the medical record and goals will be reflecting in the individual treatment plan/plan of care.
POLICY: Substance abuse history is addressed in many initial assessments; application, nursing assessment, psychosocial assessment and initial treatment plan. Residents may be referred for further substance abuse assessment based on findings. Substance Abuse assessments are completed within seven (7) days of admission and findings are reflected in the treatment plan/plan of care.

PROCEDURE:
Substance Abuse assessments are completed within seven (7) days of admission and findings are reflected in the treatment plan/plan of care.
POLICY: A Functional Assessment will be completed by nursing staff on all residential admissions within 21 days of admission. The resident Functional Assessment shall determine the resident’s ability to utilize the skills needed to function successfully in the residential treatment environment, and shall identify any obstacles to the residents’ learning or using such skills.

PROCEDURE: The Functional Assessment shall evaluate:

- Mental Status Exam
- Ability to self preserve
- Ability to maintain personal hygiene
- Ability to self administer medication
- Ability to initiate and participate in social interactions
- Ability to perform household chores
- Ability to prepare meals
- Ability to conduct financial affairs
- Ability to use public transportation
# Nursing Assessment

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Time</th>
<th>Program</th>
<th>Sex</th>
<th>Race</th>
<th>Age</th>
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Accompanied by: ______________________________________________________________________

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<thead>
<tr>
<th>Temp.</th>
<th>Pulse</th>
<th>Respirations</th>
<th>B/P</th>
<th>Weight</th>
<th>Height</th>
<th>Hair Color</th>
<th>Eye Color</th>
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State of Nourishment

<table>
<thead>
<tr>
<th>Underweight</th>
<th>Overweight</th>
<th>Well Nourished</th>
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**Resident/Family Orientation**

- ___ Room ___ Program ___ Visiting ___ Phone ___ Staff ___ Pt. Rights Explained ___ Pt. Rights Given

Legal Custodian: ___________________________ Phone Number: ___________________________

<table>
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<tr>
<th>ALLERGIES</th>
<th>DRUG/FOOD</th>
<th>TYPE OF REACTION</th>
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Search for Contraband Completed:    Y             N         Staff Signature:
Items Found: ______________________________________________________________________

(    ) No Contraband found  (   ) Contraband sent Home   (   ) Other Disposition:

**General Appearance:** (Circle all that apply)

**Grooming:**

- Neatly groomed  Casually  Disheveled  Age Appropriate  Meticulous  Unkept

**Hygiene:**

- Clean  Offensive Odor  Soiled Clothing  Other: __________

**Religion:**

What are your spiritual needs? ______________________________________________________

**Current Medications:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Time/Frequency</th>
<th>Last Taken</th>
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</table>
Have you been taking your medications as ordered?  ___ Yes  ___ No

Lacerations/Abrasions:

Tattoos or Piercings:

Scars:

Burns/ Buises:

Moles/Birthmarks:

Do you have an physical problems ?  ___ Yes  ___ No

Any need for assistive technology: _______________________________________________________

Primary Care Physician: _______________________________ Phone Number: __________________

Dentist : ____________________________________________ Phone Number: __________________

Screening for the presence of Pain:

Do you have pain now?  ___ Yes  ___ No

Have you had pain in the last several weeks or months?  ___ Yes  ___ No

Mental Status:  (Circle all that apply)

Attitude:  Cooperative Guarded Suspicious Uncooperative Hostile

Motor:  Calm Hyperactive Agitated Hypoactive Tremors

Eye contact: Good Lacking Diminished Fleeting

Affect:  Appropriate Inappropriate Liable Flat Constricted

Mood:  Normal Depressed Anxious Euphoric Irritable

Speech:  Normal Halting Pressured Slurred Incoherent

Thought Processes:  Intact Tangential Paranoid Loose Associations Disorganized Circumstantial

Attention:  Restless Distracted Easy to gain

Suicide Risk:

Resident has current Suicidal Ideation?  ___ Yes  ___ No

Plan?  ___ Yes  ___ No

Explain: __________________________________________________________________________

History of attempts/gestures: __________________________________________________________
____________________________________________________________________________________
History of Abuse
Physical: ___ Yes ___ No Explain: ______________________________________________
Sexual: ___ Yes ___ No Explain: ______________________________________________

Previous Hospitalizations:

<table>
<thead>
<tr>
<th>Medical/Place</th>
<th>Dates:</th>
<th>Reason</th>
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<th>Psychiatric/Place</th>
<th>Dates:</th>
<th>Reason</th>
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History of Substance Abuse? ___ Yes ___ No
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Nutritional Pattern:

Appetite: Good Fair Poor
Food Preferences or Religious Restrictions: ___________________________________________
Recent Weight Changes: Gain Loss Amount: ___________
History of Eating Disorder? ___ Yes ___ No ____________________________________________
Therapeutic Diet? Diabetic No Salt Low Cholesterol
Food Allergies: ___________________________________________________________________

Review of Systems:

HEENT:
History of Head Trauma ___ Yes ___ No Explain: _________________________________________
Headaches: ___ Yes ___ No Freq. __________ Type: ________________________________
Eyes: Pain Blurring Glasses Contacts
Ears: Deafness Discharge Tinnitus Pain
Throat: Soreness Redness Hoarseness Difficulty swallowing
Nose: Nasal allergies Nose Bleeds Obstruction Other

Cardiovascular:
Chest Pain Palpitations Edema Shortness of Breath Hypertension Hypotension

Pulmonary:
Tuberculosis Screening Questionnaire (Based on the past year)
A cough lasting more than three weeks?     Y  N
Coughing up blood more than once?     Y  N
An unexplained low grade fever lasting more than a week?     Y  N
Loss of Appetite?     Y  N
Weight loss not due to dieting?     Y  N
Unexplained weakness?     Y  N
Waking up at night sweating?     Y  N
Easily fatigued?     Y  N
Pain when you breathe?     Y  N
Have you had a chest X-ray?     Y  N

Gastrointestinal:
Heartburn    Hepatitis    Nausea    Encopresis    Diarrhea    Constipation    Gallbladder
Use of Laxitives: __________________________

Genitourinary:
Enuresis    Dysuria    Frequency    Nocturia    Discharge    Pain on urination
Last menstrual period: __________________________  Regular Cramps Heavy Flow
Sexually Active: __________________________      Condoms Used: __________________________  STDs: __________________________
Hx of Pregnancy: __________________________  Abortion: __________________________
Use of contraceptives:  ___ Yes  ___ No

Neurological:
Seizures:  ___ Yes  ___ No  Age of Onset:  _____  Type: __________________________
Tremors  Numbness    Tingling    Fainting    Other

Sleep Pattern:
Average number of hours:  _____  Nightmares    Difficulty falling sleep
Early morning awakening  Frequency awakening
Sleep through the night  Duration of sleep problems: __________________________

Skin:  Acne    Jaundice    Other: __________________________

Skeletal:  Arthritis    Back Pain    Scoliosis    Other: __________________________

Nursing Summary/ Admission Note:
_____________________________________________________________________________________
_____________________________________________________________________________________
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<tr>
<th>CC-01</th>
<th>Referrals</th>
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<td>Wait List</td>
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<td>CC-04</td>
<td>Orientation</td>
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<td>CC-05</td>
<td>Transitions &amp; Discharges</td>
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<tr>
<td>CC-06</td>
<td>Readmissions</td>
</tr>
</tbody>
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POLICY: It is the policy of RHG to accept referrals from a variety of sources. Referrals are accepted from, but not limited to, the following sources: physicians, psychiatrists, psychologists, social workers, primary therapists, social service agencies, independent education consultants, employee assistance providers, case managers, psychiatric hospitals, other mental health service providers, family and friends.

PROCEDURE:

1. Referral application may be made by telephone, fax, or online. RHG provides intake services 24 hours per day, 7 days a week on the (877) 845-5235 line. A Best Notes record is created by staff trained to accept Intake/Referral calls (nurses, mental health technicians, therapists, Clinical Services Manager, Admissions Coordinator, Administrator, Managing Director).

2. The referring agency or individual may be asked to supply the following information:
   A. Psychiatric Evaluation
   B. Psychosocial History
   C. Medical History and Physical
   D. Online Application

3. If the applicant is admitted, additional documents are required.
   A. Current History and Physical
   B. Copy(s) of Court Documents (if any) which Verify Custody or Legal Status
   C. Current Identification Card(s)
   D. Copy of Insurance Card signed by Policy Holder
   E. Other Clinically Appropriate Documents requested by the Clinical Director or Treatment Team.

4. After the medical records have been received from the referring family or agent, they are reviewed by the Clinical Services Manager to assess the applicant's admissibility to RHG.
5. When an applicant is deemed appropriate for possible admission, the Admissions Staff will so advise the referral source and the potential resident or resident’s family in order to arrange a date for a pre-placement visit.

6. All pre-placement and admission activities are coordinated through the Admissions Staff and Clinical Services Manager.

UNACCEPTABLE REFERRALS

1. Referrals that meet exclusionary criteria are not accepted. Information about exclusionary criteria is conveyed to client, family and/or referral source and documented in Best Notes.

2. Cases may be staffed with the clinical team for appropriateness. Participants can include the Admissions Manager, Clinical Services Manager, Administrator, Clinical Director or MD.

3. Staff may suggest appropriate alternatives to programs that may be available to serve a referred resident determined to be inappropriate for RHG.
POLICY:

It is the policy of RHG to follow guidelines to maximize the therapeutic opportunity presented by admission. To be eligible for admission to RHG, the criteria of both age and medical necessity must be met. No patient will be denied admission to RHG based on race, creed, sex, or national origin. Applicants for admission must have a psychiatric disorder classified as a clinical syndrome on Axis I of the DIAGNOSTIC STATISTICAL MANUAL FOR MENTAL DISORDERS (DSM-IV). The choice of residential treatment is made when there is a wide range of severe disturbances and it is necessary to protect the resident’s development; the severity and complexity of these disturbances require 24-hour monitoring and supervision within a structured, therapeutic setting.

An individual is a candidate for residential treatment when the needed therapy services are too great to integrate into the family’s life pattern or the impact on the family is too disruptive for successful treatment if the applicant were to remain in the home. Residents admitted to RHG are selected on the basis of individual diagnostic assessments and must be medically and psychiatrically stable. The primary consideration in each case is the determination of an applicant’s ability to benefit from the therapeutic program offered.

RHG is designed to serve male and female residents, ages 18 and older, with an IQ of, at least, 70, and a history of longstanding disturbances in behavior, age appropriate functioning, problem solving, and psychological and family functioning.

Residents must admit themselves voluntarily or under the designation of a legal guardian or conservator. Legal guardian or conservator must provide appropriate documentation and be present at the time of admission.

PROCEDURE:

Procedures are designed to prepare prospective residents and parent(s)/guardian(s) for admission to residential treatment. They are given the opportunity to understand the admission process so they are better able to cope with the new situation. Exceptions to any of the admission criteria must be approved by Administrator, Clinical Services Manager and attending physician.

I. ADMISSION CRITERIA

All persons who enter RHG must meet the following minimum criteria:

A. Diagnosed as having a mental illness;
B. Age 18 or older;
C. Ambulatory or capable of self-transfer
D. Able to participate in treatment programming and services
E. Free of major medical conditions requiring ongoing 24 hours per day, 7 days per week nursing services;
F. Self-administers medication with staff supervision;
G. Maintains personal hygiene and grooming with staff supervision;
H. Initiates and participates in social interaction with staff supervision;
I. Performs assigned household chores with staff supervision; and
J. Is capable of self-preservation in accordance with Subparagraph 65E-4.016(17)(b)2., FAC or 0940-5-4-.10, TN.

Persons who enter at Level IV Residential Treatment must meet the additional criteria:

A. Performs household chores and activities.
B. Manages income.
C. Utilizes recreational and social resources.
D. Procures food and other items necessary to maintain a household.
E. Prepares meals either individually or cooperatively, and
F. Utilizes community transportation systems.

II. EXCLUSIONARY CRITERIA

Persons are excluded from admission to RHG if any of the following exist:

A. Major medical condition requiring ongoing 24 hours per day, 7 days per week nursing services.
B. Any persons with communication barriers, such as inability to adequately communicate verbally, visual or auditory.
C. Chronic inappropriate behavior which disrupts, or could potentially disrupt, the facility’s activities or is harmful to self or others;
D. Any prior diagnosis, determination or legal charges categorizing the person as a sexual offender, sexual perpetrator or sexual predator.
E. Any person seeking residential treatment in lieu of incarceration.
F. Pattern of non-compliance with the Treatment Plan, rules or policies of the facility.
G. Any person with a history of Arson or fire setting.

III. SUSPENSION CRITERIA

Persons already admitted to RHG may be suspended and or discharged form the facility if:

A. Information is later revealed that meets exclusionary criteria
B. A resident that meets involuntary commitment criteria upon admission.
C. A resident behaves in a manner that is deemed dangerous and is unable to correct this behavior with available clinical interventions, or has shown a pattern of significant non-compliance with program guidelines or threatens/uses physical violence toward others, or threatens or damages property.
D. A resident meets involuntary commitment criteria and requires transfer to a involuntary receiving facility
POLICY:
If the referred patient is not accepted at the desired level of care or location due to unavailability of bed, then they can be voluntarily placed on a wait list.

PROCEDURE:
Wait list candidate must have a complete admission application and clinical documented in Best Notes. Admissions staff will document the time frame given to families, clients and referrals source. Information will be documented concerning updated length of time and candidates contacted at least every 2 weeks.

Wait list and bed availability will be reviewed in weekly treatment team meetings. Candidates will be asked to update information prior to admission to ensure that level of care is still appropriate.

Upon requests, families will be given alternative placement referrals for services by Admissions staff or Referral relations staff. Referrals will be documented in Best Notes.
POLICY:
RHG will provide an orientation to each person admitted that is appropriate to their needs and the type of services provided and that is understandable to the person served.

PROCEDURE:
At admission:
1. Each admission will sign the Consent for Treatment to be admitted to RHG programs prior to any treatment being administered.
2. Each person will receive and sign a copy of Resident Rights and Resident Responsibilities. The Resident Rights and Responsibilities are posted in each facility for further review. If requested, Admissions staff will review these Rights and Responsibilities verbally as well.
3. Admissions staff will review the Code of Ethics and Resident Complaint and Grievance procedure with each admission. Key staff contacts are posted in each facility for residents to contact with a complaint or grievance.
4. Admissions staff will review the Notice of Privacy Practices and other confidentiality policies with each resident and family; obtaining a signed copy of Notice of Privacy Practices and Authorization to Release Confidential Information.
5. Staff will familiarize residents and families with the premises, including emergency exits, evacuation protocol and/or fire suppression equipment.
6. Staff will review resident/client expectations, schedule, on-call staff, services and activities provided.
7. Staff will review the smoking policy, resident management, and the policies regarding illegal or legal drugs and alcohol brought into the program.
8. Staff will review the financial obligations, fees and financial contract with the financially responsible party prior to or at admission.
9. The staff responsible for service coordination will be identified at admission and the appropriate contact information given to family and resident.
10. Residents and families will participate in the initial treatment plan development and be given information about continued participation in the treatment planning process.
11. Staff will review the Resident Restrictions policy including any restrictions the program may place, events, behaviors or attitudes that may lead to loss of rights or privileges and the means by which these rights and privileges may be returned.
12. Staff will review other services provided by RHG and criteria and procedures for transition.
POLICY: It is the policy of RHG to identify criteria for transition and discharge from programs. Transitions will be reflected in the treatment plan/plan of care for individual residents.

PROCEDURE:

Transitions will be documented in the resident record via the Transition Plan within 48 hours. Attending MD will complete a Discharge Summary for residents who transition out of residential treatment, community residential or day treatment to TLLC.

Discharges from all levels of care will be documented in the resident record via the Transition Plan. Attending MD will complete a Discharge Summary for residents who discharge from residential treatment, community residential or day treatment.

Residents will be discharged from services on the date of request and/or notification. Residents whom have eloped will be discharged 24 hours after their departure.

**Transition from Residential to Community Residential Treatment:** Residents able to maintain the following skills without daily supervision, with a reduction in night supervision, and with a reduction in daily clinical intervention for 30 days.

1. Self Administers and monitors own medications with physician's approval and nursing supervision
2. Performs household chores and activities with limited assistance
3. Maintains personal hygiene and grooming with limited assistance
4. Manages income with limited assistance
5. Utilizes recreational and social resources
6. Procures food and other times necessary to maintain a household with limited assistance
7. Prepares meals either individually or cooperatively
8. Utilizes community transportation systems
9. Abstains from use of drugs or alcohol
10. Maintains compliance with individualized treatment plan
11. Demonstrates a reduction in symptoms associated with primary diagnosis.

**Transition from Community Residential to Day Treatment:** Residents able to maintain the following skills without daily supervision, with a reduction in night supervision, and with a reduction in daily clinical intervention for 30 days.

1. Engages in an independent community activity such as school, employment, or volunteer work.
2. Self administers medications utilizing a medication cassette with physician's approval and limited supervision from nursing staff.
3. Maintains personal hygiene and grooming without daily assistance.
4. Performs household chores without daily assistance.
5. Manages income without daily assistance.
6. Utilizes recreational and social resources in the community.
7. Cooks meals independently without daily assistance.
8. Utilizes community transportation systems or individual transportation.
9. Abstains from drugs or alcohol.
10. Maintains compliance with individualized treatment plan.
11. Demonstrates a reduction in symptoms associated with primary diagnosis.

**Recommended/Planned Discharge Criteria:** Residents able to meet the following criteria for 90 days will be discharged from the program of enrollment

1. Identify and set up follow up care with medication management, therapy, and other services recommended by the treatment team.
2. Self administer medications and work with nursing staff on how to coordinate with the pharmacy.
3. Maintain personal hygiene and grooming without assistance.
4. Perform household chores without assistance.
5. Manage income without assistance and develop budget to ensure basic needs are met.
6. Cook meals independently without assistance.
7. Utilize recreational and social resources in the community.
8. Utilize community transportation systems or individual transportation.
9. Abstain from drugs or alcohol and when applicable seek community support through AA/NA.
10. Maintain compliance with individualized treatment plan.
11. Demonstrate a significant reduction in symptoms associated with primary diagnosis.
12. Develop a relapse prevention plan to identify triggers to regression and plan of intervention.

**Against Medical Advice Discharge (AMA)**
Residents will be deemed an AMA Discharge if they are discharged from services against the advice of the Medical Director and/or Treatment Team. In the event that a client chooses to discharge against medical advice, no medications or scripts for medication will be provided at the time of discharge. Residents will be provided referral to the appropriate level of care by the treatment team and the Therapist will follow up with the family and/or referral source within 72 hours of discharge.

**Administrative Discharge**
Residents may be Administratively Discharged if they meet the suspension and/or exclusion criteria. Residents will be provided referral to the appropriate level of care by the treatment team and the Therapist will follow up with the family and/or referral source within 72 hours of discharge.
POLICY: Residents whom have been discharged from any level of care will be considered for readmission through the Admissions Department.

PROCEDURE:
Readmission within seven (7) days: Residents whom have been discharged from any program less than 7 days and present for readmission to the same level of care will complete the admission process with Admission Staff and the previous chart will be re-opened. Staff will initiate new program consents and update the previous treatment plan and any applicable assessments.

Readmission after seven (7) days: Residents whom have been discharged from any program longer than 7 days and present for readmission will complete the admission process with Admissions Staff and a new chart initiated. Staff will initiate new program consents, treatment plan and assessments for this record.

Readmission to a different level of care: Residents whom have been discharged from any program and present for readmission to a different level of care (regardless of length of discharge) will complete the admission process with Admission Staff and a new chart initiated. Staff will initiate new program consents, treatment plan and assessments for this record.
Policy and Procedure Manual

Management of the Environment of Care (EC)

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Fire Drill Report
Fire Alarm Report
Safety Plan
Annual Evaluation – Hazardous Materials
Annual Evaluation – Infection Control
Annual Evaluation – Life Safety Plan
Annual Evaluation – Security Management
POLICY:

The facility shall have a Safety Plan to insure the identification, development, implementation and review of safety policies and procedures for all departments and services.

PROCEDURE:

1. The Safety Plan shall be developed by the Safety Officer.

2. Mandatory to the safety plan are the following points:

   A. Establishment of a Safety Committee which contains multi disciplinary members who have diverse training and/or experience to develop, implement, and maintain a comprehensive organization wide safety program.

   B. The Managing Director appoints a Safety Officer, responsible for carrying out the functions of the safety program.

   C. The Safety Officer is the chairperson of the Safety Committee, which includes the Administrative Program Manager, Clinical Program Manager, Admissions Coordinator, Clinical Director and Managing Director.

   D. The Managing Director appoints a Risk Manager.

   E. Annual review of the Safety Plan and all of it components.

   F. Frequency of Safety Meetings no less than annually. Frequency of meetings must reflect the ever changing environment and its needs.

   G. Safety Officer action can be taken when conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or building.

3. Documentation of all meetings is through minutes, which must demonstrate evidence of information exchange and consultation between the safety committee and the various safety programs.

4. Conclusions, recommendations and actions of the Safety Committee are evaluated annually.
POLICY:
It is the policy of RHG to provide a healthy environment in which residents and staff live and work. In line with this, no smoking is permitted within the facility.

PROCEDURE:

1. Residents are allowed to keep in their possession lighters and/or matches for outside smoking. This right may be restricted by any staff for the safety of the environment.

2. Smoking will be permitted for staff, visitors, and residents only in designated areas on the grounds. The only such designated areas at RHG are in the back patio, either in the covered or uncovered areas, and in the back yard. Smoking in resident rooms or anywhere within the building is strictly prohibited. Ashtrays in the outside smoking area shall be made of suitable noncombustible materials.

3. Smoking in the front of the building is prohibited.

4. Residents are only permitted to smoke within constraints of treatment team recommendations.

5. The smoking policy shall be provided to each new resident at the center and to all new staff at orientation.
POLICY:
The facility shall have a fire plan and program to ensure the safety of the patients, employees and visitors of the facility.

PROCEDURE:
1. The Safety Committee shall be responsible for writing a Fire Plan for implementation at the facility.

2. This plan shall address:
   A. Use and function of fire alarm and detection systems, containment and the protection of lives including transfer to areas of refuge, evacuation plans and fire extinguisher equipment.
   B. Concise, pre-established, documented plans to be implemented during a disaster.
   C. The frequency of fire drills (at least annually for each shift worked).
   D. The establishment of a one (1) minute reaction time to fire drills.
   E. Staff requirements and designation of roles and functions.
   F. Methods of providing appropriate training to staff.

3. The Fire Plan is implemented, evaluated and documented annually. Documentation is to include problems identified during implementation, corrective actions taken and staff participation.

4. Documentation of compliance with this policy is provided to the Safety Committee.
POLICIES AND PROCEDURES

Fire Plan

Use of Fire Alarm at Pasadena Villa:

The fire alarm shall be activated either manually at a manual pull station, or by the smoke alarm system. There are four manual pull stations in the facility and approximately thirty smoke detection devices.

Once a staff member or resident visually sees a fire, he/she shall pull the nearest manual pull station. This will automatically transmit an emergency signal to the fire system monitoring company, CMS. CMS will then immediately call to confirm the emergency and notify the fire department for dispatch.

In the event of a fire drill, staff will call CMS prior to activation of the fire alarm to inform CMS of the drill.

Transmission of Alarm to Fire Department from Pasadena Villa

Once the fire alarm is activated, the fire system monitoring company will confirm the emergency and notify the fire department. If the alarm was a false alarm, staff shall notify the fire alarm system monitoring company, and transmission to the fire department will be voided.

Response to Fire Alarm

Response to the fire alarm shall follow the Fire Plan. Evacuation procedures shall be followed as shown on the posted facility evacuation diagrams.

When the fire alarm is activated, staff shall immediately go that area and confirm whether a fire indeed exists, or if it is a false alarm.

If it is a false alarm, the staff shall call the fire system monitoring company (PV) to avert a transmission to the fire department and reinstate the alarm monitoring (PV). All staff and clients will continue with daily schedule.

In the event of a false alarm, the staff nurse or designee will complete a fire alarm report and forward it to the Safety Officer.

In the event of a fire drill, the staff nurse or designee will complete a fire drill report and forward it to the Safety Officer. These reports are reviewed by the Safety Committee annually.

If there is indeed a fire, staff shall immediately follow the facility Fire Plan.

Isolation of Fire

If the fire is located within a room in which a door may be closed, staff shall immediately close such door to isolate the fire. Staff shall then locate and activate the nearest fire extinguisher and apply to any visible flames.
Evacuation of Fire Area

Once it is determined that a fire exists, staff shall immediately prompt the evacuation of residents from that area. If the fire is in either wing of the facility, clients shall be directed to the opposite side of the building. If the fire is in the middle section of the building, staff shall direct residents and clients outside and to the parking lot.

Prepare Building for Evacuation

Once it is determined that the activation of a fire extinguisher will not be adequate in controlling a fire, all staff shall immediately prepare the building for full evacuation. This will include the shutting of resident room and office doors. Residents shall be directed toward one of the three designated and marked emergency exits. Staff nurse or designee will take the visitor sign in sheet and daily census and staffing notebook to verify that all individuals have evacuated the building. Emergency phone lists will be located in the Daily Census and Staffing binder. Once evacuated to the front parking lot, the staff nurse or designee will account for all residents, visitors and staff. The staff nurse or designee will notify the emergency on call staff member of any missing, injured or deceased persons via facility cell phone.

If an alternate meeting place is needed for safety, staff and clients will meet in the parking lot directly across the street from Pasadena Villa.

Fire Drills

Fire Drills will be preformed at least annually for each shift worked in order to ensure staff and clients are prepared for disasters. Fire Drills will be coordinated by the Safety Officer and scheduled with the Program Manager. Client inservices will be completed quarterly to cover fire prevention and evacuation procedures. Staff will be trained at General Orientation and annually by the Safety Officer. Staff inservices will cover: how and when to operate the fire alarm, fire extinguishers, fire sprinklers, fire prevention, building evacuation and management of facility emergencies.
POLICY:
The facility shall have a fire plan and program to insure the safety of the patients, employees and visitors of the facility.

PROCEDURE:
1. The Safety Committee shall be responsible for writing a Fire Plan for implementation at the facility.

2. This plan shall address:
   
   A. Use and function of fire alarm and detection systems, containment and the protection of lives including transfer to areas of refuge, evacuation plans and fire extinguisher equipment.

   B. Concise, pre-established, documented plans to be implemented during a disaster.

   C. The frequency of fire drills (at least 1 per Month and 2 Sleep Time Drills per Year).

   D. The establishment of a one (1) minute reaction time to fire drills.

   E. Staff requirements and designation of roles and functions.

   F. Methods of providing appropriate training to staff.

3. The Fire Plan is implemented, evaluated and documented annually. Documentation is to include problems identified during implementation, corrective actions taken and staff participation.

4. Documentation of compliance with this policy is provided to the Safety Committee.
Fire Plan

Use of Fire Alarm at Pasadena Villa’s Smoky Mountain Lodge:

The fire alarm shall be activated either manually at a manual pull station, or by the smoke alarm system. There are manual pull stations at each exit in the facility and approximately forty smoke detection devices.

Once a staff member or resident visually sees a fire, he/she shall pull the nearest manual pull station. This will automatically transmit an emergency signal to the fire system monitoring company, Fleenor. Fleenor will then immediately call to confirm the emergency and notify the fire department for dispatch.

In the event of a fire drill, staff will call Fleenor prior to activation of the fire alarm to inform Fleenor of the drill.

Transmission of Alarm to Fire Department from Pasadena Villa’s Smoky Mountain Lodge

Once the fire alarm is activated, the fire system monitoring company will confirm the emergency and notify the fire department. If the alarm was a false alarm, staff shall notify the fire alarm system monitoring company, and transmission to the fire department will be voided.

Response to Fire Alarm

Response to the fire alarm shall follow the Fire Plan. Evacuation procedures shall be followed as shown on the posted facility evacuation diagrams.

When the fire alarm is activated, staff shall immediately go that area and confirm whether a fire indeed exists, or if it is a false alarm.

If it is a false alarm, the staff shall call the fire system monitoring company (Fleenor) to avert a transmission to the fire department and reinstate the alarm monitoring (Fleenor). All staff and clients will continue with daily schedule.

In the event of a false alarm, the staff nurse or designee will complete a fire alarm report and forward it to the Safety Officer.

In the event of a fire drill, the staff nurse or designee will complete a fire drill report and forward it to the Safety Officer. These reports are reviewed by the Safety Committee annually.

If there is indeed a fire, staff shall immediately follow the facility Fire Plan.

Isolation of Fire

If the fire is located within a room in which a door may be closed, staff shall immediately close such door to
POLICIES AND PROCEDURES

isolate the fire. Staff shall then locate and activate the nearest fire extinguisher and apply to any visible flames.

Evacuation of Fire Area

Once it is determined that a fire exists, staff shall immediately prompt the evacuation of residents from that area. If the fire is in either wing of the facility, clients shall be directed to the opposite side of the building. If the fire is in the middle section of the building, staff shall direct residents and clients outside and to the parking lot.

Prepare Building for Evacuation

Once it is determined that the activation of a fire extinguisher will not be adequate in controlling a fire, all staff shall immediately prepare the building for full evacuation. This will include the shutting of resident room and office doors. Residents shall be directed toward the closest designated and marked emergency exits. Staff nurse or designee will take the “In and Out Boards” visitor sign in sheet and daily census and staffing notebook to verify that all individuals have evacuated the building. Emergency phone lists will be located in the Daily Census and Staffing binder. Once evacuated to the Safe Spot; parking lot near road, the staff nurse or designee will account for all residents, visitors and staff. The staff nurse or designee will notify the emergency on call staff member of any missing, injured or deceased persons via facility cell phone.

If an alternate meeting place is needed for safety, staff and clients will meet at the MAILBOXES.

Fire Drills

Fire Drills will be performed at least monthly at different times in order to ensure staff and clients are prepared for disasters. There will be at least 2 “Sleep Time” Drills per year. Fire Drills will be coordinated by the Safety Officer and scheduled with the Program Manager. Staff will be trained at General Orientation and annually by the Safety Officer. Staff inservices will cover: how and when to operate the fire alarm, fire extinguishers, fire sprinklers, fire prevention, building evacuation and management of facility emergencies.
POLICY:

RHG shall use and maintain safety devices throughout the facilities to insure the safety of patients, personnel, visitors and property from fire and products of combustion.

PROCEDURE:

1. All safety devices shall comply with State and Federal regulations. Should there be any question as to the use of any device in connection with patient safety, the City of Orlando Fire Chief will be contacted for his decision. These decisions shall be documented by the Safety Officer.

2. At the beginning of each shift, staff shall review the current residents, admissions and discharges at each location in order to ensure resident identification in all areas of the facility.

3. Pasadena Villa shall be electrically monitored and have a manually operated fire alarm system, which automatically transmits an alarm to the appropriate fire department. The campus shall be monitored by CMS (407-830-5123). Immediate notification must be made to the Safety Committee of any change to these arrangements.

4. (PV) Preventative maintenance to the fire alarm system shall be done on a quarterly basis, providing a written report for review of the Safety Committee.

5. (PV) The automatic sprinkler systems are to be connected to the fire alarm system and must also be scheduled for preventative maintenance on a quarterly basis. Written reports are to be submitted to the Safety Committee for review.

6. All Facility buildings are to have an evacuation plan posted in a conspicuous place.

7. Fire extinguishers are installed in all locations in accordance with the proper fire authorities and are inspected on an annual basis for preventative maintenance. Written reports are to be submitted to the Safety Committee for review.
POLICIES AND PROCEDURES

SUBJECT: MANAGEMENT & DISPOSAL OF BIO-HAZARDOUS WASTE  Page 1 of 2

ISSUE DATE: June 30, 2002  POLICY NO. EC-05

REVIEWED/EVISION DATE: March 31, 2011  PROGRAM: ALL

POLICY:
It is the policy of RHG to segregate, handle, label, store and dispose of biohazardous waste in compliance with State and Federal Regulations. Biohazardous waste is defined as any solid or liquid waste that presents a threat of infection. Of the six categories defined, RHG generates two: discarded sharps, such as needles and syringes, and the second category includes used absorbent materials such as bandages or gauzes that have become saturated with blood or body fluids.

PROCEDURE:

1. The Safety Officer along with the Nurse coordinates the management of all areas of biohazardous waste disposal.

2. Direct care or indirect care staff may be exposed to unplanned contact with blood/body fluids in an emergency situation.

3. Biohazardous waste shall be segregated from other types of waste. All discarded sharps are disposed of in the accepted manner into the sharps containers. The container must be dated when first used. The leak-resistant, rigid, puncture resistant biohazardous waste container is located in the nurse’s station, out of the general flow of traffic and is accessible only to authorized personnel. It is collected by our biohazardous waste disposal company: Stericycle.

4. Discarded dressings, sponges, etc., are double bagged using the red bags located in the Blood Spill Kit. A blood spill kit is located in the kitchen and in the consult room. A one to ten solution of bleach is available in the same area for disinfection of any blood spill area. STORAGE AREAS: Biohazardous waste shall not be stored on the premises longer than thirty (30) days.

5. LABELING: Biohazardous waste being readied for off-site transport shall be labeled immediately after packaging and sealing. The name and address of the generating facility is written in indelible ink on the container. The label contains the phrase: BIOHAZARDOUS WASTE and the international symbol. Bagged biohazardous waste being prepared for off-site transport prior to final treatment shall be enclosed in a rigid type container.

6. RECORD KEEPING: RHG contracts the biohazardous waste pick up and off-site transport service; records are kept for a period of at least three years. RHG will use Stericycle, Inc. for all biohazardous waste disposal.
7. **CONTINGENCY PLAN:** RHG Contingency Plan for disposal of biohazardous waste would be to temporarily contract with another biohazardous waste disposal company.

8. **STAFF EDUCATION:** Each job position has been evaluated to determine if their position requires the performance of any task that involves exposure and/or potential exposure to blood, body fluids or tissues. Unplanned Category I tasks, such as exposure to blood spill, could occur. Consequently, all categories of staff shall be trained annually in the handling of biohazardous waste.
POLICY:

The facility shall provide for the safety of all residents and staff in the handling of cleaning materials.

PROCEDURE:

1. The facility will provide adequate equipment during the handling of cleaning materials (including bleach or any other harsh cleaning products).

2. Staff shall closely supervise residents when they are handling and/or using any of these products to insure the proper usage, handling and knowledge of need for proper ventilation, etc.

3. Transferring cleaning materials from the original containers to another is prohibited (unless the original cleaning material is meant to be diluted). All bottles must be marked clearly as to their contents.

4. Cleaning mixtures (dirty mop water, etc.) Should be disposed of properly and not left standing in its bucket.

5. Empty containers should be discarded properly. If there are any questions as to the proper disposal of a container, please consult the container’s label.

6. All staff shall be aware of any and all Material Safety Data Sheets or other information sources and the location of copies for their immediate use if necessary. Staff is to educate residents about these sheets and their availability in the Safety Manual at each facility.
Policies and Procedures

Subject: Electrical Appliance & Inspections

Issue Date: June 30, 2002

Policy: To insure the safety of the residents in the area of electrical appliances.

Procedures:

1. Extension cords and adapters:
   A. The use of extension cords and adapters, unless provided by the Facilities Operations Staff, are prohibited at Lake Highland and Summerlin Ave (level IV). The use of extension cords and adapters are not prohibited at Pasadena Villa (level II).
   B. Construction of adapters and cords will be adequate for the application to avoid overload, will be of, at least, AWG 16 gauge, will bear the list of nationally recognized testing agency, and will meet the requirements of NFPA 76-B-1988.

2. Personal Electrical Equipment:
   A. Residents and personnel may not use personal electrical equipment brought from home unless it is safety checked and approved by the Safety Officer or designee.
   B. Should an appliance not pass the safety check or become unsafe after being passed previously, the Safety Officer or designee will remove the appliance and have a receipt signed by the resident indicating the reason for its removal. Upon the resident leaving the facility, the appliance will be returned to the parent/guardian or to the resident if resident is of age with a note indicating the reason for the unsafe condition.
   C. All cord connected, electrically powered appliances used in the patient vicinity shall be provided with a three-wire power cord and a three-pin grounding type plug. An exception to this requirement would be listed, double insulated appliances having two conductor cords. Portable electrical space heaters are strictly prohibited due to the danger of fire and burns.

3. Facility Electrical Equipment:
   A. All appliances are checked for loose, broken or missing parts, loose or frayed wires and serviced annually.
B. On relevant equipment, checks are made for refrigerant, motor oil levels and interiors are cleaned.

C. Results of inspections and subsequent corrective actions by staff or outside provider(s) are reported to the Safety Committee.
POLICIES AND PROCEDURES

SUBJECT: DISASTER PLAN

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: June 13, 2011

POLICY:

RHG has prepared a Disaster Plan to ensure the safety of clients, staff and visitors in the case of power outage, fire, tornado, hurricane, acts of terrorism or other disaster which would impede facility operations for an extended period of time.

PROCEDURE:

RHG’s Kitchen staff and Safety Officer shall ensure that the facility will have a one-week’s supply of non-perishable emergency food available at all times.

An emergency weather radio shall be available at the nurse’s station at all times. The Safety Officer shall ensure that all staff members have been trained on its use and operation.

Throughout the facility, the Safety Officer shall ensure that there are rechargeable flashlights available at all times. By using rechargeable flashlights, the facility will avoid battery deterioration during storage and times of non-use.

The facility shall make available to staff an emergency phone list with all administrative and clinical staff for use during emergencies.

The facility will maintain a daily Census and staffing pattern in a binder to be used by staff at the facility or during an evacuation.

The Safety Officer shall, on a regular basis, visit the City of Orlando Emergency Management website to check on “current threats”, and shall make updates and/or revisions to this Disaster Plan as necessary. For instance, in addition to the above noted potential disasters, the City of Orlando may list severe storm, wildfire, and specific terrorism threats which may need to be addressed.

All staff shall be trained on the Disaster Plan at the time of hire, and at least annually during employment at the facility. Such training shall be documented in the personnel file and in the Safety Manual.

During a disaster which forces an evacuation from the facility:

All resident families shall be notified, and given the opportunity to house the client/relative themselves. Such clients shall be discharged from the facility and readmitted upon return.

For clients in need of housing under the continued care of Pasadena Villa, clients shall be housed at The
POLICIES AND PROCEDURES

Lakewood Center, a residential treatment center for adults located in Fern Park, Florida (Orlando area).

In the event that there is no space or capability of housing the clients at Lakewood, clients shall be housed, with staff supervision, at the following hotels: Comfort Inn Suites, Orange Avenue, Courtyard by Marriott, Magnolia Avenue.

In the event that all such facilities are unavailable and a city-wide evacuation has been declared by the City of Orlando Emergency Management Operations Center, all remaining clients shall be housed, with on-site staff supervision, at the nearest designated shelter.

In this event, all resident medications shall be taken in a secure medication container, to be used within the shelter. Also, the pharmacy shall be notified to ensure that the staff has adequate levels of client medications during the evacuation.

Specific procedures for Hurricane or Tornado:

Staff on shift shall monitor the severe weather system on the weather radio at the nurse’s station.

Staff shall notify the administrator on call, who shall make the decision as to when to inform all staff of the severe weather conditions.

The grounds shall be checked for any objects such as lawn chairs, trays, rakes, hoses, or other items which may become dangerous if blown about in high winds. All such objects shall be moved to the storage shed or indoors.

The administrator on call shall assign staff to be responsible for various functions during the severe weather condition.

Staff shall ensure that clients are monitored and all persons reach the designated areas. Staff shall ensure that the following are gathered: food, water, first aid kits, flashlights, blankets, pillows, weather radio and cell phone.

If the storm is in close proximity, the hurricane shutters attached to all windows shall be closed, and shall remain closed until an all clear has been declared by Administration.

Contact shall be maintained between the staff and administrator on call via cell phone, and the administrator on call shall be given a status report once the emergency has passed.

The facility has two propane powered automatic electrical generators, which will immediately restore power during a power outage. However, in the event of a facility-wide power outage, the staff shall contact the Administrator and the Orlando Utilities Commission to alert them of the outage. Also, additional staff shall be called in to ensure the safety and increased monitoring of the clients.

Fire Safety Plan:
The fire alarm at Pasadena Villa is monitored at all times by CMS Monitoring. All activations of the fire alarm system result in automatic transmission to CMS, and from CMS to the fire department.

The fire evacuation routes shall be posted throughout each facility.

At least four fire extinguishers shall be available at all times. All fire extinguishers shall be inspected and date tagged at least annually.

The fire alarm system and/or smoke detectors monitor smoke in all resident rooms, offices and common areas. When the system detects smoke, the fire alarm will sound, which consists of very loud audio in conjunction with strobe light visual alarms.

Once the alarm sounds, Pasadena Villa staff shall immediately go to the control panel to determine where the fire or smoke has been detected.

If it is determined that the alarm as a false alarm, either by pull station or some other means, the staff must immediately call CMS to alert them to the false alarm status. The staff must also silence the alarm and reset the system.

If a fire has been identified in any building, staff shall try to remain calm and use the R.A.C.E. approach:

- **R**escue residents and/or other individual from immediate danger.
- **A**ctivate the alarm by pulling the nearest alarm box.
- **C**ontain the fire by closing all doors, windows and other accesses.
- **E**xtinguish the fire with an extinguisher.

Staff shall immediately evacuate residents to the safe area, which is designated as the parking lot in front of Pasadena Villa, adjacent safe yard at Lake Highland and Summerlin Avenue. Staff shall count all residents to ensure that everyone is out of the building safely.

Staff shall call the administrator on call using the cordless or cellular phone.

In the event that the fire is determined to be small enough to be safely approached with a fire extinguisher, staff shall use a fire extinguisher to attempt to get the fire under control. In the event it is determined that attempting to use a fire extinguisher would pose more danger than benefit, staff shall not attempt to contain the fire using the fire extinguisher.

Residents and staff shall remain in the safe area until the fire department has declared an all clear.
POLICIES AND PROCEDURES

SUBJECT: DISASTER PLAN

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: June 13, 2011

POLICY:

RHG has prepared a Disaster Plan to ensure the safety of clients, staff and visitors in the case of power outage, fire, tornado, hurricane, acts of terrorism or other disaster which would impede facility operations for an extended period of time.

PROCEDURE:

RHG’s Kitchen staff and Safety Officer shall ensure that the facility will have a one-week’s supply of non-perishable emergency food available at all times.

An emergency weather radio shall be available at the nurse’s station at all times. The Safety Officer shall ensure that all staff members have been trained on its use and operation.

Throughout the facility, the Safety Officer shall ensure that there are rechargeable flashlights available at all times. By using rechargeable flashlights, the facility will avoid battery deterioration during storage and times of non-use.

The facility shall make available to staff an emergency phone list with all administrative and clinical staff for use during emergencies.

The facility will maintain a daily Census and staffing pattern in a binder to be used by staff at the facility or during an evacuation.

The Safety Officer shall, on a regular basis, visit the National Weather Service website to check on “current threats”, and shall make updates and/or revisions to this Disaster Plan as necessary. For instance, in addition to the above noted potential disasters, the City of Sevierville may list severe storm, wildfire, and specific terrorism threats which may need to be addressed.

All staff shall be trained on the Disaster Plan at the time of hire, and at least annually during employment at the facility. Such training shall be documented in the personnel file and in the Safety Manual.

During a disaster which forces an evacuation from the facility:

All resident families shall be notified, and given the opportunity to house the client/relative themselves. Such clients shall be discharged from the facility and readmitted upon return.

For clients in need of housing under the continued care of Pasadena Villa Smoky Mountain Lodge, clients shall
be housed at ____________.

In the event that there is no space or capability of housing the clients at __________, clients shall be housed, with staff supervision, at the following hotels: Econo Lodge and Holiday Inn Express.

In the event that all such facilities are unavailable and a city-wide evacuation has been declared by the City of Sevierville, all remaining clients shall be housed, with on-site staff supervision, at the nearest designated shelter.

In this event, all resident medications shall be taken in a secure medication container, to be used within the shelter. Also, the pharmacy shall be notified to ensure that the staff has adequate levels of client medications during the evacuation.

Specific procedures for Tornado:

Staff on shift shall monitor the severe weather system on the weather radio at the nurse’s station.

Staff shall notify the administrator on call, who shall make the decision as to when to inform all staff of the severe weather conditions.

The grounds shall be checked for any objects such as lawn chairs, trays, rakes, hoses, or other items which may become dangerous if blown about in high winds. All such objects shall be moved to the storage shed or indoors.

The administrator on call shall assign staff to be responsible for various functions during the severe weather condition.

Staff shall ensure that clients are monitored and all persons reach the designated areas. Staff shall ensure that the following are gathered: food, water, first aid kits, flashlights, blankets, pillows, weather radio and cell phone.

If the storm is in close proximity, the hurricane shutters attached to all windows shall be closed, and shall remain closed until an all clear has been declared by Administration.

Contact shall be maintained between the staff and administrator on call via cell phone, and the administrator on call shall be given a status report once the emergency has passed.

The facility has two propane powered automatic electrical generators, which will immediately restore power during a power outage. However, in the event of a facility-wide power outage, the staff shall contact the Administrator, the Operations Manager and the Sevier County Public Utilities office to alert them of the outage. Also, additional staff shall be called in to ensure the safety and increased monitoring of the clients.

Fire Safety Plan:

The fire alarm at Pasadena Villa Smoky Mountain Lodge is monitored at all times by Fleenor Security. All
POLICIES AND PROCEDURES

activations of the fire alarm system result in automatic transmission to Fleenor Security, and from Fleenor Security to the fire department.

The fire evacuation routes shall be posted throughout each facility.

At least seventeen fire extinguishers shall be available at all times. All fire extinguishers shall be inspected and date tagged at least annually.

The fire alarm system and/or smoke detectors monitor smoke in all resident rooms, offices and common areas. When the system detects smoke, the fire alarm will sound, which consists of very loud audio in conjunction with strobe light visual alarms.

Once the alarm sounds, Pasadena Villa staff shall immediately go to the control panel to determine where the fire or smoke has been detected.

If it is determined that the alarm as a false alarm, either by pull station or some other means, the staff must immediately call CMS to alert them to the false alarm status. The staff must also silence the alarm and reset the system.

If a fire has been identified in any building, staff shall try to remain calm and use the R.A.C.E. approach:

- **R**escue residents and/or other individual from immediate danger.
- **A**ctivate the alarm by pulling the nearest alarm box.
- **C**ontain the fire by closing all doors, windows and other accesses.
- **E**xtinguish the fire with an extinguisher.

Staff shall immediately evacuate residents to the safe area, which is designated as the mailboxes at the bottom of Wonderland Lane. Staff shall count all residents to ensure that everyone is out of the building safely.

Staff shall call the administrator on call using the cordless or cellular phone.

In the event that the fire is determined to be small enough to be safely approached with a fire extinguisher, staff shall use a fire extinguisher to attempt to get the fire under control. In the event it is determined that attempting to use a fire extinguisher would pose more danger then benefit, staff shall not attempt to contain the fire using the fire extinguisher.

Residents and staff shall remain in the safe area until the fire department has declared an all clear.
POLICY:

The facility shall have a policy, which directs the cleaning of equipment, storage areas, work areas, resident areas and linens.

PROCEDURE:

Mattresses and Pillows

Mattresses and pillows shall be sanitized, at a minimum, between uses by different residents.

Blankets and Bedspreads

Blankets and Bedspreads shall be washed or dry cleaned at least quarterly.

Bed Linens

Bed linens shall be washed at least weekly, or more frequently, if necessary.

Refrigerators

Each refrigerator shall be cleaned at least monthly, or more frequently, if necessary.

Ovens

Ovens shall be cleaned at least quarterly, or more frequently, if necessary.

Bathrooms

Bathrooms shall be thoroughly cleaned at least weekly, or more frequently, if necessary.

Kitchen Counters

Kitchen counters shall be cleaned and disinfected at least daily.

Tile Floors

The tile floors throughout the facility shall be deep cleaned weekly. The housekeeping staff may rotate floors
to clean on different days.

The Housekeeping staff shall keep an updated calendar of scheduled cleaning activities, and accurately document scheduled cleaning activities. These cleaning records shall be kept on file in Administration.
POLICY:

The facility shall maintain a list of qualified employee drivers, and maintain policies to ensure a safe driving environment for staff and residents.

PROCEDURE:

1. All persons applying for a position with RHG will also complete, along with the application for employment, an authorization for a background and driving record screening. A driving record screening shall be performed on all potential employees, ordered and obtained through Kroll Background Screening America.

2. The driving record screening results shall be placed in the employee’s personnel file, along with a copy of the employee’s current driver’s license. In the event of adverse findings from the screening, the Safety Officer and Risk Manager shall review the record, and make recommendations to the Managing and/or Clinical Director regarding whether the employee shall be allowed to drive company vehicles, or under what circumstances.

3. The Human Resources shall maintain a log of qualified employee drivers. This log shall include the driver’s license and personal insurance information on each driver.

4. Only employees 21 years of age or older shall be permitted to drive company vehicles.
POLICIES AND PROCEDURES

SUBJECT: DECORATION OF ROOMS

ISSUE DATE: September 1, 2010

REVIEWED/REVISION DATE: March 31, 2011

POLICY:

Residents shall be allowed to keep and display personal belongings and to add personal touches to the decoration of their rooms.

PROCEDURE:

1. All personal decorations and displays will be reviewed by the Quality Improvement committee for final decision as to the appropriateness of content to treatment milieu.
POLICIES AND PROCEDURES

SUBJECT: SECURITY

ISSUE DATE: September 1, 2010

REVIEWED/REVISION DATE: March 31, 2011

POLICY:

It is the policy of RHG to encourage the safety and security of residents and staff.

PROCEDURE:

1. Exterior lighting has been placed outside of buildings to provide appropriate illumination for entrance and parking areas.

2. Staff and residents are encouraged to lock vehicles and refrain from leaving valuables in plain sight of vehicle windows.

3. Staff and residents are encouraged to use provided sidewalk and crosswalks when available and to avoid walking in traffic areas.

4. Staff and residents are encouraged to use the local 911 system as appropriate for emergent situations.
POLICIES AND PROCEDURES

SUBJECT: HAND WASHING & FOOD HANDLING

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

PROGRAM: ALL

POLICY:

Hands are to be washed thoroughly with friction, soap and water for 15 seconds before handling or serving food, after using the toilet, smoking or eating, coughing or sneezing, touching hair or face, before and after handling raw poultry or meat, touching soiled objects or clothing, before and after providing resident care, or contaminating hands in any way that common sense dictates the need for hand washing. Hands are not to be washed in food preparation sink. Hair restraints such as a headband or rubber banded pony tail are worn if hair is longer than ear length.

No person having a communicable disease in the transmittable stage or who is a carrier of organisms that may cause a communicable disease shall prepare or serve food for others.

Any resident involved in food preparation must be supervised by staff and follow these policies and procedures.

PURPOSE: To control infection and transmission of organisms from resident to resident, staff to resident and resident to staff.

PROCEDURE:

1) Wet hands and forearms thoroughly,

2) Add soap and work up lather for at least 10-15 seconds. Use friction, wash entire surface of hands for at least 15 seconds. Wash well between fingers and around and under fingernails,

3) Rinse with hands lowered to allow soiled water to drain directly into sink. Do not allow hands to touch sink.

4) Dry hands well, especially between fingers.

5) Use disposable hand towels to turn off sink.
POLICIES AND PROCEDURES

SUBJECT: MENU PLANNING

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

PROGRAM: ALL

POLICY: A 21 day cycle menu is prepared by the Certified Food Services Manager for normal and for therapeutic diets. Modifications are made as necessary to comply with Physician's orders and residents' preferences.

PROCEDURE:

1. The menu will be planned at least one week in advance so that purchasing may be based on it. The menu will be planned around seasonal items. It will be modified to meet the needs of the therapeutic diets.

2. The planned menus will include the basic four food groups and meet the nutritional requirements of our residents.

3. Menus are posted for the week in the kitchen and resident snack area.

4. The Culinary Service Manager is responsible for dating the menus and keeping a file of used menus for a period of six month.

5. When changes in menu are necessary, substitutions shall come from the same food group. Changes will be noted and dated by the Supervising Manager.

6. Standardized recipes are utilized in planning the menus.

7. The following meal pattern is used in planning the menu.

   BREAKFAST: juice, egg, toast, cereal, milk (8 oz), coffee, tea.
   LUNCH: meat, starch, vegetable, bread/roll, fruit, dessert, tea, coffee, sandwich, salad bar.
   DINNER: meat, soup/starch, vegetable, bread, fruit/dessert, milk (8 oz) coffee, tea, sandwich, salad bar.

8. Special diet menus to be developed by Consulting Dietitian when ordered by physician.

9. The menu pattern for each therapeutic diet is checked with the menu pattern in the diet manual as to the amount and type of foods to be included.
FACTORS OR CONSIDERATIONS OF GOOD MENU PLANNING

1. The availability of various foods - especially fruits and vegetables. In season foods are best value and should be utilized to the maximum, utilize fresh fruits and vegetables whenever possible for higher quality and better tasting meals.

2. The cost of the item. Plan menus with a balance between expensive and inexpensive menu items. Include seasonal surplus items in planning. Check for utilization of inventory and open ingredients.

3. Personnel and equipment limitations require consideration of these factors:
   a) Skill of the employees; their schedules.
   b) Work distribution and the location of the work areas
   c) Use of convenience foods.
   d) Allowance of advance preparation when it does not interfere with the quality of the food.
   e) Adequacy of the facilities layout and equipment.

4. The flavor variations of the menu. A meal should provide variations between bland and sharp flavors.

5. The texture, shape and consistency of foods
   a) Include a balance between soft and crisp components in a meal.
   b) Avoid using foods of similar shape or consistency on a menu.
      Ex. Strip steak  Vegetable soup  French fries  Hot beef sandwich  Asparagus  Mixed vegetables Carrots/celery sticks  Assorted relishes  Corn sticks  Fruit cocktail

6. Use a variety of colors for attractive and appetizing meals, ex: an all white, or all brown meal appears bland, add colorful vegetables for variety and appeal.

7. Consider the seasonal acceptability of foods.
   a) Fatty foods and heavy meals are more acceptable in cooler weather than during the hot seasons.
   b) A meal itself should be balanced in terms of its relationship between "heavy" and "light" component parts.

8. Consider the regional and ethnic food preferences of your residents. Provide an alternate selection so that likes and dislikes are considered.

9. Keep in mind the necessity of modified menus and plan that regular menu items may be modified for special diets as much as possible.
DRAFTING A MENU

1. **Main Dish (meat block)**
   The aim of a meat block is to distribute beef, veal, pork, lamb, fish, poultry and meat substitutes over a well spaced period of time. The number of times the various main dishes are to be used on a menu should be directly related to the cost of the item, their relative popularity and availability. Alternate the types of meats and their specific cuts between lunch and dinner. Avoid repeating the same menu items on the same day of different weeks. All menu items other than meats are selected to compliment the main dish.

2. **Potato and Potato Substitutes**
   Alternate crisp, browned potatoes with boiled or mashed potatoes, choosing recipes according to the kind of entree used. Vegetables with high starch content such as dried/canned beans or corn can be used as a potato substitute in addition to macaroni, noodles, spaghetti and rice.

3. **Vegetables**
   Eye appeal in a meal is due largely to the selection of vegetables and salads. Consider the color, flavor and texture of the vegetable. Include at least one vegetable that is a good source of Vitamin A four times per week.

4. **Fruit or dessert**
   Provide at least two or more servings of fruit each day. Include at least one fruit (or vegetable) that is a good source of Vitamin C daily. Plan desserts to balance out a light or heavy meal, taking into consideration the color and type of dessert.

5. **Soups**
   Use heavy cream or bean soups to balance a light entree and vice versa.

6. **Breads and cereals**
   Provide four or more servings daily. Utilize these foods to round out meals, satisfy individual appetites and provide additional calories.

7. **Planning breakfast**
   Plan juices and fruits considering those given at lunch and dinner. Plan the rest of the breakfast menu taking into consideration repetition and general preferences.
POLICIES AND PROCEDURES

SUBJECT: GUIDELINES FOR FOOD PREPARATION

ISSUE DATE: June 30, 2002

REVISION DATE: March 31, 2011

POLICY:

1) A conscientious effort is made to make the food, trays and service as attractive and palatable as possible. Food is prepared to conserve nutritive value, flavor and appearance.

2) Food is prepared as quickly as possible keeping to a minimum, two hours or less, the length of time they are held at room temperature, or held ready to serve at or above 145 degrees F, to prevent bacterial contamination.

3) Foods are to be handled in such a manner as to prevent cross contamination by bacteria, dirt or non-edible items (such as metal shavings or cleaning agents).

4) Standardized recipes are used for food preparation and contain therapeutic modification when applicable. All recipes are to be returned to their proper location in the recipe file located in White notebook after use by the employee.

5) Tongs or other utensils are used in handling food whenever possible. If it is necessary to use the hands, they are to be thoroughly washed and single service plastic gloves are to be worn and used only to touch food.

6) The Culinary Services Manager reviews utilization of leftovers and amounts of food production with the Food Service Technicians on duty.

7) Pre-cooked frozen foods may not be defrosted until ready to use. They many not be refrozen after they have been defrosted.

8) No foods are to be stored in their original cans but are to be placed in non-pervious, properly covered and date labeled containers

9) All foods will be covered with lids or appropriate wrap, and labeled and dated with use-by date.

10) All refrigerated leftovers are to be stored in plastic containers with lids, labeled with use-by date, and stored no longer than 5 days.

PROCEDURE:

A) The following tables are used to assist the employee in food preparation.
POLICIES AND PROCEDURES

1) Table of measurement equivalent and portion control.

2) Table of food equivalents.

3) Cooking charts.


C) Pasadena Villa prepares food for residents using the above policy. Lake Highland and Summerlin Ave staff assists residents in independent food preparation following this policy as a guideline, when needed.
POLICIES AND PROCEDURES

SUBJECT: STORAGE OF FOOD AND SUPPLIES

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

POLICY:

1) All goods are stored as quickly as possible after they are delivered.

2) Food and supplies are rotated so that older foods or supplies are used first, utilizing practice of First In, First Out

3) Cleaning agents will be stored separately from food, supplies or equipment.

PROCEDURE:

Store as follows:

1. Meat: Meats are kept in the freezer at -10 degrees to 0 degrees Fahrenheit. They are stored according to use. All meats are stored off the floor (12 inches) and wrapped properly to guard against freezer burn and consequent unusable meat. Thawed meat is stored near the bottom of the refrigerator at 32-45 degrees Fahrenheit

2. Groceries: All goods are stored in a temperate room (65 - 75 degrees Fahrenheit) at least 6 inches off the floor and 18 inches from the ceiling with proper ventilation in the room and around the food items. There are no exposed cracks or holes in the walls, ceilings or floor.

3. Dry Goods: Are placed in plastic containers after they have been opened. All containers are labeled, have tight fitting lids and are placed on easily moveable racks. These are checked periodically for weasels, ants, etc. All containers are washed before refilling. Scooping utensils are not kept within the containers but are washed daily and placed in plastic containers.

4. Canned Goods: Are stored in order with the purchase guides and each are labeled. Like items are stored together and labels turned outward. Shelves are cleaned often. Items are rotated to prevent spillage and cans are checked often for bulging in tops and leakage in seams and lid closures. All cans are labeled correctly from purveyor. Cans not labeled are returned for credit. Shelves are not overloaded and heavier items are placed at waist level.

5. Paper Goods and Lighter Items: Are stored on top shelves. Crackers and cookies should not be stored here as the temperature is warmer and these goods, after opening, tend to diminish in quality faster.

6. Frozen Foods: Should be kept at 0 degrees Fahrenheit or lower.
POLICIES AND PROCEDURES

7. **Produce**: Store unwashed produce near the bottom of refrigerator (32-45 degrees) and washed before use. Items stored in delivery boxes should be checked for possible contamination by insects. Cleaned produce may be stored higher in the refrigerator.

8. **Bakery goods**: are stored in a cool storeroom and used as quickly as possible. Do not over order. Storage should take place at room temperature (65 - 75 degrees Fahrenheit) with no more than three days' supply. Day-old bakery items purchased in quantity should be stored in the refrigerator or frozen, if necessary.

9. **Dairy items**: Should be refrigerated at 32-45 degrees Fahrenheit and rotated at each delivery. Ice cream should be kept at 0 degrees Fahrenheit.

10. **Coffee**: should be kept in a dry place at room temperature. If purchased in large quantity, it should be placed in the refrigerator. Only the amount needed should be ordered to ensure freshness and the quantity should be rotated often.

11. **Paper Goods and supplies**: are to be stored in the storeroom.

12. **Cleaning agents**: are to be stored in the janitor's closet.
POLICY: The Equine facility is for the use of equine therapy and recreational outings with current residents only. Access is limited to trained staff with an access code. Access is limited to specific hours of operation posted. Any resident, visitor or non-trained staff must be accompanied by the Administrator, Operations Manager or trained/designated staff to access the area.

PROCEDURE:

1. Residents must sign a waiver of liability before participating in Equine Assisted Therapy.
2. Residents must complete a safety lecture and tour with trained staff before participating in Equine Assisted Therapy
3. All staff, residents and visitors may only access the barn with appropriate attire: closed toe shoes, shirts and pants
4. All residents and visitors must adhere to posted Equine Facility Rules
5. Only staff may feed the horses
6. No food or drink is allowed at the Equine facility
7. There is no smoking allowed at the Equine facility
ANNUAL EVALUATION OF PROGRAM

PROGRAM: Hazardous Materials Management Program

DATE: March 31, 2011

Description of Current Program: The current program encompasses policies and procedures that describe the facility’s responsibility in managing hazardous materials. Given the scope of the services provided by Renaissance Healthcare Group, and the minimal and infrequent use of any hazardous materials, this program is very limited. Potential bio-hazardous wastes are handled in accordance with proper medical procedures utilizing the Universal Precautions methodology.

Current Program Monitoring Activity: Significant hazardous materials spills are reported immediately to the Risk Manager, and an Incident Report is completed and forwarded to the Risk manager. Reports related to the Hazardous Materials Management Program are provided to the Safety Committee.

Stericycle has a current contract to pick up hazardous material twice a year. They are available if additional needs are required. As part of their contract they have provided OSHA/blood borne pathogen training materials for all staff. Personal protective devices; gloves, mask, gowns are available to all staff.

GEM Supply Company and Sam’s supplies most cleaning materials and the corresponding MSDS information for each product. The MSD Sheets were organized and updated into an easily-accessible binder, which is kept at the nurses’ station.

During 2008, all employees were provided with a CD with relevant hazardous materials handling training material. All MSDS materials will be available to staff in the safety manual and updated semi-annually.

Evaluation of Effectiveness: There have been no hazardous materials spills over the last year that required special clean-up beyond the current capacity of each area.

Impact on Resident Care: The Hazardous Materials Management Program considers the impact of program implementation on in-house occupants at the time of drill activation. As such, the impact on patient care is minimized when possible.

Future Improvements Identified:
None
Performance Measure for 2011
During regular safety rounds, staff members will be asked to identify the correct method for cleaning up a spill.

Date of Next Evaluation: March 2012

Safety Committee Members Reviewing Program:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Managing Director: __________________________
PROGRAM: Infection Control Program

DATE: March 31, 2011

Description of Current Program: The current program encompasses policies and procedures that describe infectious diseases and outlines ways to prevent control and eliminate their spread through staff and residents. Educational activities for staff and residents are monitored through initial/annual employee general orientation.

Current Program Monitoring Activity: Information is collected through infection control reports and data presented to the Risk Management committee on a regular and consistent basis.

Evaluation of Effectiveness: Communication is adequate at this time.

Improvements Implemented: All staff and residents participate in TB test at the time of hire and admission respectively and annually.

Impact on Operations: We anticipate that there will be a positive impact on the staff’s ability to provide a healthy treatment environment.

Evaluation of Effectiveness: There were 2 reports of positive PPDs (2 residents). All had negative chest x-rays, and have no signs or symptoms of illness. This is Latent TB and is non-infectious. Latent TB is not a reportable infection. There were no cases of Active TB reported.

Impact on Patient Care: The Infection Control Program is a key component that ensures the safety and physical well-being of patients, as well as staff. Continued monitoring has insured a healthy environment.

Future Improvements Identified: Continued training and inservices will address Infection control, universal precautions and proper hand washing techniques for staff annually and residents semi-annually.

Performance Measure for 2011: During regular safety rounds, staff members will be asked to identify correct method of universal precautions. They will be able to fill out an Infection Control Report completely and correctly.
Date of Next Evaluation: March 2012
Safety Committee Members Reviewing Program:

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Managing Director:____________________________
ANNUAL EVALUATION OF PROGRAM

PROGRAM: Life Safety Management Program

DATE: March 31, 2011

Description of Current Program: The current program covers both the mechanical and educational aspects of the facility systems of maintaining acceptable levels of Life Safety compliance. As such, this program covers all individual systems of Life Safety equipment as well as their function in the aggregate. Key areas and systems covered by the Life Safety Management Program are: fire plan and fire safety, electrical and utility systems, appliance safety, and Department of Health compliance. Educational activities are monitored through annual requirements for remedial education as well as new employee initial orientation.

Current Program Monitoring Activity: Inspection and preventive maintenance data on all systems and components of the Life Safety Program are recorded and reported to the Safety Committee on a regular and consistent basis.

The fire sprinkler system will be inspected quarterly by VSC Fire & Security Inc. (agreement on file).
The fire alarm system will be inspected annually by High Security.
Fire extinguishers will be monitored annually by Hernando Fire & Safety Equipment.
The Ansul fire extinguishing hood shall be inspected semi-annually by Hernando Fire and Safety.
Hood shall be cleaned annually and certified.
Electrical appliances shall be monitored semi-annually by the Safety Officer.
The Department of Health shall perform regular Food Service and Residential Group Care inspections (reports of which are retained indefinitely in Administration).
The Orlando Fire Department shall perform annual Fire Inspections.
Vehicle maintenance log and refrigerator temperature log will be kept on file.

The facility installed hurricane shutters to cover all windows and doors in the facility. The installation was completed in 2005. Most of the shutters are manual accordion style, with five electronic remote controlled. Each hurricane shutter will be inspected and tested prior to each hurricane season by the Safety Officer.

The facility installed two generators in 2005 on opposing sides of the building. Each generator has a 100 gallon propane tank. Generators are automatically tested monthly for fifteen minutes to assess diagnostics and systems.

Evaluation of Effectiveness: The mechanical components of the Life Safety Program throughout the year have been relatively consistent in their function and reliability. Documentation is thorough in all areas of the Life Safety Program. The preventive
maintenance agreements on all necessary equipment are current with testing being done per schedule.

**Fire Sprinklers** – The facility has contracted with Davy Fire protection to perform quarterly inspections of the sprinkler system. The last inspection was completed on 3/10/2011

**Fire Alarm System** – The fire alarm system was inspected on 05/19/2011 by High Security, Inc.

**Fire Extinguishers** – The fire extinguishers were inspected by Hernando Fire and Saftey on 01/15/2011. The Ansul Hood was inspected by Hernando Fire and Safety Equipment on 01/15/2011.

**Electrical Appliances** – Pasadena Villa has a service agreement with Blair Heating and Air Conditioning to inspect the air conditioning system quarterly, and maintain as needed.

**Department of Health Inspections** – The Orange County Department of Health performed Food Service Inspections on 01/12/2011. All inspection comments being addressed and no deficiencies.

The Orange County Department of Health performed a Residential Group Care Inspection on 04/12/2011. All inspections resulted in no deficiencies.

**Fire Department Fire Inspection** – The City of Orlando Fire Department conducted their annual inspection on 04/23/2011 with comments being fixed.

**Impact on Operations:** The Life Safety Management Program is consistent with the mission of the facility and supports its continued operation through continuous monitoring and improvement functions.

The Life Safety Program appears to have been successful during the year, as internal operations are running smoothly, and no life safety elements have inhibited the day to day operations of the facility.

**Impact on Patient Care:** The Life Safety Management Program is the key component that ensures the safety and well being of patients, as well as staff. Constant monitoring of this function and receptiveness to changes and improvements has insured a safe environment.

The Life Safety Program appears to have been successful during the year, as no life safety elements have impeded the delivery of quality healthcare services. Moreover, the environment appears to be safe and free of hazards that could place residents, staff and visitors at risk.
Future Improvements Identified

1. The Safety Officer will enhance the new employee safety trainings, as well as the annual employee trainings. Also, the Safety Officer will utilize other facility employees in monitoring and data collection, and involve as many of the staff in safety-related activities as possible.

Performance Measures for 2011

The Safety Officer will utilize the master schedule grid to ensure timely monitoring of all life safety key functions. The Safety Officer will include as many direct care staff in program monitoring and improvement activities.

Date of Next Evaluation: March 2012

Safety Committee Members Reviewing Program:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Managing Director: __________________________
ANNUAL EVALUATION OF PROGRAM

PROGRAM: Security Management Program

DATE: March 31, 2011

Description of Current Program: The current program covers activities that provide security to residents, staff and visitors, consistent with the conditions and risks associated with the facility’s location, as well as functions in-house to ensure monitoring and improvement processes in the Security Management function. The program has been enhanced during the year to also focus on the security of protected health information (PHI), and HIPPA Compliance. Current activities include:

- In-house policies and procedures addressing patient confidentiality
- The security of medical records
- The security and identification of patients, visitors and staff

Property security, individual security, interior building security and fiscal security are provided by in-house personnel.

Current Program Monitoring Activity: Documented activities are reported to the Safety Committee at their regularly scheduled meetings.

Information related to physical security would routinely be communicated by the initiation of an Incident Report, which is forwarded to the Risk Manager. The Risk Manager, in turn, contacts and consults with the Safety Officer, as appropriate.

Other pertinent information related to security issues may be communicated to the Safety Officer through the weekly staff meeting, or through the staff communication book.

Evaluation of Effectiveness:

1. No significant new safety or security measures were required during this time period. Existing major safety items (emergency generators, hurricane shutters, sprinkler systems, weather alert systems, fire and evacuation protocols, computer security and power backup systems) have all been working within established parameters.

2. Several minor safety and security improvements were made including
   a. Ten additional security cameras were installed at outdoor locations to increase security in the parking lot and building perimeter (response to vehicle break-in and content theft in the parking lot).
   b. Automatic door closures were installed in the kitchen and employee entrance doors to ensure positive automatic locking.
   c. Additional security lights were installed on the patio and parking lot at the NW corner.
Impact on Patient Care: No security related issues have impacted negatively on resident care during the year.

Future Improvements Identified

1. Inservice training continue to be provided to all staff members as to the importance of their individual involvement in ensuring that security is maintained in the workplace.

Performance Measures

The Safety Committee will strive to include as many direct care staff as possible in security related discussions and activities, and educate all staff on the security management program.

Date of Next Evaluation: March 2012

Safety Committee Members Reviewing Program:

__________________________________________  ______________________________
__________________________________________  ______________________________
__________________________________________  ______________________________

Managing Director: _________________________
FIRE ALARM REPORT

Directions: Please complete this form by the end of your shift for any alarm. Fill out a separate form for each alarm and deliver to the Managing Director by the next business day morning.

Date:_________________________ Time of Signal_________________a.m./p.m.

Staff Present: ______________  ____________________  ____________________
_______________________  ____________________  ____________________

Complete only the section that applies to the signal by checking the correct answers and filling in the blanks.

Trouble Signal:
1. Signal related to phone lines/dialer Yes___ No___
   Signal related to fire alarm panel Yes___ No___
2. Monitoring Company was called Yes___ No___ Time:___a.m./p.m.
3. System was restored to operational status: Yes___ No___
   System was restored by: Plant Operation Staff ___ Monitoring Company___ Other Staff
   Member ___ Other___

ALARM SIGNAL

1. Alarm was activated in Zone _________ (Refer to panel, not keypad)
2. Device that activated alarm was: S#_____ P#:_____ H#:_____ Sprinklers
   (Refer to Fire/Safety Info Book for device map to determine location number)
3. Fire Department responded to alarm: Yes___ No___ Time:___a.m./p.m.
4. Monitoring Company was called: Yes___ No___ Time___a.m./p.m.
5. System was restored to operational status Yes___ No___ Time__a.m./p.m.
6. System was restored by: Plant Operations Staff ___ Monitoring Company___
   Other Staff Member ___ Fire Department___ Other___

IMPORTANT: If the monitoring company is called out to perform work on the device, it is a imperative that the Service Tech mark on his work order, the device number and the building number.

Describe why signal occurred:_____________________________________________________
______________________________________________________________________________

Completed by:___________________________

Date___________   Time__________a.m./p.m.
Fire Drill Report

Date: ____________________________

Time/Shift: ____________________________

Number of staff evacuated during the drill:

Number of residents evacuated during the drill:

Number of visitors evacuated during the drill:

Time to Safe Meeting Point:

Findings and Comments:

________________________________________________________________________

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_____________________________  ________________________________
Safety Officer                  Managing Director
Renaissance Healthcare Group, LLC

SAFETY PLAN
2010

Overview

In order to preserve and protect the safety of residents, staff, visitors, equipment and facilities, Renaissance Healthcare Group, LLC shall implement a comprehensive Safety Plan.

Safety Officer/Committee

The Managing Director shall appoint, on an annual basis, a Safety Officer, who shall be the Chairperson of the Safety Committee, and who is responsible for the coordination and implementation of the Safety Plan and related polices and procedures.

The Safety Committee shall consist of the Safety Officer, the Managing Director, the Clinical Director, a nurse, a therapist, a care manager and housekeeping. The Committee shall meet quarterly, and provide quarterly reports to the CQI Committee. The Safety Committee reports will subsequently be presented to the Management Team meeting, and then to the Governing Board.

The Safety Officer may take any necessary action to ensure safety when conditions exist that pose an immediate threat to life or health, or pose a threat to equipment or facilities.

Safety Education

The Safety Officer is responsible for new employee safety orientation, as well as continuing trainings and in-services for existing staff. Continuing trainings and in-services will be performed on an annual basis. All new and existing employee safety education shall be documented by the Safety Officer and kept on file.

Reporting

The Safety Committee shall report quarterly, and the Safety Officer shall produce an Annual Safety Plan Report and Evaluation.

The Safety Officer shall also produce, on an annual basis, annual evaluations for the five key functions within the Safety Plan, i.e., 1) Emergency Preparedness/ Disaster Plan 2) Life Safety Management 3) Hazardous Materials Management 4) Security Management 5) Infection Control.
Key Functions

Within the Safety Plan are five key functions that require specific policies, procedures, attention, monitoring, and reporting. These key functions are:

- Emergency Preparedness/Disaster Plan
  Policy: EC-08
- Life Safety Management
  Policies: EC-01, EC-02, EC-03, EC-04, EC-10, EC-09
- Hazardous Materials Management
  Policies: EC-06, EC-09
- Security Management
  Policies: LD-01, IM-01 through IM-10
- Infection Control
  Policies: TX-06, IC-01 through IC-07

Coordination with Risk Management

The Managing Director, on an annual basis, shall appoint a Risk Manager, who will implement the Risk Management Program, including collecting and analyzing Quality Review Reports, and producing quarterly Risk Management Reports. These quarterly reports will be made to the CQI Committee, and will subsequently be reported to the Management Team and Governing Board.

The Risk Manager and the Safety Officer will respond in tandem, from their respective disciplines, on safety related issues. Working together they can initiate any incident reports needed as well any actions required to resolve the issue.

Data Collection and Monitoring

The Safety Officer has many venues at his/her disposal to receive information and data about safety issues. The most common method is the reporting of safety related issues on the Quality Review Report, which is forwarded to the Risk Manager. When the Risk Manager identifies a safety related issue, the Safety Officer is contacted for consultation and coordination.

Staff may also bring concerns, ideas or suggestions to the direct attention of the Safety Officer, without an incident report being initiated. The communication may be informal, may come through the weekly staff meeting, or may be a formal letter of suggestion.
Lastly, the Safety Officer, through ongoing monitoring and evaluation, will identify areas of concern and opportunities for improvement.

Summary

It is expected that the Annual Safety Plan Report and Evaluation, including the five key function annual evaluations, will, in the long term, present a proactive approach to identifying potential safety issues, resolving safety issues, and preventing future occurrences of safety issues.
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POLICY: It is the policy of RHG to maintain a current chart of accounts that provides for identifying specific revenues and expenses separately. The chart of accounts is defined by guidelines developed by the Managing Director and the company’s authorized tax professional, Celita Davis, CFP, EA, Financial Directions.

PURPOSE:

To provide guidance to all for (1) coding of assets, liabilities, revenue and expenses and (2) preparing annual line item budgets and (3) to provide clarification on the utilization of each component of the chart of accounts.

PROCEDURE:

1. The Managing Director, or designee, develops and maintains the chart of accounts, adding or inactivating accounts as necessary in QuickBooks Online Edition.

2. The Managing Director, or designee, is responsible for ensuring the new accounts are included in the appropriate financial statement formats.

3. All revenues and expenses are entered by the appropriate Program Class.

4. If there are questions regarding creating a new account or editing any current accounts in the chart of accounts, The Managing Director, or designee, shall contact Financial Directions, and the company approved Enrolled Agent tax professional, for guidance.
POLICY: It is the policy of RHG to maintain appropriate levels of insurance coverage and to include an annual review of insurance coverage prior to policies being renewed. Required insurance coverage includes, but is not limited to:

Property—to include all owned and leased buildings and contents, vehicles, computers and all other owned and leased properties. This coverage also includes business interruption insurance for all locations in which the company does business.

Directors/Officers—limits and coverage to be reviewed and approved by the Managing Director on an annual basis.

General and Professional Liability Coverage—to be appropriate based on the level and type of activities being provided by the agency.

Worker’s Compensation—coverage for employees injured in the course of their employment.

Terrorism—coverage for loss of property or business due to acts of terrorism.

PURPOSE:
To provide assurance that the company has adequate financial protection against possible loss.

PROCEDURE:

1. The Managing Director is charged with the responsibility of ensuring that all company insurance coverage is maintained at adequate levels.

2. The bookkeeping designee copies invoices for any capitalized purchases, lease contracts or any other items that the insurance company needs to be notified of in order to keep the coverage current and forwards to the Managing Director.

3. The Managing Director notifies the insurance company of any additions and deletions within fifteen days when the change involves equipment with an cost in excess of $5,000 and within forty-eight hours when adding/deleting facilities, both owned and rented.

4. Three months prior to the beginning of the policy year, the Managing Director meets with the insurance agent to review all insurance coverage.

5. The Managing Director is charged with the responsibility of insurance renewals.
POLICY: It is the policy of RHG that all accounting records are stored in a locked area. Records will be retained in accordance with contract requirements, and applicable local, state, and federal laws.

PURPOSE:

To provide specified instructions to staff for the storage and retention/disposal of accounting records and to ensure that accounting records are maintained according to contractual and legal obligations.

PROCEDURE:

1. All accounting, financial and payroll records are to be kept in a locked area.

2. Computerized accounting data is backed up daily and stored in a locked area.

3. Current bank statements, investment statements, contracts and other critical documents are kept in a locked area on site.

4. Immediate prior-year records are boxed, labeled and then stored in a locked area with limited access.

5. All accounting and payroll records older than the previous fiscal year may be maintained in a designated storage area on or off property.

6. All accounting, fiscal, contract and payroll records will be kept for a minimum of seven years.

7. After seven years, records may be destroyed at the direction and in a manner approved by the Managing Director.
POLICY: All leases, regardless of term or total cost shall be signed by either the President or Vice President/Managing Director of the company.

PURPOSE:

To ensure that no staff member can encumber the organization for a significant amount of money over and extended period of time without (1) knowledge of the organization’s ability to assume the lease, and (2) review and approval by the President and/or Vice President/Managing Director.

PROCEDURE:

1. The President or Vice President/Managing Director negotiates, reviews and ensures there is adequate funding in the budget for all leases.

2. Original leases and contracts are maintained in the bookkeeping office.

3. The Managing Director may authorize company credit card accounts based on organizational need. The bookkeeper or designee is responsible for setting up accounts and maintaining credit cards in a secure location.
POLICY: It is the policy of RHG to capitalize all acquisitions of long lasting, substantial property and equipment with a cost in excess of $1000, to depreciate those items over their useful life. RHG will maintain a detailed schedule of fixed assets, including date of acquisition, cost and location. The company will complete a physical inventory of all fixed asset items on an annual basis. Disposal of fixed assets requires the approval of the Managing Director.

PURPOSE:

To provide a method of tracking fixed assets to reduce the likelihood of theft and loss, and to ensure the accuracy of bookkeeping and financial records.

PROCEDURE:

1. The bookkeeper, or designee, is responsible for the upkeep of the fixed asset inventory schedule.

2. The bookkeeper, or designee, will enter purchase of fixed assets into QuickBooks Online Edition.

3. The bookkeeper, or designee, is responsible for recording all disposals of fixed assets and for making sure that depreciation is calculated appropriately.

4. Prior to the end of the fiscal year, the bookkeeper, or designee, prepares an “inventory detail” for the Managing Director.

5. Prior to disposal of any asset, the bookkeeper, or designee, will obtain the Managing Director’s approval.
POLICY: It is the policy of RHG to reconcile all bank statements within to (10) working days of receipt and to perform the bank reconciliation function.

PURPOSE:

To assure bank reconciliations are completed prior to financial statements being issued and to allow for timely corrections of any bank errors.

PROCEDURE:

1. The Managing Director reviews and gives the opened bank statements to the bookkeeper, or designee.

2. The bookkeeper, or designee, reviews the statements and puts each set of checks in numerical order.

3. The bookkeeper, or designee, uses QuickBooks Online Edition to clear deposits, checks and other bank activity and to reconcile each cash account.

4. Checks outstanding for more than 90 days should be investigated. When appropriate, payment is stopped, the original check voided, and if appropriate, the check is reissued.

5. Once the statements are reconciled, the bank reconciliation reports and bank statements are given to the Managing Director for review and approval.

6. The bookkeeper files the approved bank reconciliation reports and bank statement in the individual bank account folders.
POLICY: It is the policy of RHG to reconcile balance sheet accounts on a quarterly basis and to compare general ledger control totals with detail sub-ledgers for accounts receivable and accounts payable.

PURPOSE:
To ensure the balance sheet is accurate when presented on a monthly basis.

PROCEDURE:
1. The bookkeeper, or designee, prepares aged accounts payable detail report that reconciles to the balance sheet in the account payable ledger.

2. The Managing Director reviews the fixed asset detail schedule and verifies that the asset cost and accumulated depreciation totals agree to the general ledger balances in the accounts.

3. The bookkeeper, or designee, makes all monthly journal entries necessary to expense prepaid assets. Once these entries are make, the general ledger balances in each prepaid asset account is reconciled to the balance of the prepaid asset schedules.
POLICY: It is the policy of RHG that no member of the Executive Team or member of his/her family shall directly or indirectly financially benefit from their association with Renaissance Health care Group without full disclosure and that all transactions be true arms length transactions.

It is the policy of RHG that no staff member or member of his/her family shall directly or indirectly financially benefit from their association with the company. Any questions regarding staff conflict of interest should be directed to the Managing Director.

PURPOSE:

To provide guidance regarding conflict of interest for the Executive Team and staff.

PROCEDURE:

1. Financial transactions of the company which involve the Executive Team shall be subject to the same policies and procedures as all other such transactions.

2. Real estate transactions must be at market-apprised value of less when a company member, Director or Officer benefits from, or directly participates in the transaction.

3. The procedure for declaring and ruling on possible conflict of interest will be as follows:
   - A company Member, Director or Officer suspecting a possible conflict of interest shall declare same to the President/Managing Director.
   - The President/Managing Director, shall rule as to whether or not there is a conflict of interest.
   - The Member, Director, Officer or staff in conflict may participate in the discussion of the matter prior to the determination.
   - In the event it is determined that a conflict exists, the Member, Director, Officer or staff determined to have a conflict shall not have a vote as to the resolution of the conflict.
   - Any issue on which a determination of a conflict of interest has been made shall require a majority of the vote of the Members eligible, and shall be duly reported.
POLICY: It is the policy of RHG that all checks written against company funds be signed by and authorized signer.

PURPOSE:

To ensure that all checks written against company funds are approved by an authorized company representative and signed by an authorized company representative.

PROCEDURE:

1. The bookkeeper, or designee, shall process all checks in accordance with the accounts payable policy.

2. The bookkeeper, or designee, shall provide to the VP/Managing Director all checks, with supporting documentation, invoices and bills attached each check.

3. The VP/Managing Director shall sign the checks, and route them back to the bookkeeper, or designee, for distribution and mailing.

4. In the event that the VP/Managing Director is not available for signing, the President of the company shall sing the checks.

5. In the event that neither the President, nor the VP/Managing Director are available to sing the checks, the Managing Director may authorize the bookkeeper, or designee, to use the approved signature stamp in order to process the checks. The signature stamp shall be used infrequently and only in extenuating circumstances.
POLICY: It is the policy of RHG to: (1) pay all vendors in a timely manner, not to exceed the vendors due date; (2) require appropriate documentation for all distributions; (3) require documentation of receipt of goods prior to payment; (4) require that all disbursement (except petty cash) be made by check; and (5) properly record all disbursements in QuickBooks Online Edition.

PROCEDURE:

1. All mail that comes into RHG is opened upon receipt by the Administrative Assistant, and disbursed as needed.

2. All invoices, bills and statements should be forwarded to the bookkeeper, or designee.

3. For vendors who provide monthly statements, individual invoices should be reconciled with the monthly statements.

4. All other requests for disbursements are routed to the bookkeeper, or designee, after approval is obtained and necessary receipts attached.

5. The bookkeeper, shall obtain approval from the Managing Director before paying any suspicious, unfamiliar or first time invoice or bill.

6. The bookkeeper, or designee, enters the checks into QuickBooks Online Edition, prints off the checks, and attaches the checks and all supporting documentation.

7. All checks and supporting documentation are given to the Managing Director for signature, and then returned to the bookkeeper, who mails out payments immediately.
POLICY:

It is the policy of RHG to allow the use of petty cash for expenditures for supplies or payments less than $200 and to restrict access to the petty cash fund to the designated parties, which include the Managing Director, Office Manager, Administrative Assistant, and Accounting Clerk, or designee. Petty cash funds will be established, eliminated or increased based on program needs at the discretion of the Managing Director.

PURPOSE:

To provide for the control and management of petty cash accounts as deemed appropriate by the Managing Director.

PROCEDURE:

1. Petty cash is for purchases of items of an emergency or urgent nature that cannot wait to be processed through the normal purchasing system.

2. All purchases or reimbursements over $200 should be processed via the normal check process.

3. The Accounting Clerk is assigned complete responsibility for the petty cash fund.

4. Petty cash is obtained via counter checks processed at a branch of Regions Bank.

5. Petty cash requests must be approved prior to the distribution of petty cash funds in exchange for a receipt.

6. In the event that the petty cash request is for a purchase of an unknown amount, the employee must return the receipt and any change back to the Accounting Clerk. The Accounting Clerk will reconcile the total of the receipt amount and the funds returned with the original funds disbursed.

7. Petty cash funds shall never be co-mingled with personal funds under any circumstances. Under no circumstance should any staff borrow from petty cash for any reason. Violation of these rules or abuse of petty cash for unauthorized use may result in immediate termination.

8. The petty cash account will be reconciled and replenished on an as-needed basis, at least monthly, by the Accounting Clerk, who provides a monthly report to the Managing Director at the end of each month. The Managing Director, or designee, makes the appropriate entries into QuickBooks Online Edition to account for petty cash.

9. Cashing checks from petty cash is strictly prohibited.
POLICY: It is the policy of RHG to keep a current fee schedule and to provide the current fee schedule upon request by client, family or referent. The company may also post the current fee schedule on the website. It is also the policy of RHG to charge prices in line with the current fee schedule, and to provide a mechanism for administrative discounts and/or scholarships, as appropriate.

PURPOSE:
To provide a current fee schedule at all times and mechanisms to vary from the fee schedule, as approved and appropriate.

PROCEDURE:

1. The governing body approves the rate schedule and communicates this to the Managing Director. The governing body shall approve rate schedules at least annually.

2. The Managing Director is responsible for communicating to the Admissions Coordinator, Administrative Assistant, business office personnel, Program Managers, and other key staff any changes in the fee schedule.

3. Responsible staff then update the Fee Schedule Policy in the Policy Manual, as well as the website, financial agreements and any other relevant documents.

4. Billing staff invoices clients each based on the current fee schedule and admission.

5. Rates will not be changed during treatment, with a length of stay less than two years, if the rates change during treatment.

6. For lengths of stay over two years, Administration may apply the newest rates to the account.

7. The client or financial sponsor must pay one month in advance for residential treatment and three months in advance for TLLC.

8. The company will not provide any refunds of prepaid amounts in the event of a discharge against medical advice (AMA), or other discharge that is not known by and approved by the treatment team.

9. For regular and treatment team approved discharges, a refund of the prorated, unused balance of any prepaid amount will be refunded.

10. If a client or family requests a discount to the current fees, such request must be forwarded to the
MANAGING DIRECTOR. No rate discounts are given for new admissions.

11. For active clients of the program, who are motivated and compliant with treatment, the Managing Director may approve rate discounts when a family demonstrates financial need.

12. If a client is non-compliant and utilizing a high level of staff and program resources, the Managing Director shall not approve a discount of fees, even if the family demonstrates financial need.

13. Rate changes due to level of service changes or transfers between our programs must be accompanied by a Rate Change Form, duly signed by the client or financial sponsor and witnessed by staff. This will ensure that the client or financial sponsor has guaranteed payment for the current level of service, whether more or less costly than the initial level of service.
POLICY: It is the policy of RGH to bill clients according to established policies and to manage accounts receivable to minimize delinquent accounts.

PURPOSE:
To provide clear policies for billing and collection of payments due.

PROCEDURE:

1. At the time of admission or enrollment, client and/or financial sponsor MUST sign wither a Financial Responsibility Contract, for residential treatment, or an Enrollment Agreement, for TLLC.

2. The financial and enrollment agreements shall specifically and clearly state the rate that will be charged for services, and the frequency of billing. The agreements shall also clearly stipulate any late fees that may apply, as well as the refund policy.

3. The financial and enrollment agreements are legal guarantees of payment.

4. Upon admission or enrollment, the Admissions Coordinator shall communicate to the Client Services Representative, or designee, the rates for the new clients. It is the responsibility of the Client Services Representative to obtain the first payment for admission or enrollment.

5. The Client Services Representative or billing clerk, or designee, shall send out invoices to all clients between the 15th and 17th of each month, with a due date of the 27th of that month, for services of the following month. The invoices shall be processed through QuickBooks Online Edition. All payments shall be prepaid in full, in advance, each month.

6. As payments are received, the billing clerk, or designee, shall make appropriate deposits, process appropriate credit card payments, and enter all payments into QuickBooks Online Edition.

7. At the end of each month, the billing clerk and Managing Director shall review the Accounts Receivable Report, and determine which accounts require reminder follow up calls and/or emails. The billing clerk, or designee, shall make the appropriate follow up phone calls or emails in order to collect the past due payments.

8. Late fees shall be levied on any account not paid in full by the 5th of the month of service.

9. The company has contracted with an outside billing company, MedPro Billing, to facilitate all claims, billing, utilization review, appeals and collection for clients wishing to attempt to utilize insurance benefits to
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help pay for treatment. All clients wishing to use their insurance benefits must complete ALL required forms and paperwork from MedPro, allowing MedPro to bill on their behalf and allowing the company to receive any insurance payments under an assignment of benefits.

10. Even if insurance benefits are being utilized, the company still requires the financial guarantor to pay for treatment in advance. Any overpayments will be refunded to the financial guarantor.

11. Payment options are as follows:

Program Costs

The Pasadena Villa Network of Services programs offer a comprehensive continuum of residential treatment, day treatment, transitional living and life skills/social mentoring services. The clinical needs of our clients and the length of stay will affect total treatment costs. Length of stay is a highly individualized issue and is dictated by progress toward mutually agreed upon treatment and independent living skills goals and objectives.

The program costs are daily per diem rates, except for the TLLC (Transitional Living & Learning Center, which has monthly rates). The clinical program daily rates include:

- Room and Board
- Diagnostic assessment and treatment planning
- Social Integration Model program groups and activities
- Individual, group and family psychotherapies
- Specialty clinical groups
- Psycho-educational groups, life skills training, independent living skills training, and social mentoring
- Cognitive-behavioral therapy (CBT) and dialectical behavioral therapy (DBT)
- Medication management
- Recreational therapy, art therapy, equine therapy (in TN) and expressive arts therapies
- Meetings with the interdisciplinary team
- Case management and discharge planning
- Addictions Assessment, groups and Relapse Prevention Planning
- One year of free aftercare through OASIS: Outreach and Social Integration Service
- Academic assistance, tutoring, IEP coordination and college preparation

Arrangement for Payment of Services

Our Client Services Representative will assist you before admission to:

- Verify insurance benefits, if applicable
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- Coordinate with you and our Utilization Review Specialist to obtain the necessary forms, documents and information needed to bill your insurance, if applicable
- Collaborate with you to set up a financial plan for payment of services.
- Complete and sign all required financial agreements.

Although we do accept insurance, most insurance companies will not cover treatment in our programs. But, we will work with your insurance company on your behalf to seek insurance payment for services.

We accept Visa, Mastercard and American Express, as well as personal checks, wire transfers and ACH payments for services.

Insurance Information

Our programs are primarily private pay, and the vast majority of our clients pay privately for care. But, we understand that some clients desire to attempt to access insurance funds. In an effort to provide exemplary customer service to our clients and families, we have put systems in place to assist with the process of seeking insurance reimbursement.

We are not contracted with any insurance companies or managed care organizations, and services rendered are done so out-of-network.

Given the restrictions, limitations and biases toward mental health treatment, it is highly probable that your insurance plan will not cover any of the costs associated with treatment in our programs. Please be aware that even if you have mental health benefits, there are no guarantees that your insurance will pay for treatment in our programs.

Insurance companies determine eligibility for mental health treatment based on their own criteria for medical necessity. It is imperative that the client, family and/or guarantor, as well as the Pasadena Villa Admissions and Client Services staff, are aware of the criteria applied by your insurance plan. It is extremely important to make yourself aware of the benefit limitations, clinical criteria, and any other requirements that your insurance company may have.

We strongly encourage all clients, families and/or guarantors to directly contact their insurance companies to learn about specific benefit coverage, limitations, and criteria for medical necessity prior to admission.

Our contract is with you and/or the guarantor, and not with your insurance company. As such, the financial guarantor is responsible for all costs of treatment not covered by insurance. All out of pocket and private pay expenses are limited to the approved Self Pay Scholarship Rates.
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Due to the high likelihood that there will be no insurance payments made for our services, it is our policy not to accept full assignment of benefit from any insurance company and a one-month deposit will be required from the financial guarantor.

Even if your insurance company agrees to pay for our services, our experience is that the authorization and claims reimbursement process tends to be a lengthy and often frustrating ordeal. We are happy to do everything we can possibly do to access appropriate insurance funds, but we cannot accept full assignment of benefit, and cannot provide treatment based solely on the hopes that your insurance will pay.

Please note that no insurance company dictates the length of treatment with us, nor do they dictate the course of treatment. The insurance company decides what, if anything, they will pay for, and they decide when to stop paying, if they ever start. But, the decision to stop paying for treatment by any insurance company does not affect our treatment plan, discharge plan, or the manner in which we treat our clients. Families utilizing insurance benefits must be prepared for the insurance to stop paying at any time. We ask that families be emotionally and financially prepared to continue treatment even if insurance denies payment or stops paying for any reason.

Payment Options

We offer two payment options. The first is a **Private Pay Plan** with the following highlights:

- Our charged rate is reduced by an administratively approved Self Pay Scholarship (this applies automatically whenever insurance benefits will not be utilized).
- Full payment of one-month is required at or before admission
- Monthly payments are required during the course of treatment
- The private pay rate is further reduced by an administratively approved adjustment if the guarantor agrees to pay for treatment automatically using either ACH or a credit card on file.

The second option is a hybrid **Insurance/Private Pay Plan** with the following highlights:

- Payment of one month of the Self Pay Scholarship Rate is required at or before admission
- We will coordinate verification of insurance benefits
- If there appears to be benefits that could cover our services, our Utilization Review Specialist will take the case and coordinate between us, our external billing company, and your insurance company, to seek the needed authorization and bill for services
- Our Utilization Review Specialist will coordinate concurrent reviews, doctor to doctor reviews, as well as appeals, when necessary, to attempt to receive payment from the insurance company
- The guarantor must make subsequent payments, for the client to be able to continue in treatment while we are billing for services.
- The insurance company will be charged our full charges
• The guarantor’s total potential self pay or out of pocket exposure is limited to our Self Pay Scholarship Rate, which is the same rate our private pay clients pay.

• In the event we receive payment from an insurance company for days already paid for by the guarantor, we will refund the guarantor if the total paid between the two payers is more than our full charges. If the total paid by the two payers is less than our full charges, there will be no refund.

• Please note that in the event the insurance company denies payment for any reason, or when insurance coverage stops for any reason, the account will be automatically approved for a self-pay scholarship, and the financial guarantor shall be responsible solely for our Self Pay Scholarship Rate, not our full charges.

Rate Structure

The approved daily Self Pay Scholarship Rates are:

Residential Treatment
- Pasadena Villa private room: 550
- Pasadena Villa semi private: 500
- Smoky Mountain Lodge private room: 550

Community Residential Homes: 440

Day Treatment: 375

Transitional Living & Learning Center: $7000/month

Auto-Pay Discounts: We are pleased to offer a financial incentive for families who chose to pay for the costs of treatment on an Auto-Pay option. Acceptable Auto-Pay options include: ACH (automatic clearing house) payments, automatic credit card payments, automatic wire transfer payments.

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<tr>
<td>Smoky Mountain Lodge private room</td>
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<td>Community Residential Homes</td>
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<td>Day Treatment</td>
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<td>Transitional Living &amp; Learning Center</td>
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For further information about our policies and rates related to utilizing insurance benefits, please contact our Client Services Representative for more details.

Financial Assistance

We understand that quality care can be expensive, and one option to assist you in obtaining the highest quality services available may be financing. We offer two financing options.

Clark Behavioral Health Financing offers multiple loan products with convenient qualification. Loans may be approved for all, or a portion, of treatment costs.
POLICY: It is the policy of RGH to establish clear procedures for client refunds and for communicating these policies to customers.

PURPOSE:

To provide procedures for client refunds.

PROCEDURE:

1. RHG is a private pay company, and does not contract with any insurance company, managed care company or other third party payor.

2. The Managing Director may make exceptions to this policy and may contract with a third party payor which is willing to meet the payment expectations of the organization.

3. Payments are made by clients monthly, in advance of services being rendered.

4. All refunds must be approved by the Managing Director before being paid.

5. Refunds are only approved for client discharges when the discharge was planned, in conjunction with the treatment team, and the treatment team knew the date of the planned discharge.

6. Refunds may also be approved for clients when it is mutually agreed that the client is not a good fit, and would be better served in another treatment facility. In such a circumstance, the client shall be discharged directly to the other treatment program, and not to home.

7. The company shall not refund any prepaid amounts for clients who discharge against medical advice (AMA), who leave the program without advance notice and without the involvement of the treatment team, or who leave the program due to non-compliance.

8. The program may discharge any client from services who is non-compliant and who is a detriment to the safety or care of the other clients. In such instances, the company shall not refund any prepaid amounts.
POLICY: It is the policy of RGH to require monthly presentation of a complete set of Financial Statements (income statement/P&L) and statement of financial position (balance sheet) in adherence with generally accepted accounting principles. The income statement will reflect a comparison of prior year to actual revenues and expenses for the current period and the year to date.

PROCEDURE:

1. The bookkeeper, or designee, must ensure that all revenues and expenses are entered on a timely basis during the month.

2. The Managing Director, or designee, ensures that a complete set of Financial Statements and statement of financial position is prepared each month.

3. The income statement must compare monthly and year to date to prior year, and also to budget. The Managing Director may provide explanations for significant variances.

4. The Managing Director shall distribute the financial statements by the 15th of each month, for the previous month to the applicable parties.
POLICY: It is the policy of RGH to provide specific and detailed guidance in order for journal entries to be made to QuickBooks Online Edition to account for all non-check activity and electronic and automatic payments and deposits.

PURPOSE: To provide a system that ensures that all non-check, electronic and automatic payments and activities are accurately and timely recorded into QuickBooks Online Edition.

PROCEDURE:

1. Every Monday, the bookkeeper, or designee, shall print off the online statements of the checking accounts for both, Renaissance Healthcare Group, LLC and Colonialtown Properties, LLC.

2. The bookkeeper, or designee, shall note all non-check activity, and if there are any questions as to the transactions or relevant accounts, the VP/Managing Director shall be consulted.

3. The bookkeeper, or designee, shall make appropriate journal entries into the QuickBooks Online Edition to reflect all relevant account activity.

4. At the end of the month, a final statement shall be printed off, and all month end journal entries shall be made.
POLICY:
It is the policy of RHG to deposit monies received on behalf of clients for discretionary spending into a Regions or TN bank account and allow access to the client or designee of the Administrative Office through the use of purchasing cards or cash. It is the policy and responsibility of RHG to insure the safety of all funds belonging to it residents. Access to these funds is limited to clients who have funds on deposit and by the designee from the Administrative Office or through individual purchasing cards authorized by the designee for individual clients. Authorized access limits will be established for each client based on a reconciliation of funds deposited and funds expended weekly by the Accounting Clerk.

PURPOSE:
To provide for the control and management of client discretionary funds accounts as deemed appropriate by the Managing Director.

PROCEDURE:
1. The client funds are for providing discretionary spending funds for the programs’ clients.

2. All purchases are monitored weekly to ensure clients do not exceed spending limits imposed by amounts of deposit and therapeutic guidelines.

3. It is recommended that no resident shall have in his/her possession more than $50 in cash. Residents are allowed to keep more than this amount in his/her own room’s safe, if so desired.

4. Should a resident receive funds totaling more than the above amount, the funds are to be kept locked in the nurse’s station for safe-keeping.

5. A client holding account will be established, which will provide the resident’s name, amounts of deposit, and check number and amounts of withdrawal in the electronic record.

6. Should a resident wish to have funds from the holding account, cash in the amount desired shall be withdrawn from the account, and the transaction shall be noted in the electronic record by staff.

7. Upon receipt of the requested monies it is the responsibility of the direct care staff to insure the monies are used appropriately and not kept on hand by the resident.

8. The Client Services Coordinator is assigned responsibility for depositing monies into the client funds account.

9. The Accounting Clerk has sole responsibility for reconciling deposits and withdrawals and providing
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these amounts to the Client Services Coordinator.

10. Client funds shall never be co-mingled with personal funds under any circumstances. Under no circumstance should any staff borrow from the client or client funds for any reason. Violation of these rules or abuse of client funds for unauthorized use may result in immediate termination.

11. The client fund account(s) will be reconciled on a weekly basis by the Accounting Clerk, who provides a monthly report to the Client Services Coordinator for the client’s financial file and to the Therapist of the client for treatment planning purposes.

12. RHG will not take funds or property of the client for the facility’s own use or gain.

13. RHG will not mix its funds with those of the client.

14. RHG will provide an annual reporting to the client or the client’s parent or guardian of the client’s funds that are being held and disbursed by the facility.
POLICY: It is the policy of RHG to designate the use of funds for client weekend activities in a Regions bank account and allow access through the use of debit cards. Access to these funds is obtained by authorized users through the use of Activities Funds Debit Cards. Authorized users retain receipts from expenditures for reconciliation and replenishment weekly by the Accounting Clerk. Activities funds will be established, eliminated or increased based on program needs at the discretion of the Managing Director.

PURPOSE:

To provide for the control and management of activities funds accounts as deemed appropriate by the Managing Director.

PROCEDURE:

1. The activities fund is for providing funds for the programs’ weekend activities.

2. All purchases or group activities over the normal weekly allotment should be requested in advance for approval.

3. The Accounting Clerk is assigned complete responsibility for reconciling and replenishing the activities funds.

4. Activities accounts are replenished via transfer of funds from the Regions Main bank account.

5. Activities account funds shall never be co-mingled with personal funds under any circumstances. Under no circumstance should any staff borrow from activities account funds for any reason. Violation of these rules or abuse of activities accounts funds for unauthorized use may result in immediate termination.

6. The activities fund account(s) will be reconciled and replenished on a weekly basis by the Accounting Clerk, who provides a monthly report to the Managing Director at the end of each month. The Managing Director, or designee, makes the appropriate entries into QuickBooks Online Edition to account for client activities.
Policy and Procedure Manual

Human Resources
(HR)

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Orientation and Staff Development Plan
Organizational Charts
POLICY: It is the policy of RHG to employ individuals voluntarily and at-will. The employment relationship is not guaranteed for any length of time and both parties are free to end it at any time, for any reason, with our without cause or advanced notice.

Renaissance Healthcare Group is an equal opportunity employer and does not discriminate against any person because of race, color, creed, religion, sex national origin, disability, age, genetic information or any to her characteristic protected by law. The nondiscrimination policy extends to all terms, conditions and privileges of employment as well as the use of all company facilities, participation in all company-sponsored activities, and all employment actions such as promotions, compensations, benefits and termination of employment.

RHG is committed to complying fully with the Americans with Disabilities Act (ADA) and applicable state law, and to ensure equal opportunity in employment for qualified persons with disabilities. All employment practices and activities are conducted on a non-discriminatory basis.

Renaissance Healthcare Group is committed to employing only United States citizens and aliens who are authorized to work in the United States.

PROCEDURE:

1. Employees are given a copy of employee handbook and review company policies and procedures. These are not intended to create a contract, nor are they to be construed to constitute contractual obligations of any kind or contract of employment between RHG and any of its employees.

2. If your position requires additional pre-employment criteria, such as a driver’s examination, license verification, a background investigation and/or a pre-employment drug test and if you have been offered employment before any such investigation or test is completed, your employment is contingent upon a satisfactory result on all required tests.

3. Employment will only be considered for candidates with clear background screens for the last five (5) years. Those who have charges prior to five (5) years may be considered by employment at the discretion of the hiring manager and/or Human Resource department.

4. Any employees with questions or concerns about any type of discrimination in the workplace are encouraged to bring these issues to the attention of the immediate supervisor. Employees can raise concerns and make reports without fear of reprisal. Anyone found to be engaging in any type of unlawful discrimination will be subject to disciplinary action, up to and including termination of employment.
5. In compliance with the Immigration Reform and Control Act of 1986, each new employee, as a condition of employment, must complete the Employment Eligibility Verification Form I-9 and present documentation establishing identity and employment eligibility. Former employees who are rehired may also be required to complete the form. Employees can raise concerns about immigration law compliance without fear of reprisal.

6. Hiring procedures are designed to provide persons with disabilities meaningful employment opportunities. Pre-employment inquiries are made only regarding an applicant's ability to perform the duties of the position. Reasonable accommodations for qualified individuals with known disabilities will be made unless to do so would be an undue hardship. All employment decisions are based on the merits of the situation in accordance with defined criteria, not the disability of the individual.

7. Contract personnel will meet the same pre-employment and general orientation requirements as hired employees. The Human Resource office will maintain a contract personnel file that is consistent with the requirements of hired employees. The signed contract will be placed in the file and reviewed annually and/or upon renewal.
POLICY:

It is the policy of RHG to employ individuals who are capable of performing assigned tasks, are free of communicable and infectious disease, and who are drug free.

To determine emotional health, pre-employment interviews and employment reference checks will be conducted prior to any applicant being considered for employment. Employment is conditional on being able to perform job duties.

PROCEDURE:

All employees or potential employees will be directed to contact the designate pre-employment screening site where employee physicals will take place. Employees are screened for TB, Substance Abuse and Fitness for Duty. The cost of the employee physicals and drug screens will be paid for by RHG.
POLICY:

It is the policy of RHG to give new employees the opportunity to demonstrate their ability to achieve a satisfactory level of performance and to determine whether the new position meets their expectations. Renaissance Healthcare Group uses this introductory period to evaluate employee capabilities, work habits, and overall performance. Either the employee or Renaissance Healthcare Group may end the employment relationship at will at any time during or after the introductory period, with or without cause or advance notice.

Supervisors and employees are strongly encouraged to discuss job performance and goals on an informal, day-to-day basis. Formal performance evaluations are conducted to provide both supervisors and employees the opportunity to discuss job tasks, identify and correct weaknesses, encourage and recognize strengths, and discuss positive, purposeful approaches for meeting goals.

Your supervisor is responsible for overseeing all the job training for employees within their department. This may include safety training, CPR and First Aid. The facility will pay for any required training programs. If business needs allow and your supervisor has given approval for you to attend training during your scheduled shift, it will be considered unpaid time. The cost of the training is paid by the company; however, the time that actually spent in training is unpaid. Employees may be tested from time to time to evaluate the effectiveness of the training program.

PROCEDURE:

1. All new and rehired employees work on an introductory basis for the first 90 calendar days after their date of hire. Any significant absence will automatically extend an introductory period by the length of the absence. If Renaissance Healthcare Group determines that the designated introductory period does not allow sufficient time to thoroughly evaluate the employee's performance, the introductory period may be extended for a specified period. Upon satisfactory completion of the introductory period, employees enter the "regular" employment classification.

2. Each employee is evaluated at the end of 90 days as a new hire and annually on their anniversary date thereafter. The exception to this procedure is when an employee is promoted. The date of the promotion will dictate the date of annual performance evaluations going forward.
Employees are expected to participate in the evaluation process by completing a self-evaluation utilizing the same form as the supervisor to evaluate performance. It will be included as part of the evaluation and be retained with the supervisor’s evaluation in the personnel file.

3. Each employee is also expected to complete a reorientation annually to keep abreast of changes and new information pertinent to their position. It is also a requirement that each employee maintain licensure and certifications pertinent to their position which may include CPR and First Aid. A copy of the current certificate of completion or updated license must be given to Human Resources for inclusion in the personnel file.
POLICY:

To ensure that individuals who join Renaissance Healthcare Group are well qualified and have a strong potential to be productive and successful, it is the policy of Renaissance Healthcare Group to check the employment references of all applicants.

Some positions require (or may require) licensure or certification. For those license and certifications requiring renewal, a record of renewal must be kept on file in Administration. License/Certification numbers must be submitted upon hire, and updated as renewed as needed.

PROCEDURE:

1. Upon hire, all Licensed or Certified employees in applicable positions will submit the original of their license to Human Resources for copy. It is the responsibility of the employee to maintain current licensure for applicable positions. Employment is contingent on valid and current licenses and certifications. Employees with expired licenses or certifications will not be able to work until proper licensure/certification is reinstated.

2. When an employee is hired with a temporary license, the expiration date will be noted. It is the responsibility of the employee to notify Human Resources when the permanent license is issued. An employee whose license has expired will not be allowed to function in that capacity until the license is renewed.

3. It is the responsibility of each employee to promptly notify Renaissance Healthcare Group of any changes in personnel data. Personal mailing addresses, telephone numbers, number and names of dependents, individuals to be contacted in the event of an emergency, educational accomplishment, and other such status reports should be accurate and current at all times.

4. Each employee upon hire will have their references verified, obtain uniform Level 2 background screening and pre-employment drug and T.B. testing.
POLICIES AND PROCEDURES

SUBJECT: Employee Conduct

ISSUE DATE: January 1, 2011

POLICY NO. HR-05

REVIEW/REVISION DATE: PROGRAMS: All Programs

POLICY: To ensure orderly operations and provide the best possible work environment, it is the policy of RHG to expect employees to follow rules of conduct that will protect the interests and safety of all employees and the organization.

PROCEDURE: It is not possible to list all the forms of behavior that are considered unacceptable in the workplace. The following are examples of infractions of rules of conduct that may result in disciplinary action, up to and including termination of employment:

- Supplying false or misleading information when applying for employment or during employment
- Personal use of company gas or credit cards
- Theft or inappropriate removal or possession of property
- Falsification of timekeeping records
- Working under the influence of alcohol or illegal drugs
- Possession, distribution, sale, transfer, or use of alcohol or illegal drugs or abuse of prescription drugs in the workplace, while on duty, or while operating employer-owned vehicles or equipment
- Failure or refusal to submit or consent to a required alcohol or drug test
- Fighting or threatening violence in the workplace
- Boisterous or disruptive activity in the workplace
- Negligence or improper conduct leading to damage of employer-owned or customer-owned property
- Insubordination or other disrespectful conduct
- Engaging in unethical or illegal conduct
- Having a conflict of interest
- Violation of safety or health rules
- Smoking in prohibited areas
- Sexual or other unlawful or unwelcome harassment
- Possession of dangerous or unauthorized materials, such as explosives or firearms, in the workplace
- Excessive absenteeism or tardiness or any absence without notice
- Unauthorized absence from work station during the workday
- Unauthorized use of telephones, mail system, or other employer-owned equipment
- Unauthorized disclosure of business "secrets" or confidential proprietary information
- Conduct that reflects adversely upon you or RHG
- Making or publishing false or malicious statements concerning an employee, supplier, client, or RHG
- Violation of personnel policies
POLICIES AND PROCEDURES

- Unsatisfactory performance or conduct or performance or conduct that does not meet the requirements of the position
- Other circumstances which warrant discipline

Behavior that is illegal or affects the safety and well being of residents or other employees are not subject to progressive discipline. Although not comprehensive of all conduct issues, the following are examples of infractions of rules of conduct that will result in immediate termination of employment:

- Theft
- Fighting and other acts of violence
- Leaving the worksite during the shift without supervisor approval
- Cursing, temper tantrums, or other forms of disrespect for colleagues, managers, or clients
- Gross insubordination to a supervisor
- Any action that compromises the safety and security of company assets
- Any action that damages the reputation of the company
- Employee collaboration in any of these acts, i.e., a staff member who has knowledge of another staff member engaging in these infractions and not reporting it to a supervisor.
POLICY:
RHG provides employees an opportunity to indicate their interest in open positions and advance within the organization according to their skills and experience. In general, notices of all regular, full-time job openings are posted, although RHG reserves its discretionary right to not post a particular opening. Job posting is a way to inform employees of openings and to identify qualified and interested applicants who might not otherwise be known to the hiring manager. Other recruiting sources may also be used to fill open positions in the best interest of the organization.

PROCEDURE:

1. Job openings will be posted on the company website and normally remain open for 30 days. Each job posting notice will include the job title and location.

2. To be eligible to apply for a posted job, employees must have performed competently for at least 12 months in their current position. Employees who have a written warning on file, or are on probation or suspension are not eligible to apply for posted jobs. Eligible employees can only apply for those posted jobs for which they possess the required skills, competencies, and qualifications.

3. To apply for an open position, employees should submit a job posting application to the Human Resources Department listing job-related skills and accomplishments. It should also describe how their current experience with Renaissance Healthcare Group and prior work experience and/or education qualifies them for the position.
POLICIES AND PROCEDURES

SUBJECT: Access & Confidentiality of Employment Records

ISSUE DATE: June 30, 2002

POLICY NO. HR - 07

REVIEW/REVISION DATE: March 31, 2011

PROGRAM: All Programs

POLICY:

It is the policy of RHG to maintain a confidential file of each employee’s work history and personnel record. This record is the property of the company. Access to this information is restricted to the following:

1. The employee;
2. The employee’s supervisor;
3. A department head or supervisor considering the employee for a requested transfer or promotion;
4. Human Resources; and
5. Administration

With advanced notice, employees may review their own personnel files in RHG offices and in the presence of an individual appointed by RHG to maintain the file. Human Resources will handle all employment inquiries made by outside agents for present or former employees, whether the inquiry is made by telephone or in writing. In compliance with the Privacy Act, Human Resources will only verbally verify positions held and dates of employment to all inquiries, but may comply in writing with a written authorization to release the information. Verification of salary or wage history will only be completed with a written authorization from the present or former employee.

If a prospective employer contacts a RHG supervisor, that contact should be referred to Human Resources.

Each employee is responsible for reporting changes in information such as name, address, and telephone number, marital status, dependents, etc. This information is kept confidential. Addresses may be used for facility mailings.

Officers and employees are permitted to access and use certain personal information, such as Social Security Numbers, only as necessary and appropriate for such persons to carry out their assigned tasks for Renaissance Healthcare Group and in accordance with Renaissance Healthcare Group’s policy.

The unauthorized access, viewing, use, disclosure, or the intentional public display of such information and the unauthorized removal of documents from Renaissance Healthcare Group’s premises that contain social security number information is prohibited and can result in discipline up to and including termination of employment.
If you come into contact with Social Security Numbers or other sensitive personal information without authorization from Renaissance Healthcare Group or under circumstances outside of your assigned tasks, you may not use or disclose the information further, but must contact your supervisor and turn over to him or her all copies of the information in whatever form.

When necessary, documents containing social security information will be properly destroyed through shredding or other means prior to disposal to ensure confidential social security information is not disclosed.
POLICY:

It is the policy of RHG to maintain a confidential personnel file on all employees. Each personnel file will be reviewed annually and updated as necessary. This record is the property of the company. Access to this information is restricted to authorized representatives.

Each personnel file shall include qualifications for the position hired, verified pre-employment references, evaluation of performance at least annually, and dates and subjects of in-service training and attendance at conferences, workshops and other related activities. Personnel files will be audited annually for compliance.

PROCEDURES:

1. Applications and resumes are taken by Human Resources for all open positions.
   A. Applications are given to the Human Resources; Resumes are required for all management positions.
   B. When a candidate has been selected for hire, the Human Resources representative will forward the application and resume to the supervisor along with any and all reference checks to determine that all of the proper procedures for hiring personnel have been completed.
   C. Human Resources will file the application and resume in the individual’s personnel file and perform background screens, verify references and request a pre-employment physical, TB test and drug screen.

2. At the time of hire, each new employee will be given the job description for his/her position by the Human Resources representative.
   A. The employee should read the job description, review the organizational chart and sign the Resident Rights, Resident Responsibilities and Employee Attestation.
   B. A copy of the acknowledgment of receipt shall be kept in the personnel file.

3. For those who hold licenses and certifications that are renewed annually, biannually, etc., a record of renewal must be kept on file in the Human Resources.
   A. License/Certification numbers and copies must be submitted upon hire.
   B. It is the responsibility of the employee to maintain current licensure or certification for applicable positions.
   C. All Licenses will be verified with the assigning agency prior to the first day of service.

4. Other requirements of employment include the following, which are maintained in the individual’s personnel file:
Employee Information Sheet, background screen (includes: County, State and Federal criminal checks and motor vehicle screening), employee drug screen (including fingerprinting), copies of all orientation checklists, valid state Driver’s License, current CPR certification, benefits acknowledgement form, employee handbook acknowledgment, organization chart and new hire checklist.

5. The employee’s performance evaluation form is placed in the personnel file and becomes a permanent part of the employment record.

6. Progressive discipline and counseling procedures have been established to ensure all employees are given fair treatment and an opportunity to improve their performance and conduct. Any documentation of disciplinary action is maintained in the personnel file.

7. Documentation of General Orientation, Annual re-orientation and other trainings and inservices.
POLICY:
It is RHG’s desire to provide a drug-free, healthful, and safe workplace. To promote this goal, employees are required to report to work in appropriate mental and physical condition to perform their jobs in a safe and satisfactory manner. While on RHG premises and while conducting business-related activities off RHG, no employee may use, possess, distribute, sell, or be under the influence of alcohol or illegal drugs. The legal use of prescribed drugs is permitted on the job only if it does not impair an employee's ability to perform the essential functions of the job effectively and in a safe manner that does not endanger other individuals in the workplace.

PROCEDURE:
RHG has a Drug Free Workplace Program, you will be subject to drug testing under certain circumstances, in accordance with applicable laws. In this event, you will either have the opportunity to review or will receive a copy of the Drug Free Workplace policy.

Violations of this policy may lead to disciplinary action, up to and including immediate termination of employment, and/or required participation in a substance abuse rehabilitation or treatment program. Such violations may also have legal consequences.

Employees with drug or alcohol problems that have not resulted in, and are not the immediate subject of, disciplinary action may request approval to take unpaid time off to participate in a rehabilitation or treatment program. Leave may be granted if the employee agrees to abstain from use of the problem substance; abides by all RHG policies, rules, and prohibitions relating to conduct in the workplace; and if granting the leave will not cause RHG any undue hardship.

Under the Drug-Free Workplace Act, an employee who performs work for a government contract or grant must notify RHG of a criminal conviction for drug-related activity occurring in the workplace. The report must be made within five days of the conviction.
POLICY:

It is the policy of RHG to consider any request by an employee not to participate in an aspect of patient care or treatment where there is perceived conflict with the employee’s cultural values, ethics, or religious beliefs.

PROCEDURES:

1. Employees shall have the right to request not to participate in an aspect of patient care or treatment if the employee believes there is conflict with his/her cultural values, ethics, or religious beliefs.

2. The request must be directed to the employee’s supervisor identifying the personal view for the request.

3. The Administrator will assess the situation along with the employee’s request to determine if the request can be appropriately justified based on cultural values, ethics, or religious beliefs. The Administrator will serve as the authority of ethical issues.

4. The Administrator may grant the request if there is an alternative method(s) of delivery of care.

5. The supervisor will ensure that an individual employee not participating in an aspect of care will not negatively affect the resident’s treatment if the request is granted, or reflect negatively on the staff performance.
POLICY:

It is the policy of RHG to conduct exit interviews with all voluntarily terminated employees. The exit interview is a confidential appointment between the staff member and a representative of Administration.

The interview should be an information sharing opportunity, during which the representative from personnel outlines options regarding benefits and other related issues. The employee should feel free to discuss any issues that he/she feels could be helpful to the facility in the future, and the reason(s) for the termination.

PROCEDURE:

1. Resignation is a voluntary act initiated by the employee to terminate employment with RHG. Although advance notice is not required, RHG Group requests at least 2 weeks' written resignation notice from all employees and that the employee agrees to an exit interview in order for PTO pay out to be considered.

2. Upon receipt of the letter of resignation, Administration will contact the terminating employee requesting him/her to schedule a time for the exit interview with either the Human Resources, which should be conducted prior to the employee's last day of work.

3. In the event of Termination, employee access to email, the electronic medical record and RHG access to property will be terminated immediately. Current employees will refrain from discussing residents or RHG business immediately with the terminated employee. Human resources will mail all appropriate separation documentation to the address on file within 1 business day. Final paychecks will be live (not direct deposit) and available for pick up at Human Resources when RHG property is returned.

3. All RHG property must be returned by employees on or before their last day of work. Where permitted by applicable laws, RHG may withhold from the employee's check or final paycheck the cost of any items that are not returned when required. RHG may also take all action deemed appropriate to recover or protect its property.
POLICY:

It is the policy of RHG to consider qualified former residents for employment with the facility.

There is no time limitation required between discharge as a resident and employment as a staff member, although the former resident will be expected to be actively continuing in on-going care, as documented on the most recent discharge summary. Each candidate will be considered based on program requirements and that candidate’s abilities.
POLICY:
Dress, grooming, and personal cleanliness standards contribute to the morale of all employees and affect the business image RHG presents to clients and visitors. During business hours or when representing RHG, you are expected to present a clean, neat, and tasteful appearance. You should dress and groom yourself according to the requirements of your position and accepted social standards. This is particularly true if your job involves dealing with customers or visitors in person.

PROCEDURE:
1. Clothing that reveals cleavage, your abdomen or your underwear is prohibited and not appropriate for a business casual setting.
2. Employees are not permitted to wear torn, dirty or frayed clothing; all seams must be finished.
3. Clothing that has words, terms or graphics that may be offensive to other employees or residents is prohibited. Alcohol and drug references are prohibited.
4. Pants:
   a. Permitted: Cotton, synthetic, wool or jeans
   b. Not permitted: “worn” or torn jeans, sweats, exercise pants, flannel pants, short shorts, bib overalls, leggings and spandex
5. Dresses:
   a. Permitted: business or casual dresses and skirts
   b. Not permitted: Mini-skirts, “skorts”, and beach dresses
6. Shirts and Tops:
   a. Permitted: Casual shirts, dress shirts, sweaters, golf-type shirts and turtlenecks
   b. Not permitted: Tank tops, midriff tops, halter-tops, sweatshirts, and t-shirts (unless worn under another blouse, shirt, jacket or dress)
7. Shoes:
   a. Permitted: Conservative athletic or walking shoes, loafers, clogs, sneakers, boots, flats, dress heels and leather deck-type shoes
   b. Not permitted: Thongs, flip-flops, slippers and dirty athletic shoes
   c. Closed toe and closed heel shoes are required in the food preparation area and barn.
8. Hats are not permitted anywhere indoors, but are appropriate for some outings for the purpose of sun shielding.
9. Visible piercings other than earrings are not allowed.

*Consult your supervisor if you have questions as to what constitutes appropriate appearance. Where necessary, reasonable accommodation may be made to a person with a disability.
POLICIES AND PROCEDURES

SUBJECT: Professional & Personal Boundaries

ISSUE DATE: January 1, 2011

POLICY NO. HR-14

REVIEW/REVISION DATE:

PROGRAMS: All Programs

POLICY:

It is the policy of RHG that the rights and needs of residents/clients should be considered and respected at all times. Although it is recognized that staff must establish a rapport with residents/clients and be accessible, it is the responsibility of the employee to establish and maintain appropriate boundaries between themselves and residents/clients. Staff must understand and remember that they are in a position of power and should maintain all interactions with residents/clients from the perspective of a professional relationship. It is the responsibility of employees to ensure that working relationships are not misunderstood or confused with friendship or any other type of personal relationship.

PROCEDURE:

The following list of unacceptable practices, while not exhaustive, may be used to establish appropriate boundaries:

- Sexual or physical contact which may be construed as sexually suggestive
- Inappropriate dress or use of body or verbal language that are not likely to serve any therapeutic purpose
- Inappropriate questions regarding sexual habits
- Acceptance of gifts
- Inappropriate personal disclosure by staff about themselves or other staff members
- Concealing information about residents/clients from clinical staff
- Providing substances to clients that are not indicated in the treatment plan or prescribed by the attending physician
- Mishandling or misappropriation of resident/client monies
- Misuse of resident/client’s personal property
- Discrimination
- Deviation from the treatment plan or use of alternative therapies
- Socializing outside of the therapeutic relationship such as exchanging personal information: address, cell phone number, etc.
- Using the resident/client to meet the employee’s emotional needs

If an employee is unsure of whether or not an action or behavior is a violation of professional or personal boundaries, he or she should consult his or her direct supervisor for clarification. Failure to observe this policy may lead to formal disciplinary action up to and including termination.
POLICY:
Employees may hold outside jobs as long as they meet the performance standards of their job with Renaissance Healthcare Group. All employees will be judged by the same performance standards and will be subject to RHG’s scheduling demands, regardless of any existing outside work requirements. Outside employment that constitutes a conflict of interest is prohibited. Employees may not receive any income or material gain from individuals outside Renaissance Healthcare Group for materials produced or services rendered while performing their jobs.

Transactions with outside firms must be conducted within a framework established and controlled by the executive level of RHG. Business dealings with outside firms should not result in unusual gains for those firms. Unusual gain refers to bribes, product bonuses, special fringe benefits, unusual price breaks, and other windfalls designed to ultimately benefit either the employer, the employee, or both. Promotional plans that could be interpreted to involve unusual gain require specific executive-level approval.

An actual or potential conflict of interest occurs when an employee is in a position to influence a decision that may result in a personal gain for that employee or for a relative as a result of RHG. For the purposes of this policy, a relative is any person who is related by blood or marriage, or whose relationship with the employee is similar to that of persons who are related by blood or marriage.

PROCEDURE:
1. If RHG determines that an employee's outside work interferes with performance or the ability to meet the requirements of the company as they are modified from time to time, the employee may be asked to terminate the outside employment if he or she wishes to remain with RHG.

2. Transactions with outside firms must be conducted within a framework established and controlled by the executive level of RHG. Business dealings with outside firms should not result in unusual gains for those firms. Unusual gain refers to bribes, product bonuses, special fringe benefits, unusual price breaks, and other windfalls designed to ultimately benefit either the employer, the employee, or both. Promotional plans that could be interpreted to involve
unusual gain require specific executive-level approval.

3. No "presumption of guilt" is created by the mere existence of a relationship with outside firms. However, if employees have any influence on transactions involving purchases, contracts, or leases, it is imperative that they disclose to an officer of RHG as soon as possible the existence of any actual or potential conflict of interest so that safeguards can be established to protect all parties.

Personal gain may result not only in cases where an employee or relative has a significant ownership in a firm with which RHG does business, but also when an employee or relative receives any kickback, bribe, substantial gift, or special consideration as a result of any transaction or business dealings involving RHG.
POLICY:

It is the policy of RHG to provide opportunities for colleges and universities to place medical, intern and practicum students onsite for training and to provide a mechanism for facilitating such placements.

PROCEDURES:

1. The college or university interested in placing a medical student, an intern and/or practicum student with RHG shall contact Human Resources to discuss the opportunities, including the responsibilities of all parties.

2. The college or university shall provide a listing of all students who will be placed at RHG programs.

3. All medical students, intern and practicum students must fill out an application for placement, sign an authorization for background screening and drug screen (or provide evidence of such in the last 30 days), sign a confidentiality notice, and provide evidence of insurance. All documentation shall be placed in the student file.

4. All medical students, intern and practicum students must participate in full Orientation, provided by the management staff of RHG, before the student can be onsite and engage in any placement activities.

5. All intern and practicum students function in a supportive capacity and are under the supervision of appropriate designated staff members.

6. All medical students may function in a full capacity with access to medical records, documentation and physician’s orders, patient consultation and access to the facility under the supervision of the attending physician.

6. The appropriate RHG member who is identified as the student supervisor for placement at RHG programs shall communicate with the placement coordinator at the college or university. Such communication shall include any concerns about the student’s participation in the placement, feedback as to the student’s progress and learning, as well as any other information that the placing school requires.

7. Volunteers are used in an educational or supportive capacity only and are not responsible for direct patient care. Volunteers will sign in as visitors and be accompanied/supervised by staff at all times.
POLICY:
The purpose of this policy is to state RHG’s position on administering equitable and consistent discipline for unsatisfactory conduct in the workplace. By complying with these standards you will help to maintain a positive, safe work environment for you and your colleagues.

To address those times when you have not lived up to positive standards, we may provide you with counseling, institute progressive discipline, or terminate your employment if your conduct warrants it. We have the discretion to decide whether counseling, progressive discipline or immediate termination is appropriate. The best disciplinary measure is the one that does not have to be enforced and comes from good leadership and fair supervision at all employment levels.

RHG’s own best interest lies in ensuring fair treatment of all employees and in making certain that disciplinary actions are prompt, uniform, and impartial. The major purpose of any disciplinary action is to correct the problem, prevent recurrence, and prepare the employee for satisfactory service in the future.

Although employment with Renaissance Healthcare Group is based on mutual consent and both the employee and RHG has the right to terminate employment at will, with or without cause or advance notice and may use progressive discipline at its discretion.

Disciplinary action may call for any of four steps -- verbal warning, written warning, suspension with or without pay, or termination of employment -- depending on the severity of the problem and the number of occurrences. There may be circumstances when one or more steps are bypassed.

PROCEDURE:
Progressive discipline means that, with respect to most disciplinary problems, these steps will normally be followed:

- A first offense may call for a verbal warning – All emails, texts, or other electronic communications between employees and managers may be included in the personnel file as written documentation of a verbal warning. Any reply from an employee to a supervisor’s email shall be considered an electronic signature of the employee acknowledging the warning.

- A next offense may be followed by a written warning – a written counseling record which will include written documentation.

- Another offense may lead to a suspension.

- Another offense may then lead to termination of employment.
POLICIES AND PROCEDURES

Progressive discipline will be used when your supervisor feels it is appropriate. The system of progressive discipline gives you notice of deficiencies in performance and an opportunity to improve. When misconduct occurs, progressive disciplinary action may include but is not limited to the following: counseling and/or verbal warning, written warning, suspension with or without pay, and/or termination.

Depending on the nature and severity of the misconduct as well as whether it has previously occurred, your supervisor and/or Human Resources Professional may investigate your actions. An investigation is designed to obtain all pertinent facts and may include interviewing you and other witnesses, reviewing documents, etc. Your friends, relatives, attorneys or other third parties are not allowed to participate in internal investigations. Failure to cooperate with an internal investigation is grounds for disciplinary action up to and including discharge.

When the investigation is complete, your supervisor and/or Human Resources professional will review the facts and the policies. At that point, your supervisor will determine whether you should be disciplined up to and including termination.

RHG recognizes that there are certain types of employee problems that are serious enough to justify either a suspension, or, in extreme situations, termination of employment, without going through the usual progressive discipline steps.

By using employee discipline, we hope that most employee problems can be corrected at an early stage, benefiting both the employee and Renaissance Healthcare Group.
POLICY:

Workplace monitoring may be conducted by Renaissance Healthcare Group to ensure quality control, employee safety, security, and customer satisfaction.

While on Renaissance Healthcare Group's premises, employees have no expectation of privacy in their belongings or in the non-private workplace areas which include, but are not limited to, offices, cubicles, work locations, Company provided or designated parking areas, desks, computers, lockers, rest or eating areas, or vehicles engaged in Company operations, and any personal belongings on or in any of the above.

Employees who regularly communicate via the telephone may have their conversations monitored or recorded. Telephone monitoring is used to identify and correct performance problems through targeted training. Improved job performance enhances our customers' image of Renaissance Healthcare Group as well as their satisfaction with our service.

Computers furnished to employees are the property of Renaissance Healthcare Group. As such, computer usage and files, including e-mail usage and related files, may be monitored or accessed.

Desks, lockers, and other storage devices may be provided for the convenience of employees but remains the sole property of Renaissance Healthcare Group. Accordingly, they, as well as any articles found within them, can be inspected by any agent or representative of Renaissance Healthcare Group at any time, either with or without prior notice.

Renaissance Healthcare Group likewise wishes to discourage theft or unauthorized possession of the property of employees, Renaissance Healthcare Group, visitors, and customers. To facilitate enforcement of this policy, Renaissance Healthcare Group or its representative may inspect not only desks and lockers but also persons entering and/or leaving the premises and any packages or other belongings. Any employee who wishes to avoid inspection of any articles or materials should not bring such items onto Renaissance Healthcare Group's premises.

Renaissance Healthcare Group may conduct video surveillance of non-private workplace areas. Video monitoring is used to identify safety concerns, maintain quality control, detect theft and misconduct, and discourage or prevent acts of harassment and workplace violence.

Because Renaissance Healthcare Group is sensitive to the legitimate privacy rights of employees, every effort will be made to conduct workplace monitoring in an ethical and respectful manner.
POLICIES AND PROCEDURES

SUBJECT: Workplace Violence

ISSUE DATE: January 1, 2011

POLICY NO. HR-19

REVIEW/REVISION DATE: PROGRAMS: All Programs

POLICY:
Renaissance Healthcare Group is committed to preventing workplace violence and to maintaining a safe work environment. Given the increasing violence in society in general, RHG has adopted the following guidelines to deal with intimidation, harassment, or other threats of (or actual) violence that may occur during business hours or on Company premises.

PROCEDURE:
1. All employees, including supervisors and temporary employees, should be treated with courtesy and respect at all times. Employees are expected to refrain from fighting, "horseplay," or other conduct that may be dangerous to others.

2. Firearms, weapons, and other dangerous or hazardous devices or substances are prohibited from the premises of the company unless contrary to state law.

3. Conduct that threatens, intimidates, or coerces another employee, a customer, or a member of the public will not be tolerated. This prohibition includes all acts of harassment, including harassment that is based on an individual's protected status.

4. All threats of (or actual) violence, both direct and indirect, should be reported as soon as possible to your immediate supervisor or any other member of management. This includes threats by employees, as well as threats by customers, vendors, solicitors, or other members of the public. When reporting a threat of violence, you should be as specific and detailed as possible. All suspicious individuals or activities should also be reported as soon as possible to a supervisor. Do not place yourself in peril. If you see or hear a commotion or disturbance near your work station, do not try to intercede or see what is happening.

5. RHG will promptly and thoroughly investigate all reports of threats of (or actual) violence and of suspicious individuals or activities. The identity of the individual making a report will be protected as much as is practical. In order to maintain workplace safety and the integrity of its investigation, Renaissance Healthcare Group may suspend employees, either with or without pay, pending investigation. Anyone determined to be responsible for threats of (or actual) violence or other conduct that is in violation of these guidelines will be subject to prompt disciplinary action up to and including termination of employment.
POLICY:
To provide for the safety and security of employees and the facilities at RHG, only authorized visitors are allowed in the workplace. Restricting unauthorized visitors helps maintain safety standards, protects against theft, ensures security of equipment, protects confidential information, safeguards employee welfare, and avoids potential distractions and disturbances.

PROCEDURE:
1. All visitors should enter Renaissance Healthcare Group facilities at the main entrance. Authorized visitors will receive directions or be escorted to their destination. Employees are responsible for the conduct and safety of their visitors.

2. All visitors must sign the Visitor Sign In and Confidentiality statement.

3. If an unauthorized individual is observed on a Renaissance Healthcare Group's premises, employees should immediately notify their supervisor or, if necessary, direct the individual to the main entrance.
POLICY
In an effort to ensure a productive and harmonious work environment, persons not employed by Renaissance Healthcare Group may not solicit or distribute literature in the workplace at any time for any purpose.

Renaissance Healthcare Group recognizes that employees may have interests in events and organizations outside the workplace. However, employees may not solicit or distribute literature concerning these activities during working time.

In addition, the posting of written solicitations on company bulletin boards is prohibited. Bulletin boards are reserved for official organization communications on such items as:

- Affirmative Action statement
- Postings required by law
- Employee announcements
- Internal memoranda
- Job openings
- Organization announcements
- Payday notice
- Workers’ compensation insurance information
- State disability insurance/unemployment insurance information
POLICIES AND PROCEDURES

SUBJECT: Sexual and other Unlawful Harassment

ISSUE DATE: January 1, 2011

POLICY NO. HR-22

REVIEW/REVISION DATE:

PROGRAMS: All Programs

POLICY:
Renaissance Healthcare Group is committed to preventing workplace violence and to maintaining a safe work environment. Given the increasing violence in society in general, RHG has adopted the following guidelines to deal with intimidation, harassment, or other threats of (or actual) violence that may occur during business hours or on Company premises.

PROCEDURE:
1. All employees, including supervisors and temporary employees, should be treated with courtesy and respect at all times. Employees are expected to refrain from fighting, "horseplay," or other conduct that may be dangerous to others.

2. Firearms, weapons, and other dangerous or hazardous devices or substances are prohibited from the premises of the company unless contrary to state law.

3. Conduct that threatens, intimidates, or coerces another employee, a customer, or a member of the public will not be tolerated. This prohibition includes all acts of harassment, including harassment that is based on an individual's protected status.

4. All threats of (or actual) violence, both direct and indirect, should be reported as soon as possible to your immediate supervisor or any other member of management. This includes threats by employees, as well as threats by customers, vendors, solicitors, or other members of the public. When reporting a threat of violence, you should be as specific and detailed as possible. All suspicious individuals or activities should also be reported as soon as possible to a supervisor. Do not place yourself in peril. If you see or hear a commotion or disturbance near your work station, do not try to intercede or see what is happening.

5. RHG will promptly and thoroughly investigate all reports of threats of (or actual) violence and of suspicious individuals or activities. The identity of the individual making a report will be protected as much as is practical. In order to maintain workplace safety and the integrity of its investigation, RHG may suspend employees, either with or without pay, pending investigation. Anyone determined to be responsible for threats of (or actual) violence or other conduct that is in violation of these guidelines will be subject to prompt disciplinary action up to and including termination of employment.
POLICIES AND PROCEDURES

SUBJECT: Reports of Patient Abuse & Neglect

ISSUE DATE: June 30, 2002

REVIEW/REVISION DATE: March 31, 2011

POLICY NO. HR-23

PROGRAMS: All Programs

POLICY: It is the policy of RHG that any staff member having contact with residents must exhibit the greatest professional discretion and appropriate actions.

Any time a report is received of resident neglect or abuse, an investigation shall immediately be undertaken, and the results reviewed and approved by the Administrator. If allegations are found to be based on fact, the employee will be terminated.

PROCEDURE:

1. Reports of neglect and/or abuse will be documented on a Quality Review Report and the allegation will be reported to the Abuse Hotline/AHCA by the Administrator.

2. The report will be reviewed by the supervisor, the Administrator and the Managing Director. If action is warranted, the employee will be suspended without pay indefinitely pending investigation.

3. If investigation shows the incident to have actually occurred, the employee will be immediately terminated. A report will be prepared and submitted to file.

4. If allegations prove false, the employee will be re-instated with back pay for the time lost.
POLICIES AND PROCEDURES

SUBJECT: Schedules, Attendance and Meal Breaks

ISSUE DATE: January 1, 2011

POLICY NO. HR-24

PROGRAMS: All Programs

POLICY:
Work schedules for employees vary throughout our organization. Supervisors will advise employees of their individual work schedules. Staffing needs and operational demands may necessitate variations in starting and ending times, as well as variations in the total hours that may be scheduled each day and week.

All employees are provided with one meal period of 30 minutes in length each workday. Supervisors will schedule meal periods to accommodate operating requirements. Employees are expected to interact and eat with residents during meal periods and will be compensated for that time.

To maintain a safe and productive work environment, RHG expects employees to be reliable and to be punctual in reporting for scheduled work. You are also expected to take your lunch/meal times within the time limits set by your supervisor. Absenteeism and tardiness place a burden on other employees and on RHG.

PROCEDURE:

1. In the rare instances when employees cannot avoid being late to work or are unable to work as scheduled, they should notify their supervisor as soon as possible in advance of the anticipated tardiness or absence. If you are going to miss work because you are going to be late or you or a family member is sick, you must notify your supervisor before the time you are to report for work. Your supervisor will advise you of an alternative person to contact if he or she is unavailable.

2. If you do not inform either; your supervisor or the alternative person, your tardiness or absence will be considered an unapproved, unscheduled absence. If you fail to notify your supervisor after three (3) business days of consecutive absences, you will be considered to have abandoned your job. These rules will be enforced uniformly on a non-discriminatory basis.

Poor attendance and excessive tardiness are disruptive. Either may lead to disciplinary action, up to and including termination of employment.
POLICY:
RHG are committed to all employees. Part of this commitment is encouraging an open and frank atmosphere in which any problem, complaint, suggestion, or question receives a timely response from the company's supervisors and management. RHG strive to ensure fair treatment of all employees. Supervisors, managers, and employees are expected to treat each other with mutual respect. Employees are encouraged to offer positive and constructive criticism.

PROCEDURE:
If employees disagree with established rules of conduct, policies, or practices, they can express their concern through the problem resolution procedure. No employee will be penalized, formally or informally, for voicing a complaint with the company in a reasonable, business-like manner, or for using the problem resolution procedure.

If a situation occurs when employees believe that a condition of employment or a decision affecting them is unjust or inequitable, they are encouraged to bring those issues to management's attention using the same procedure described in the Harassment policy.

1. Employee presents problem to immediate supervisor at RHG after incident occurs. If supervisor is unavailable or employee believes it would be inappropriate to contact that person, employee may present problem to any other member of management at RHG.
2. Supervisor at RHG responds to problem during discussion or after consulting with appropriate management, when necessary. Supervisor documents discussion.
3. Employee contacts the ADP TotalSource Employee Service Center at 800-554-1802 if problem is unresolved.
4. The ADP TotalSource Employee Service Center counsels and advises employee.
5. ADP TotalSource Employee Service Center presents problem to the Human Resources Department at ADP TotalSource.
6. Human Resources Department at ADP TotalSource reviews and considers problem. Human Resources Department at ADP TotalSource informs employee of decision and forwards copy of written response to employee's file.

Not every problem can be resolved to everyone's total satisfaction, but only through understanding and discussion of mutual problems can employees and management develop confidence in each other. This confidence is important to the operation of an efficient and harmonious work
environment.
POLICIES AND PROCEDURES

SUBJECT: Company Email, Computer & Printer Use

Page 1 of 3

Issue Date: September 14, 2010

Policy No.: HR-26

Review/Revision Date: January 1, 2011

PROGRAM: All Programs

POLICY:
Computers, computer files, the email system, and software furnished to employees are RHG property intended for business use. Employees should not use a password, access a file, or retrieve any stored communication without authorization. To ensure compliance with this policy, computer and email usage may be monitored.

Renaissance Healthcare Group strives to maintain a workplace free of harassment and sensitive to the diversity of its employees. Therefore, RHG prohibits the use of computers and the email system in ways that are disruptive, offensive to others, or harmful to morale.

For example, the display or transmission of sexually explicit images, messages, and cartoons is not allowed. Other such misuse includes, but is not limited to, ethnic slurs, racial comments, off-color jokes, or anything that may be construed as harassment or showing disrespect for others.

Email may not be used to solicit others for commercial ventures, religious or political causes, outside organizations, or other nonbusiness matters.

RHG purchases and licenses the use of various computer software for business purposes and does not own the copyright to this software or its related documentation. Unless authorized by the software developer, RHG does not have the right to reproduce such software for use on more than one computer.

Employees may only use software on local area networks or on multiple machines according to the software license agreement. RHG prohibits the illegal duplication of software and its related documentation.

Employees should notify their immediate supervisor, the Managing Director or any member of management upon learning of violations of this policy. Employees who violate this policy will be subject to disciplinary action, up to and including termination of employment.

Computers are provided at your worksite for professional and business purposes ONLY.

Computers are provided as professional tools to make performance of your job duties quick, easy and efficient and to allow you to enhance services provided to our residents.

These are not your personal computers, nor are they your personal entertainment devices.
You may use these computers ONLY to produce Office and other business and professional related documents, utilize ONLY the pasadenavilla.com email system, and surf the web ONLY for purposes directly related to business or resident care at your worksite location.

You may NOT use company computers to access your personal email accounts.

You may NOT change any system settings whatsoever on any company owned computer.

You may NOT install any software whatsoever without express permission from the Clinical or Managing Director:

“unauthorized software” includes but is not limited to ANY:
1. toolbars or search engines
2. web browsers (like Safari, Firefox, Mozilla, etc)
3. computer ‘performance enhancer’ programs
4. media players (like Real Player, QuickTime, Viewpoint, etc)
5. music, video or I-Pod/I-Tunes downloads
6. Photo programs
7. other software not specifically licensed for use at Renaissance Healthcare Group and/or specifically authorized by the Clinical Director or Managing Director

(Installation of unauthorized software can cause extreme slowdown of computer performance, and compromises both the security and usability of these business owned computers.)

You may NOT use this or any other company computer to visit ANY social networking sites (like FaceBook, MySpace, etc), auction sites (like E-Bay, etc), gambling sites or pornography sites.

All programs, e-mail, information and data on all company computers are considered the property of Renaissance Healthcare Group.

Violation of this policy may result in disciplinary action up to and including termination of employment.

****If you wish to utilize a computer for any purposes other than direct business or professional use, you may bring in a personal laptop and connect through the wireless network.****

**PRINTER USE POLICY:**
Our ‘green goal’ is for a paper free workplace. The company printer is ONLY for printing business related documents, faxes and copies so that we may be ecologically
sound and conservative in use of paper and ink. You may NOT use it for any personal printing or copying purposes whatsoever.
POLICY:
Whether the cellular phone is provided by RHG or the employee is using his or her own phone, employees who have access to a cell phone while in their cars should remember that their primary responsibility is driving safely and obeying the rules of the road. Employees are prohibited from using cell phones to conduct business while driving and should safely pull off the road and come to a complete stop before dialing or talking on the phone or writing, sending, or reading a text-based communication.

As a representative of RHG, cell phone users are reminded that the regular business etiquette employed when speaking from office phones or in meetings applies to conversations conducted over a cell phone.

PROCEDURE:
If you are provided a cellular phone by RHG (“Company Cellular Phone”), it is provided to you as a business tool only. Company Cellular Phones are provided to assist employees in communicating with management and other employees, their RHG’s associates, and others with whom they may conduct business. Company Cellular Phone use is intended for business-related calls only and personal calls are not permitted. Company Cellular Phone invoices and text messages (including those sent on data pagers) may be regularly monitored to ensure compliance with this policy.
POLICIES AND PROCEDURES

SUBJECT: Internet Usage, Social Networking & Blogging

ISSUE DATE: January 1, 2011

POLICY NO. HR-28

REVIEW/REVISION DATE: PROGRAMS: All Programs

POLICY:

Internet access to global electronic information resources on the World Wide Web is provided by RHG to assist employees in obtaining work-related data and technology. The following guidelines have been established to help ensure responsible and productive Internet usage.

All Internet data that is composed, transmitted, or received via our computer communications systems is considered to be part of the official records of RHG and, as such, is subject to disclosure to law enforcement or other third parties. Consequently, employees should always ensure that the business information contained in Internet email messages and other transmissions is accurate, appropriate, ethical, and lawful.

The equipment, services, and technology provided to access the Internet remain at all times the property of RHG. As such, RHG reserves the right to monitor Internet traffic, and retrieve and read any data composed, sent, or received through our online connections and stored in our computer systems.

Data that is composed, transmitted, accessed, or received via the Internet must not contain content that could be considered discriminatory, offensive, obscene, threatening, harassing, intimidating, or disruptive to any employee or other person. Examples of unacceptable content may include, but are not limited to, sexual comments or images, racial slurs, gender-specific comments, or any other comments or images that could reasonably offend someone on the basis of race, age, sex, religious or political beliefs, national origin, disability, sexual orientation, or any other characteristic protected by law.

The unauthorized use, installation, copying, or distribution of copyrighted, trademarked, or patented material on the Internet is expressly prohibited. As a general rule, if an employee did not create material, does not own the rights to it, or has not gotten authorization for its use, it should not be put on the Internet. Employees are also responsible for ensuring that the person sending any material over the Internet has the appropriate distribution rights.

Abuse of the Internet access provided by RHG in violation of law or company policies will result in disciplinary action, up to and including termination of employment. Employees may also be held personally liable for any violations of this policy. The following behaviors are examples of previously stated or additional actions and activities that are prohibited and can result in disciplinary action:

- Sending or posting discriminatory, harassing, or threatening messages or images
- Using the organization's time and resources for personal gain
- Stealing, using, or disclosing someone else's code or password without authorization
- Copying, pirating, or downloading software and electronic files without permission
POLICIES AND PROCEDURES

- Sending or posting confidential material, trade secrets, or proprietary information outside of the organization
- Violating copyright law
- Failing to observe licensing agreements
- Engaging in unauthorized transactions that may incur a cost to the organization or initiate unwanted Internet services and transmissions
- Sending or posting messages or material that could damage the organization's image or reputation
- Participating in the viewing or exchange of pornography or obscene materials
- Sending or posting messages that defame or slander other individuals
- Attempting to break into the computer system of another organization or person
- Refusing to cooperate with a security investigation
- Sending or posting chain letters, solicitations, or advertisements not related to business purposes or activities
- Using the Internet for political causes or activities, religious activities, or any sort of gambling
- Jeopardizing the security of the organization's electronic communications systems
- Sending or posting messages that disparage another organization's products or services
- Passing off personal views as representing those of the organization
- Sending anonymous email messages
- Engaging in any other illegal activities
- Failure to protect private health information of clients

In general, Renaissance Healthcare Group views websites, web logs and other information published on mediums accessible by the public by its employees positively, and it respects the right of employees to use them as a medium of self-expression. If you choose to identify yourself as a RHG employee or to discuss matters related to our business, please bear in mind that although the information you publish will generally be viewed as a medium of personal expression, some readers may nonetheless view you as a de facto spokesperson for RHG. In light of this possibility the following guidelines must be followed:

- Company equipment, including computers and electronic systems, are limited to business use only.
- You must make it clear to your readers that the views expressed by you are yours alone and do not represent the views of RHG.
- If you blog or otherwise publish information about our products or services, you must clearly and conspicuously disclose your relationship with RHG to your readers.
- Understand that you assume full responsibility and liability for your public statements.
- You are not permitted to disclose confidential or proprietary information. You must at all times abide by all non-disclosure and confidentiality policies.
- Company policies governing the use of corporate logos and other branding and identity apply, and only individuals officially designated have the authority to speak on the company’s behalf. Therefore, you are not permitted to use any company logo or graphics without first obtaining permission.
- You are prohibited from making discriminatory, defamatory, libelous or slanderous comments when discussing RHG, and/or your supervisors, co-workers, customers, clients and/or competitors.
- You must always comply with all other employment policies, including the Harassment Policy.
Since the information you publish is accessible by the general public, Renaissance Healthcare Group hopes your comments will be truthful and respectful to Renaissance Healthcare Group, its employees, customers, partners, affiliates and others (including our competitors) as the Renaissance Healthcare Group itself endeavors to be. If you are going to criticize individual employees, consider discussing the criticism personally before making it public. RHG will not tolerate statements about it or its employees that are defamatory, obscene, threatening or harassing.

Please be aware that RHG may request, in its sole and absolute discretion, that you temporarily confine your website, web log or other commentary to topics unrelated to the Company if it believes this is necessary or advisable to ensure compliance with laws or regulations.

All employees are prohibited from socializing with any current or former clients in any internet networking or social networking site. This includes sites such as Facebook, My Space, and a host of others. Violation of this policy may result in disciplinary action and could lead to immediate discharge.

Failure to comply with these requests may lead to discipline up to and including termination, and if appropriate, Renaissance Healthcare Group will pursue all available legal remedies.
I. Orientation of New Employees

On the first day of employment, the employee will attend new hire orientation and meet with a human resources representative to review and complete all personnel forms and to ensure his/her employee file is complete. At this time, the employee will be given information and documentation regarding the following:

- Employee Handbook
- Fire and Safety Plans
- Resident Rights/Resident Responsibilities
- Risk Management/Incident Reporting Policies
- Infection Control Policies
- Physical Health and Emergency Medical Policies
- Reporting of Abuse and Neglect Policies
- Charting and Documentation
- Staff Development and Orientation Policies
- Employee Job Requirements and Job Description
- Customer Service Plans and Expectations
- Performance Improvement and Quality Improvement Plans
- Orientation Checklist for worksite and Job Description
- Staff Boundaries and Documentation
- Complaints & Grievances
- HIPAA Plan and Policies
- Prevention of Workplace Violence

The Orientation Checklist will assist the employee and his/her supervisor to track the new employee’s progress toward completing this very important orientation period. It is the responsibility of the new employee to give to the supervisor the checklist on a daily basis for review during the orientation period.

The Checklist will include supervised and monitored on-the-job training, review of policies and procedures, and required personnel documents. Each employee
will also obtain training from nursing, clinical staff or physicians on the health needs of the residents. This training will be updated throughout the year as the health needs of residents change.

II. Annual Re-Orientation

On an annual basis, each employee will complete a re-orientation. This re-orientation process is intended to provide our employees the opportunity to continually enhance skills and knowledge to improve service delivery and customer service.

The annual re-orientation will include all of the elements of the New Employee Orientation, except for the on-the-job training and observation.

III. Staff Development

Staff development shall be planned and conducted on a regular and continuing basis, under the direction of the Administrator or designee. Documentation of these sessions shall include date, subject, attendance and instructor. Attendance at professional workshops and conferences should also be documented and placed in the employees’ human resources file.

IV. Documentation

All Orientation, Re-Orientation and Staff Development activities will be documented in each employee’s human resources file.
Infection Control
(IC)

Table of Contents

IC-01  Infection Control Program
IC-02  HBV/HIV Policy and Procedure for Staff
IC-03F  Reportable Diseases Florida
IC-03T  Reportable Diseases Tennessee
IC-04  Needle Sticks and Cuts
IC-05  Universal Precautions Category I and II Tasks
IC-06  Infection Control Reporting
IC-07  Client and Staff T. B. Testing

Infection Control Report
TB Form
POLICY: The primary purpose of infection control policies and procedures is to establish guidelines to follow in preventing, controlling, and eliminating the spread of contagious, infectious, and/or communicable disease. These policies and procedures apply equally to all personnel, residents, visitors and the general public, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status.

The objectives of our infection control policies and procedures are to:

1. Prevent and control the spread of communicable/contagious disease.
2. Maintain a sanitary environment for our personnel, residents, visitors and the general public.
3. Establish policies and procedures to follow in implementing "universal precautions".

PROCEDURES:

1. It shall be the responsibility of the Nurse to ensure that all infection control policies and procedures are implemented and followed.

2. The Nurse shall be responsible for making periodic reports, both oral and written, to the Safety Committee concerning changes in our established infection control practices.

3. All personnel shall be informed of our infection control policies and procedures through our orientation program and regularly scheduled in-service training classes.

4. The facility has adopted our infection control policies and procedures, as outlined herein, as those that best reflect the needs and operational requirements of this facility in the prevention, control, and elimination of communicable disease, as set forth in OSHA and CDC guidelines and recommendations.

5. Prevention of Infectious Diseases:
   A. Infection disease prevention measures include both mandatory and voluntary testing and immunization for employees.
   B. A physician's permit to return to work is required following any suspicion of an infectious disease.
   C. Resident TB testing and Symptom Questionnaire completed at admission and annually.
   D. Inservice education of infection prevention is conducted both with residents and staff.

6. Our infection control policies and procedures will be reviewed for revision and updating as necessary, but at least annually.

7. Such policies and procedures, will be reviewed by the Infection Control Designee, Safety Committee,
as well as other committees annually, for their content and effectiveness.
POLICY:

It is the policy of RHG to follow Center for Disease Control Guidelines and to maintain confidentiality of all employees relative to HBV/HIV status.

PROCEDURE:

1. HBV/HIV positive employees need not be restricted from work, but infected employees should be evaluated on an individual basis. Our facility will not discriminate against an HBV/HIV-positive employee. The employee would be expected to alert the facility that he/she is HBV/HIV-positive. As with any other employee, he or she would have to demonstrate their physical and mental well-being to handle the specific job responsibilities. The infected employee is expected to observe and follow basic infection control procedures and be diligent in following CDC's Universal Precautions.

2. Routine screening of employees for the HBV/HIV will not be done.

3. Confidentiality will be maintained at all times to insure the privacy of the employee, unless the employee gives permission to share the information. Anyone, however, who has a business related reason to know about an employee with HBV/HIV will be informed.

4. All employees are expected to work with any residents (including HBV/HIV-positive residents or infected co-workers) unless the employee has written medical certification from a physician regimenting that an individual not be exposed to residents or staff who are HBV/HIV-positive.

5. All attempts will be made to dispel myths about transmission of HBV/HIV.

6. Those employees who are HBV-positive or seroconvert during the course of employment must present a medical certificate affirming that he/she is antibody positive for HBV.

7. Follow-up Procedures After Possible Exposure to HIV/HBV:

   (a) If an employee has a percutaneous (needle stick or cut) or mucous membrane (splash to eye, nasal mucosa or mouth) exposure to body fluids or has a cutaneous exposure to blood when the employee's skin is chapped, abraded or otherwise nonintact, the source patient shall be informed of the incident and tested for HIV and HBV infections, after consent is obtained.

   (b) If patient consent is refused or if the source patient tests positive, the employee shall be evaluated clinically and by HIV antibody testing as soon as possible and advised to report and seek medical evaluation of any acute febrile illness that occurs within 12 weeks after
exposure. HIV seronegative employees shall be retested 6 weeks post-exposure and on a periodic basis thereafter (12 weeks, 6 months and 12 months after exposure.)

(c) Follow up procedures shall be taken for employees exposed or potentially exposed to HBV. The types of procedures depends on the immunization status of the employee (i.e., whether HBV vaccination has been received and antibody response is adequate) and the HBV serologic status of the source patient. The CDC Immunization Practices Advisory Committee has published its recommendations regarding HBV post-exposure prophylaxis in table format in the June 7, 1985, Morbidity and Mortality Weekly Report.

(d) If an employee refuses to submit to the procedures in (b) or (c) above when such procedures are medically indicated, no adverse action can be taken on that ground alone, since the procedures are designed for the benefit of the exposed employee.

8. New employees will be advised that HBV/HIV patients may be admitted and that HBV/HIV positive employees will not be discriminated against or terminated because of that condition unless the employee is not capable to do required job tasks.
POLICY:
It is the policy of RHG to report all infections, and contagious or communicable diseases to appropriate county and/or state health department officials.

PROCEDURES:
1. Should a resident or employee be diagnosed as having any of the following diseases, it shall be promptly reported to the Infection Control Designee, who will then notify appropriate county and/or State of Florida Health Department officials.

The following notifiable diseases or conditions are declared as dangerous to the public health. The occurrence or suspected occurrence of these diseases listed in Rule 10D-3.062, except cancer and carriers of certain diseases listed in Rule 10D-3.091 in any person or persons affected at the time of death, shall be reported to the attending practitioner as defined in Rule 10D-3.076 and to the HRS county public health unit director/administrator. Such reports shall be made within 48 hours of recognition by telephone or in writing, except for certain specified diseases as indicated below by a (T) which shall be reported immediately by telephone. Exceptions to the reporting time frames required as defined by this rule are provided for syphilis, as indicated in Rule 10D-e.098 (1) (all., 2. Cancer cases treated in hospitals shall be reported to the Florida Cancer Data System as required by 385.202, F.S.

(a) Acquired Immune Deficiency Syndrome (AIDS)
(b) Amebiasis
(c) Animal bite to humans only by a potentially rabid animal
(d) Anthrax (T)
(e) Botulism (T)
(f) Brucellosis
(g) Campylobacteriosis
(h) Chancroid
(i) Cryptosporidiosis
(j) Dengue
(k) Diphtheria (T)
(l) Encephalitis
(m) Giardiasis (acute)
(n) Gonorrhea
(o) Granuloma Inguinale
(p) Haemophilus Influenzae Type b invasive disease
(q) Hansen’s Disease (Leprosy)
(r) Hemorrhagic Fever (T)
(s) Hepatitis
POLICIES AND PROCEDURES

(t) Histoplasmosis
(u) Lead Poisoning
(v) Legionnaire's Disease
(w) Leptospirosis
(x) Lyme Disease
(y) Lymphogranuloma Venereum
(z) Malaria
(aa) Measles (T)
(bb) Meningitis
(cc) Meningococcal Disease
(dd) Mercury Poisoning
(ee) Mumps
(ff) Paralytic Shellfish Poisoning
(gg) Pertussis
(hh) Pesticide Poisoning
(ii) Plague (T)
(jj) Poliomyelitis (T)
(kk) Psittacosis
(ll) Rabies
(mm) Relapsing Fever
(nn) Rocky Mountain spotted Fever. R. rickettsia
(oo) Rubella including congenital
(pp) Salmonellosis
(qq) Shigellosis
(rr) Smallpox (T)
(ss) Syphilis
(tt) Tetanus
(uu) Toxoplasmosis acute
(vv) Trichinosis
(ww) Tuberculosis
(xx) Tularemia
(yy) Typhoid Fever
.zz) Typhus (T)
(aaa) Vibrio cholera (T)
(bbb) Vibrio Infections
(ccc) Yellow Fever (T)
(ddd) Any disease outbreak in a community, a hospital, or other institution, or a food
bourne, or waterbourne outbreak as described in Rule 10D-3.064.
(eee) Cancer (except non melanoma skin cancer)
(fff) Ciguatera
(ggg) Chlamydia trachomatis

10D-3.096 Diseases Designated as Sexually Transmissible diseases for the purposes of Chapter 384, F.S.
(a) Acquired Immunodeficiency Syndrome
(b) Chancroid
(c) Gonorrhea
(d) Granuloma Inguinale
(e) Human Immunodeficiency Virus Infection
(f) Lymphogranuloma Venereum
(g) Syphilis
(h) Chlamydia trachomatis
POLICY:
It is the policy of RHG to report all infections, and contagious or communicable diseases to appropriate county and/or state health department officials.

PROCEDURES:
1. Should a resident or employee be diagnosed as having any of the following diseases, it shall be promptly reported to the Infection Control Designee, who will then notify appropriate county and/or State Health Department officials.

The diseases and events listed below are declared to be communicable and/or dangerous to the public and are to be reported to the local health department by all hospitals, physicians, laboratories, and other persons knowing of or suspecting a case in accordance with the provision of the statutes and regulations governing the control of communicable diseases in Tennessee.

Category 1A: Requires immediate telephonic notification (24 hours a day, 7 days a week), followed by a written report using the PH-1600 within 1 week.

[002] Anthrax (Bacillus anthracis)\textsuperscript{B}
[005] Botulism-Foodborne (Clostridium botulinum)\textsuperscript{B}
[004] Botulism-Wound (Clostridium botulinum)
[505] Disease Outbreaks (e.g., foodborne, waterborne, healthcare, etc.)
[108] Encephalitis, Arboviral: Venezuelan Equine\textsuperscript{B}
[023] Hantavirus Disease
[096] Measles-Imported
[026] Measles-Indigenous
[095] Meningococcal Disease (Neisseria meningitidis)
[516] Novel Influenza A
[032] Pertussis (Whooping Cough)
[037] Rabies: Human
[112] Ricin Poisoning\textsuperscript{B}
[132] Severe Acute Respiratory Syndrome (SARS)
[107] Smallpox\textsuperscript{B}
[110] Staphylococcal Enterotoxin B (SEB) Pulmonary Poisoning\textsuperscript{B}
[111] Viral Hemorrhagic Fever\textsuperscript{B}

Category 1B: Requires immediate telephonic notification (next business day), followed by a written report using the PH-1600 within 1 week.

[006] Brucellosis (Brucella species)\textsuperscript{B}
[010] Congenital Rubella Syndrome
[011] Diptheria (Corynebacterium diptheriae)
[121] Encephalitis, Arboviral: California/LaCrosse Serogroup
[123] Encephalitis, Arboviral: Eastern Equine
[122] Encephalitis, Arboviral: St. Louis
[124] Encephalitis, Arboviral: Western Equine
[506] Enterobacteriaceae, Carbapenemase-producing
[053] Group A Streptococcal Invasive Disease (Streptococcus pyogenes)
[047] Group B Streptococcal Invasive Disease (Streptococcus agalactiae)
[016] Hepatitis, Viral-Type A acute
[513] Influenza, pediatric deaths
[515] Melioidosis (Burkholderia pseudomallei)
[102] Meningitis-Other Bacterial
[031] Mumps
[033] Plague (Yersinia pestis)
[035] Poliomyelitis-Nonparalytic
[034] Poliomyelitis-Paralytic
[119] Prion disease-variant Creutzfeldt Jakob Disease
[109] Q Fever (Coxiella burnetii)
[040] Rubella
[041] Salmonellosis: Typhoid Fever (Salmonella Typhi)
[131] Staphylococcus aureus: Vancomycin non-sensitive – all forms
[075] Syphilis (Treponema pallidum): Congenital
[519] Tuberculosis, confirmed and suspect cases of active disease (Mycobacterium tuberculosis complex)
[113] Tularemia (Francisella tularensis)

Category 2: Requires written report using form PH-1600 within 1 week.

[501] Babesiosis
[003] Botulism-Infant (Clostridium botulinum)
[007] Campylobacteriosis (including EIA or PCR positive stools)
[503] Chagas Disease
[069] Chancreoid
[055] Chlamydia trachomatis-Genital
[057] Chlamydia trachomatis-Other
[056] Chlamydia trachomatis-PID
[009] Cholera (Vibrio cholerae)
[001] Cryptosporidiosis (Cryptosporidium species)
[106] Cyclosporiasis (Cyclospora species)
[504] Dengue Fever
[116] Ehrlichiosis-HGE (Anaplasma phagocytophilum)
[051] Ehrlichiosis-HME (Ehrlichia chaffeensis)
[117] Ehrlichiosis/Anaplasmosis-Other
[060] Gonorrhea-Genital (Neisseria gonorrhoeae)
[064] Gonorrhea-Ophtalmic (*Neisseria gonorrhoeae*)
[061] Gonorrhea-Oral (*Neisseria gonorrhoeae*)
[063] Gonorrhea-PID (*Neisseria gonorrhoeae*)
[062] Gonorrhea-Rectal (*Neisseria gonorrhoeae*)
[133] Guillain-Barré syndrome
[058] Hemolytic Uremic Syndrome (HUS)
[480] Hepatitis, Viral-HbsAg positive infant
[048] Hepatitis, Viral-HbsAg positive pregnant female
[017] Hepatitis, Viral-Type B acute
[018] Hepatitis, Viral-Type C acute
[021] Legionellosis (*Legionella species*)
[022] Leprosy [Hansen Disease] (*Mycobacterium leprae*)
[094] Listeriosis (*Listeria species*)
[024] Lyme Disease (*Borrelia burgdorferi*)
[025] Malaria (*Plasmodium species*)
[118] Prion disease-Creutzfeldt Jakob Disease
[036] Psittacosis (*Chlamydia psittaci*)
[105] Rabies: Animal
[039] Rocky Mountain Spotted Fever (*Rickettsia rickettsii*)
[042] Salmonellosis: Other than S. Typhi (*Salmonella Species*)
[517] Shiga-toxin producing *Escherichia coli*
(including Shiga-like toxin positive stools, *E. coli* O157 and *E. coli* non-O157)
[043] Shigellosis (*Shigella species*)
[130] *Staphylococcus aureus*: Methicillin resistant Invasive Disease
[518] *Streptococcus pneumoniae* Invasive Disease (IPD)
[074] Syphilis (*Treponema pallidum*): Cardiovascular
[072] Syphilis (*Treponema pallidum*): Early Latent
[073] Syphilis (*Treponema pallidum*): Late Latent
[077] Syphilis (*Treponema pallidum*): Late Other
[076] Syphilis (*Treponema pallidum*): Neurological
[070] Syphilis (*Treponema pallidum*): Primary
[071] Syphilis (*Treponema pallidum*): Secondary
[078] Syphilis (*Treponema pallidum*): Unknown Latent
[044] Tetanus (*Clostridium tetani*)
[045] Toxic Shock Syndrome: Staphylococcal
[097] Toxic Shock Syndrome: Streptococcal
[046] Trichinosis
[101] Vancomycin Resistant Enterococci (VRE) Invasive Disease
[114] *Varicella* deaths
[104] Vibrios (*Vibrio species*)
[125] West Nile virus Infections-Encephalitis
[126] West Nile virus Infections-Fever
[098] Yellow Fever
[103] Yersiniosis (*Yersinia species*)
Category 3: Requires special confidential reporting to designated health department personnel within 1 week.

[500] Acquired Immunodeficiency Syndrome (AIDS)
[512] Human Immunodeficiency Virus (HIV)

Category 4: Laboratories and physicians are required to report all blood lead test results monthly and no later than 15 days following the end of the month.

[514] Lead Levels (blood)

Category 5: Events will be reported monthly (no later than 30 days following the end of the month) via the National Healthcare Safety Network (NHSN - see http://health.state.tn.us/ceds/hai/index.htm for more details); Clostridium difficile infections (Davidson County residents only) will also be reported monthly to the Emerging Infections Program (EIP).

[509] Healthcare Associated Infections, Clostridium difficile
[510] Healthcare Associated Infections, Methicillin resistant Staphylococcus aureus positive blood cultures
[511] Healthcare Associated Infections, Surgical Site Infections

The following pathogens do not need to be reported using form PH-1600, but a reference culture is required to be sent to the State Public Health Laboratory.

[502] Burkholderia mallei
[507] Francisella species
POLICY:

It is the policy of RHG that all personnel take precautions to prevent injuries caused by needlesticks, sharps, or other instruments or devices and to report all incidents that occur.

PROCEDURE:

1. Caution must be exercised when handling used needles, sharp blades, or other sharp objects or devices to reduce the possibility of needlestick injuries and/or cuts.

2. To aid in preventing needlestick injuries, needles shall not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand.

3. Used needles and other sharp objects must be placed in a puncture resistant container located in the staff office.

4. All personnel must report needlestick injuries and cuts to their supervisor at the time of the occurrence and an Incident Report must be filed.

5. Staff will be sent to Emergency/urgent care for appropriate follow up and testing.

6. Key procedural points when using needles or sharps:

   A. Wash your hands thoroughly before beginning, and after the procedure.
   B. Use protective equipment as indicated.
   C. Use caution when handling used needles and syringes.
   D. To minimize the risk of a needlestick injury, keep the puncture resistant container as close to the work area as practical.
   E. Gloves must be worn when handling blood specimens, body fluids, excretions, as well as surfaces, materials, and objects exposed to them.
POLICIES AND PROCEDURES

SUBJECT: UNIVERSAL PRECAUTIONS CATEGORY I AND II TASKS

ISSUE DATE: June 30, 2002

REVIEW/REVISION DATE: March 31, 2011

PROGRAM: All Programs

POLICY: It is the policy of RHG for all staff performing Category I and II tasks to participate in an initial and annual training program.

PROCEDURES:

1. Orientation and annual inservice training programs are conducted to provide all personnel who perform Category I and II tasks with information concerning standard operating procedures, work practices, and protective equipment for each task performed.

2. Personnel will not be permitted to perform a Category I or II task until such training has been completed.

3. Each employee who is required to perform Category I and II tasks shall undergo an initial and annual training program. Our training program includes:
   a. The modes of transmission of AIDS (HIV) and Hepatitis B (HBV) viruses.
   b. How to recognize and differentiate Category I and II tasks.
   c. Instructions on types of protective clothing and equipment generally appropriate for Category I and II tasks, as well as instructions on the basis for selecting the clothing and equipment.
   d. Instructions on the actions to take and persons to contact if unplanned Category I tasks are encountered.
   e. Instruction on where protective clothing and equipment is kept, how to use it, and how to remove, handle, decontaminate, and dispose of contaminated clothing or equipment.
   f. Instruction on the limitation of protective clothing and equipment.
   g. Instruction on the corrective action to take in the event of spills or personnel exposure to fluids or tissue, the appropriate reporting procedures, and the medical monitoring recommended in cases of suspected parenteral exposure.

4. Training records, indicating the dates of each training session, the contents of each session, the names of all persons attending the session, and the name(s) of the person(s) conducting the class shall be maintained for a minimum of three (3) years. A copy of the "Record of Training" form is located in the Staff Development File.
5. To ensure personnel have access to appropriate precautions, the Policy and Procedure Manual, including the Infection Control Section, is located at each nursing station.

6. Inquiries concerning Universal Precautions should be directed to the Clinical Director.

EXPOSURE CATEGORIES/JOB CLASSIFICATION

Exposure Categories

Category I. Tasks that involve exposure to blood, body fluids, or other infectious materials.

All procedures or other job-related tasks that involve an inherent potential for membrane or skin contact with blood, body fluids, or other infectious materials, or a potential for spills or splashes of them, are Category I tasks. Use of appropriate protective measures should be required for every employee engaged in Category I tasks.

Category II. Tasks that involve no exposure to blood, body fluids or other infectious materials, but employment may require performing unplanned Category I tasks.

The normal work routine involves no exposure to blood, body fluids, or other infectious materials, but exposure or potential exposure may be required as a condition of employment. Appropriate protective measures should be readily available to every employee engaged in Category II tasks.

Category I

Tasks:
Tasks that involve exposure to blood, body fluids or tissue but that may require performance of tasks involving exposure either unexpectedly or on short notice. These would include linen changes and/or emergency first aid.

Employees: Nursing, Patient Care Managers/Counselors, Therapist, Clinical Director, Housekeeper

Protection:
Protective equipment readily accessible for use on short notice. Policies and Procedures detail mandated practices to be followed. Employees encouraged to be immunized for HBV at facility's expense.

Category II

Tasks:
Involve no exposure to blood, body fluids or tissues, but employment may require performing unplanned Category I tasks.

Employees: Managing Director, Business Manger, Interns or Volunteers
Protection:
Universal Precautions
POLICY: It is the policy of RHG to detect and record all infectious diseases that occur in every program and every area of the facility and to identify potential infection problems in specific areas and to evaluate the results and trends and make reports and recommendations for appropriate follow-up.

PROCEDURES:

1. The Infection Control Report form is located at each nurse's station.

2. The report is to be completed by a licensed nurse when any resident or staff exhibits symptoms of an infectious disease. The following is a list of possible symptoms:
   
   A. Abnormal finding of physical examination (i.e., redness, swelling, rashes, lice, etc.)
   B. Laboratory studies suggestive of infection.
   C. Temperature elevation above 100° orally, 101° rectally.
   D. Any employee in bed 24 hours with suspicion of medical/infectious problems.
   E. Nausea, vomiting, diarrhea of continuous or severe nature.
   F. History of hepatitis, VDRL, TB within the past year.
   G. Purulent wound or skin infection.
   H. Draining lesions.
   I. Abnormal discharge from any orifice.
   J. Any staff on any antibiotic or anti-infective medication.
   K. Positive mantoux/positive chest X-ray.

3. The form is to be completed when any staff "calls off" sick because of infectious signs/symptoms. It is the responsibility of each employee to notify the Nurse.

4. The form is to be completed by the Nurse when any resident presents with infections signs or symptoms.

5. The form is to be completed by the Nurse when any potential source of infection is discovered in the environment. (Examples include but are not limited to molds, ants, unsanitary conditions, etc.)

6. The Infection Control Designee will review the report.

7. If the report is resident related, the original copy will be filed in the monthly Infection Control Log.

8. If the report is employee related, the form will be placed in the Infection Control Log.
9. If the reporting form is environmental, the original copy will be filed, after review, in the monthly Infection Control Log. The copies will be made available to the Clinical Director.

**Infection Definitions**

**Nosocomial infection**

Nosocomial infections are infections acquired directly or indirectly in a medical setting. The probability of a microorganism causing infection in a host is dependent upon the dose (number of microorganisms), a receptive host site of contact with the organism, time of contact (sufficient for multiplication or not) and the virulence of the organism.

**Routes of transmission**

- Direct contact transmission involves direct physical transfer of microorganisms from an infected or colonised person to a susceptible host. Indirect contact transmission involves the contact of a susceptible host with a contaminated inanimate object, such as contaminated instruments or equipment.
- Droplets are generated during coughing, sneezing, talking, and during certain procedures such as suctioning and bronchoscopy. Transmission occurs when droplets containing microorganisms come in contact with the conjunctiva, nasal mucosa or mouth of a susceptible person.
- Airborne transmission occurs by dissemination in the air of either droplet nuclei or dust particles containing the infectious agent. Microorganisms carried in this manner can be widely dispersed via air currents and can remain airborne for long periods before being inhaled by the susceptible host.
- Vehicle transmission applies to microorganisms transmitted by contaminated food, water, drugs, blood or body fluids.
- Vectorborne transmission occurs when mosquitoes, flies, rats or other vermin transmit microorganisms

**CONTROLLING INFECTION SOURCES**

**Autogenous Sources**: Self-infection from the normal organisms in or on the person himself.

**Human Sources**: All humans are potential reservoirs of infectious disease organisms that can be transmitted to a susceptible host.

**Environmental Sources**: An indirect means of transmission. Some microbes can survive for relatively long periods in an inanimate environment.

**Ingestible Vehicles**: Ingestible materials, such as food, water, and milk can be considered infectious disease sources.
EXAMPLES OF CONTACT TRANSMISSION ROUTES

Direct contact - The most common routes are touching, kissing and sexual intercourse.

Indirect Contact - The spread of infection via non-living objects such as linens, clothing, instruments, and dressings.

Droplet Spread - Agents of disease can be spread by droplets of saliva or mucous discharged into the air by coughing, sneezing, laughing or talking. Such droplets travel less than one meter through the air from the reservoir to host.

EXAMPLES OF ROUTES OF TRANSMISSION OF INFECTION

<table>
<thead>
<tr>
<th>MODE</th>
<th>TYPE</th>
<th>DISEASE</th>
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<tbody>
<tr>
<td>CONTACT</td>
<td>DIRECT</td>
<td>HEPATITIS A /HCV</td>
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<td>PSEUDOMONAS</td>
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<td>INFECTION (SOME)</td>
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<td>MALARIA (NEEDLE)</td>
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<td>HEPATITIS B</td>
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<td>STREPTOCOCCAL</td>
<td>INFLUENZA</td>
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<td>FOODBORNE</td>
<td>SALMONELLOSIS</td>
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<td>STAPHYLOCOCCAL</td>
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<td>DISEASES</td>
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STANDARD:
State Health Departments maintain a tuberculosis registry of all persons in their jurisdiction with current TB.

POLICY:
The Nurse coordinates the facility's program to control the transmission of T. B. All clients presenting for admission will be required to complete a T.B. test. All new hire staff will be required to complete a T. B. test as part of their new employee physical.

PROCEDURES:

1. All clients and staff will be required to receive T.B. testing through RHG and/or a referred provider.

2. The result will become part of the client’s chart or in the case of staff, their HR file.

3. Individuals who present with a positive Mantoux test will be required to receive a chest x-ray. Employees must present a negative chest x-ray prior to returning to work. To treat or not treat with medication is the decision of the attending physician or designee. Clients with a positive Mantoux test will be referred to the attending physician for treatment.

4. If a client or staff had a positive Mantoux test in the past, a TB symptom questionnaire will be completed and reviewed by the Infection Control designee. Results will be discussed with the Medical Director. A referral for treatment and follow up will be the decision of the Medical Director or primary care physician.

5. T. B. assessments will be performed annually on employees and clients.
Infection Control Report

Use Black Ink Only

Name: __________________________ Age: ________ Sex: ________

Address: ____________________________

Home Phone: ___________ Alt. Phone: ___________

Circle One:   Resident   Visitor   Employee

Date Symptom Developed: ___________ Time: ___________

Attending Physician (if applicable): __________________________

Describe Condition Before Symptom Noticed: __________________________

Please Check If Appropriate:

_____ Abnormal Finding of Physical Examination
_____ Laboratory Studies Suggestive of Infection
_____ Temperature Elevated Above 100 degrees Orally
_____ Any Resident in Bed 24 hours With Suspicious Problems
_____ Nausea, Vomiting, Diarrhea of Continuous or Severe Nature
_____ History of Hepatitis, VDRL, TB Within Last Year
_____ Purulent Wound or Skin Infection
_____ Location of Draining Lesions __________________________
_____ Abnormal Discharge from Any Orifice
_____ Any Staff or Resident on any Antibiotic or Anti-Infective
_____ Positive Tine Test/Positive Chest X-Ray

Was Physician Called? Yes________ No ________ Time: ___________

Physician Responding: __________________________ Time: ___________

Medical Aid and/or Nursing Intervention:

Action/Education:

Signature of Person Initiating Report: ______________ Date: ___________

Infection Control Designee: __________________________ Date: ___________
TB FORM

Name:_______________________________________________

Address: _____________________________________________

City: _____________________  State:____ Zip:_____________

Telephone:____________________________________________

Skin Test Information ___________________________________

Administrator Name _____________________________________

Date Administered _______________ Time __________________

Arm of Skin Test Placement (circle)    Left    Right

Brand of PPD Solution ___________________________________

Lot# _______________  Expiration Date of PPD Solution ________

Results: Induration = ____ mm Date of Reading ________ Time ____

Name of Reader _________________________________________

Signature: _____________________________________________
Policy and Procedure Manual

Information Management (IM)

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IM-01  Release of Information
IM-02  Release and Disclosure of Confidential Information
IM-03  Release of Information for Legal Investigation
IM-04  Faxing of Medical Information
IM-05  Patient request to Inspect, Amend or Copy Protected Health Information.
IM-06  Compilation, Storage, Dissemination, and Destruction of Medical Record
IM-07  Clinical Charting Policy
IM-08F  Content of Medical Record
IM-08T  Content of Medical Record

Approved Abbreviations for Renaissance Healthcare Group, LLC
Notice of Privacy Practices
Authorization for Release of Information
Revocation of Authorization for Release of Information
Request of Accounting of PHI Disclosure
Request to Inspect or Copy Protected Health Information
Request to Amend Protected Health Information
Policy: Original Medical records, although kept for the benefit of the residents, are the property of RHG and can only be removed in accordance with a court order.

Resident Records and communication between staff members and residents shall be protected as stated in Section 394.4615, F.S., 42 CFR, Part 2, HIPPA, 65E-5, F.A.C. and/or T.C.A. 33-3-104(10).

RHG medical records contain information related to psychiatric, HIV, drug and alcohol, and medical treatment and as such are considered super confidential.

- Release of any information in the record is subject to state and federal laws.
- Only the medical records representative(s) will process requests for release of information to ensure that the release complies with applicable state and federal laws.
- Information for the records (copies) can only be released with a valid authorization from the resident or by court order.
- Records will be available for use within the facility by all authorized patient care staff.

Procedure: All clients are given a Notice of Privacy Practices at admission. A signed copy by the patient or guardian will remain on the chart acknowledging that the client has read and approved the Notice of Privacy Practices.

1. Authorizations- Prior to any use or disclosure health information an Authorization to Release Confidential Information will be signed by patient or guardian. Authorizations are valid if they contain all of the following information:
   a. Name of the facility that is to release information.
   b. Name of the person or institution and address the information is to be given.
   c. Name of the patient.
   d. Specific items to be released.
   e. Expiration date of authorization
   f. Right to revoke authorization
   g. Statement of potential re-disclosure
   h. Signature of patient or legal representative.
   i. Signature of a witness who observed the signature.
   j. Dated at the time of signature.
   k. A legible photocopy of the authorization is acceptable.

2. Revocation- Revocation of authorizations are valid if they contain the following information.
   a. Name of the patient
   b. Date of original consent.
   c. Effect of revocation.
   d. Effective date of revocation.
   e. Signature of patient or legal representative.
f. Signature of a witness who observed the signature.

3. **Exceptions**- In a life threatening situation or when an individual’s condition or situation precludes the possibility of obtaining written consent, Pasadena Villa may release medical information to the medical personnel responsible for the individual’s care without the individual’s authorization, if obtaining such authorization would cause any excessive delay in delivering treatment to the individual.

4. **Accounting**- Clients have the right to request an accounting of certain instances when protected health information about them is disclosed. The accounting will be in writing within 60 days of receipt of the request and include the following:
   a. Date of disclosure
   b. A brief description of the protected health information disclosed
   c. A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure and/or a copy of the Authorization to Release Confidential Information
   d. Name and title of the person or officer responsible for receiving and processing request of an accounting by individuals.

   The first accounting to an individual in any 12 month period will be without charge. A copy of the document will be retained with the chart.

5. **Refusal to Honor Authorizations-RHG** will refuse to honor a written authorization if there is:
   a. Reasonable doubt as to the identity of the person presenting the authorization, or evidence that the person requesting the information is not the person named in the authorization or refusal to offer reasonable proof identity.
   b. Reason to suspect that the patient’s signature is not authentic.
   c. Reason to question the current validity of an authorization because it is general in nature and does not specifically identify the type of records to be released or the specific item to be released.
   d. The physician and/or Clinical Director documents that release of information is detrimental to the resident.
   e. The physician may dictate a report of the examination and treatment in lieu of releasing copies of the record.

6. **General Guidelines:**
   a. Only those portions of the record specifically requested will be released.
   b. Written consent is not required by staff for use of the record for information for: business office procedures, monitoring and evaluating quality of resident care, reviewing work performance, official surveys for compliance and accreditation, regulatory and licensing standards, or for educational purposes and/or approved research programs which do not include the identity of the resident.
   c. Requests from physicians who are attending the resident at the time of the request will be honored. Physicians not attending the resident will not be honored, unless it is for approved research or study, in which the resident’s identity is not to be used.
   d. Third party records will not be released.
   e. All requests for records will be logged in the Log of PHI in the resident’s chart.
POLICY: It is the policy of RHG to take all reasonable steps to satisfy its legal or moral obligation for information of a confidential nature, which is created or obtained through the daily operation of the Facility.

During the course of the delivery of health care and the conduct of business activities within the facility, a large quantity of information, verbal and written, in the form of records and reports is created, accumulated, transmitted, and/or retained. Some significant portion of this information is of a private, personal nature, is strictly business oriented, or is of such nature that its disclosure might result in an adverse reflection upon the system or upon another party. The indiscreet and/or untimely disclosure of such information, however innocently tendered, is a breach of trust and is to be avoided. Special care is to be exercised in the dissemination, disclosure and release of such information both within and without the facility.

CONFIDENTIAL INFORMATION- This term is construed to include patient information and medical records, all information pertinent to employees and their employment records, business and financial information, and such other information as may be determined for "official use" only.

PROCEDURE:

1. The general rule is that such information will be transmitted or released only to those individuals or organizations on an official need to know basis.

2. The general rule in all instances will be applied consistent with any statutory or regulatory requirement(s), the customary practices prevailing in the conduct of business activities and operations, the desirability to cooperate and extend mutual courtesies to other parties and organizations, and the responsibility to provide a service requested by employees or residents or to accommodate to their written instructions concerning the dissemination and release of information personal to them.

3. Resident information and medical records will be treated as required by law, customary practice and RHG policy and procedures. Managing Director should be consulted when these guidelines are not sufficient.

4. Information pertaining to employees, either individually or collectively, will be treated consistent with legal requirements, policy and procedures of RHG and the expressed wishes of respective employees.

5. Financial information will be administered in such a manner as to conform with legal requirements, RHG policy and procedures and the customary practices in the community and industry.

6. Other information deemed confidential will be administered consistent with the above guidelines in a prudent manner by the responsible department supervisor.

7. The dissemination and release of information to the news media will be coordinated between the Managing Director and Clinical Director.
8. The provisions of this directive are not intended to deny or delay the dissemination and release of confidential information when such is necessary or desirable to the delivery of health care, the conduct of business, and to other operational facets of the organization.
POLICY: It is the policy of RHG to release appropriate information to attorneys who are investigating or bringing a lawsuit involving RHG utilizing the below procedure.

NOTE: A subpoena is not sufficient for this purpose (a Court Order is an order, signed by a Judge, for release of the records).

PROCEDURE:

1. All court orders, subpoenas, or legal correspondence from attorneys that may be relevant to a potential or actual lawsuit will routinely go to the Managing Director.

2. All court orders, subpoenas, or legal correspondence from attorneys will be reviewed by the Risk Manager prior to honoring the request(s) to facilitate early identification of potential or actual lawsuits.

3. The Managing Director will be responsible for releasing the information to the courts or attorneys.
POLICIES AND PROCEDURES

SUBJECT: FAXING OF MEDICAL INFORMATION

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

POLICY NO. IM-04

PROGRAM: All Programs

POLICY: It is the policy of RHG to limit the faxing of medical information concerning residents at the facility. Faxing will be done only in accordance with this policy and will be accompanied by the fax cover letter provided for in this policy.

The faxing of patient information is a valuable technology for immediately meeting patient care needs for information, particularly in the event of a medical emergency. However, the faxing of patient information places the facility at risk for breach of confidentiality due to lack of control over the recipient of the information, and due to the element of human error involved in misdialing a number or sending the information to a wrong number.

PROCEDURE:

1. Resident medical information will be transmitted to outside facilities by fax only for urgent and immediate treatment needs when the mail delivery or overnight mail copies will not serve, and only as needed for patient encounter.

   (NOTE: Information may be faxed to third party payors to maintain certification of treatment.)

2. Faxing of medical information will not be used for routine release of information to insurance companies, attorneys, or other health care entities for convenience.

3. The Compliance Manager will determine when faxing is appropriate in questionable instances.

4. A faxed authorization will be considered valid for release of information if it meets the requirements of a valid consent form.

5. Information will be faxed only to and from machines located in secure areas as determined by a telephone call to the requestor prior to the faxing of information.

6. The information will be faxed using the cover letter. If the receiver does not call to acknowledge receipt, as directed by the cover letter, a follow-up call will be made to ensure the information was received.

7. If information is inadvertently sent to a wrong number (misdialed, wrong number, etc.) An incident report will be completed giving complete details of the error and will be submitted to the Risk Manager.
8. If a fax is received in error, the sender will be notified that it has been received and the copies will be shredded.

9. In the event of a medical emergency when the patient is unable to sign the consent form, information will be faxed only to a physician (using the above guidelines); the complete circumstances of the faxing of the information will be documented and filed in the resident’s medical record.
POLICY: RHG, in compliance with all state and federal regulations concerning protected health information provides each current or former client the right to inspect their record. Patients have the right to request an amendment (clarification or challenge) to their medical/clinical file if they feel the information is incorrect or inaccurate, in writing.

PROCEDURE:
Inspect/Copy: Clients should submit their request to Inspect or Copy to the Patient Advocate. The Patient Advocate will review the request and provide a written response within 15 days.

Amendment: Clients should submit their request to Amend to the Patient Advocate. The Patient Advocate will review the request or appoint an individual not involved in patient care to review and provide a written response within 5 days. These requests for amendments and responses are to be placed in the clinical file. All denials will be reviewed by the Risk Manager and/or Clinical Director within the week with a response in 5 days.
POLICIES AND PROCEDURES

SUBJECT: COMPILATION, STORAGE, DISSEMINATION and DESTRUCTION of MEDICAL RECORDS

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

POLICY NO. IM-06

PROGRAM: All Programs

POLICY: It is the policy of RHG to ensure the safety and confidentiality of Resident Records at all times.

PROCEDURE:

1. All records of current patients are kept at the staff desk or internet based secure records system, which will be accessible to authorized personnel only. The facility shall maintain a master filing system, which includes a comprehensive record of each resident’s involvement in every aspect of the program.

2. Any resident information delivered to the facility will be scanned immediately into the resident’s electronic record. (Examples: transcribed reports, assessments from various clinical personnel, consultations from outside sources, past records).

3. Information is released only with an authorization except where stated in the Release of Information policy. Requests for information, when satisfied, are placed in the resident record.

4. After discharge, medical records are maintained in a locked medical records room with access limited to authorized personnel only.

5. Resident paper records shall be maintained on-site for a minimum of seven (7) years from the date of the last entry. After such time the facility may microfilm or scan the records and shred, through a professional shredding company, all documents and records.

6. Electronic records will be maintained on a HIPAA compliant electronic health record software system.

7. Each employee will have a unique ID and password to access the record system with access limited to the individual’s role within the company. Employees are not to loan/borrow other’s login.

8. Each author should “lock” their final entry to ensure privacy and accuracy of the medical record.
POLICY: It is the policy of RHG to maintain a record on each resident, which is located on a secure HIPPA compliant internet based database. The resident record contains past and current data regarding the resident and his/her progress throughout their treatment at the facility.

PROCEDURE:

Documentation in the clinical record must be completed in accordance with state licensing and accrediting bodies. Each entry is labeled by date and time and locked by author when completed.

Only licensed nurses and physicians (and medical interns) will make entries relative to nursing issues (such as medication and their effects, treatment, and assessment of medical/physical complaints.)

All significant events will be charted in individual charts and include but not limited to:

A. Psychotic behaviors
B. Mood swings
C. Verbal threats
D. Sexual behavior
E. Aggression toward self or others
F. Suicidal ideation or attempts
G. Emergency phone calls:
   (1) Police
   (2) Rescue
   (3) Physician
   (4) Ambulance
   (5) Supervisor
H. Change in eating and/or sleeping habits
I. Passes off grounds without supervision of staff
J. Visits from significant others and how tolerated
K. Physical and somatic complaints
J. Significant change in mental status
L. Elopement
M. Hospitalization
N. Any other event resulting in unusual incident reports
O. Abnormal lab values and action taken

"Late Entry" notes will be used, if necessary, are to be clearly labeled as such, and are to indicate the current date.

Documentation will be divided by discipline as follows:
# Policies and Procedures

## Admissions staff or designee:
- Emergency Contact Sheet: Admission
- Notice of Privacy Practices: Admission
- Resident Rights: Admission
- Resident Responsibilities: Admission
- Consent for Treatment: Admission
- Equine Consent (TN only): Admission
- Authorization for Release of Information: Admission

## Nurses:
- Vital Signs and Weights: Weekly
- Dental/medical Form: Admission
- Functional Assessment: 21 days
- TB form: Admission
- Nursing Assessment: Admission
- Weekly Nursing Summary: Weekly
- MAR: Daily

## Physicians/Medical Interns:
- Psychiatric Admission Evaluation: one Week
- Psychiatric Progress Report: Weekly
- Physicians Orders: PRN
- Abnormal Involuntary Movement Scale: PRN
- Discharge Summary: Within 15 days of discharge

## Therapists/Counseling interns (including Clinical Services Managers):
- Initial Treatment Plan: 72 hours
- Psychosocial History: 21 days
- Master Treatment Plan: 30 days
- Treatment Plan Review: Every 30 days
- Substance Abuse Assessment: 7 days
- Referral Communication Log: Weekly, PRN
- Group Notes: Daily on each group completed
- Family Sessions: Weekly
- Psychotherapy Notes: Weekly
- Transition Plan: PRN, change of level of care
- Suicide Risk Assessment: PRN
- Therapeutic Alliance: PRN
- Therapeutic Off Grounds Pass Plan: PRN
- Discharge Summary: Within 15 days of discharge
- Transfer Log/Communication Record: PRN, change of location

## Recreation and Adjunctive Therapists and Equine Program Coordinator:
- Recreation Therapy Assessment: 7 days
- Recreation Therapy Group Note: Weekly
## Residential Care Coordinators:
<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property Inventory (TN only)</td>
<td>Admission</td>
</tr>
<tr>
<td>Interdisciplinary Progress Note</td>
<td>Daily</td>
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</table>

## Case Managers:
<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Action Plan</td>
<td>30 days</td>
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<tr>
<td>Action Plan Review</td>
<td>Every 30 days</td>
</tr>
<tr>
<td>Case Management Note</td>
<td>Weekly</td>
</tr>
<tr>
<td>Aftercare Plan</td>
<td>Within 15 days of Discharge</td>
</tr>
</tbody>
</table>

## Life Skills Mentor
<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oasis Progress Report</td>
<td>Monthly</td>
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</table>

## Outside Providers:
<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and Physical</td>
<td>30 days from admit or 60 days prior to admit</td>
</tr>
<tr>
<td>Labs</td>
<td>PRN</td>
</tr>
</tbody>
</table>

Documentation that is not completed in a timely manner will be addressed with the Compliance Manager and direct supervisor and may subject to disciplinary process.
Policy:
The Medical Record will be maintained by clinical staff under the following general guidelines for documentation and consists of reports listed in this policy, which must be completed in accordance with the time frames and approved formats specified in this policy. Any proposed changes in any medical record report must be reviewed and approved by the Management Team and forwarded to the Governing Board for their concurrence.

Procedures:

General Guidelines:

1. All medical records are the property of RHG and may only be removed from the facility’s premises by subpoena, court order or statute.

2. The medical record shall be confidential, current and accurate.

3. All entries in the medical record must be legible.

4. Progress notes shall include all significant clinical information or events pertaining to the resident.

5. No abbreviations may be used when entering the final diagnosis in the medical record.

6. Correction of errors in the medical record shall be made in the following manner:

   A line shall be drawn through the erroneous statement, initialed, dated and the correct statement written below.

7. Only those abbreviations on the Approved Abbreviation List for the facility may be used in the medical record.

Content of the Medical Record:

1. Face Sheet - to be completed by the admitting staff before admission and filed in the medical record immediately upon assembly of the record. The Face Sheet will include demographic information as well as emergency contact data.

2. Notice of Privacy Practices – to be completed by the admitting staff at the time of admission and filed in the medical record.

3. Psychiatric Evaluation - to be completed by the attending psychiatrist within 21 days of admission in the approved format and the full dictated report entered into the record within 30 days of admission.
4. Physical Examination:
   
a. To be initiated on each new resident within 24 hours of admission by the off campus community provider physician, if the resident does not come for admission with a physical examination not older than 60 days old. The physical examination shall be completed within thirty days of admission. The physical examination will include, at a minimum: (a) a medical history, including responses to medication, physical diseases and physical handicaps; (b) the date of the last physical examination; (c) a description of physical status, including diagnosis and any functional limitation; (d) recommendations for care, including medication, diet; and (e) to the extent possible, a determination of the presence of a communicable disease.

   b. The attending psychiatrist may accept a prior history and physical on a direct admission from an acute care facility if the history and physical has been completed within 60 days prior to admission. He must review the history and physical and document that it is acceptable by signing and dating the history and physical and documenting on the Doctor's Order Sheet that it is acceptable.

5. Consultation Reports (off campus community providers) are to be filed immediately upon the resident's return from the consulting physician's appointment.

6. The attending physician shall give an order for each admission.

7. Psychosocial History - to be completed by the Therapist within 21 days of admission, and included in the resident record within 30 days of admission. The Psychosocial History and Assessment will include: (a) developmental problems, including past experiences that may have affected development; (b) peer group relationships and activities; (c) social skills deficits; (d) past and present relationship with family and community; (e) prior placement settings; (f) recreational experiences, activities and interests; (f) expectations and role of the family in the treatment process; (g) psychiatric history, including any previous treatment and the reason for termination; (h) vocational history; and (i) educational history.

8. Nursing Admission Assessment - to be completed by the unit nurse on the day of admission on all new admissions.

9. Psychological Evaluation - to be completed by a psychologist within (7) seven days of completion of testing, when applicable.

10. Chemical Dependence Assessment – to be completed as part of psychosocial when needed.

11. Educational Assessment – to be completed by a therapist when needed.

12. Speech, Hearing and Language Screening - to be completed during the physical examination with referral for further evaluation when indicated.

13. Medical History and dental screening forms are completed by the patient or guardian immediately after admission.

14. Nutritional Screening - to be completed as part of the nursing assessment.
15. Initial (Preliminary) Plan of Care - to be completed by the assigned therapist within seventy-two (72) hours of admission by the assigned therapist in the approved format.

16. Functional Assessment – to be initiated within seven (7) days of admission.

17. Master Plan of Care - to be completed within thirty (30) days of admission by the assigned therapist based on information from the assessments in the approved format. The Master Plan of Care must contain:
   a. Discharge Criteria
   b. Treatment goals based on the assessments
   c. Objectives stated in incremental steps to achieve the treatment goals and a projected date for achievement.
   d. Interventions to meet the treatment goals to include the person responsible for the intervention and frequency of the intervention.
   e. Discharge Plan.

(Note: The therapist is responsible for informing the parents or guardians of the patient’s treatment progress, reviewing the treatment plan and all updates with them, and to obtain patient signatures on the treatment plan and updates.)

18. Review of Plan of Care and Plan of Care Update – reviews will be completed by the assigned therapist every thirty (30) days and Treatment Plan Update, which shall occur every thirty (30) days.

19. Physician’s Progress Notes – To be handwritten or dictated in the approved format within ten (10) days after the weekly session of patient’s treatment and progress in all clinical areas.

   Family and Individual Therapy summary notes - to be written within seventy-two (72) hours after the final weekly session in the approved format by the Family or Individual Therapist.

20. Nursing Progress Notes - to be completed weekly, summarizing the patient’s treatment. In addition, nursing assessment notes are to be written as necessary for critical events arising during patient’s stay.

21. Record of Vital Signs and Weights - to be completed by the nurse.

22. Interdisciplinary Progress Notes – to be written by clinical staff other than the attending physician generally once per day, or as needed.

23. Physician Orders – orders are to be written by the physician subject to the following guidelines:
   1. Telephone orders are acceptable only when the following stipulations are met:
      a. The situation is an Emergency and/or the situation is URGENT.
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   2. Psychiatric Evaluation must include the patient’s diagnosis.
3. Only the attending physician can order a discharge and the discharge can be ordered no more than twenty-four (24) hours prior to the discharge and must be documented in the medical record prior to discharge.

24. Medication or treatment shall be administered only upon written and signed orders of a practitioner acting within the scope of his/her license.

25. Medication Administration Records – will include date, time, medication given, dosage as well as over the counter medication. The MAR will be filed in the medical record at the end of each month.

26. Discharge Summary - to be completed, in the record within thirty days of discharge of the patient in the approved format. The attending physician is responsible for completion of the discharge summary.

27. Completion of the discharged record - It is the responsibility of all members of the clinical staff to insure that the discharged medical record is completed, including signatures, within thirty (30) days after discharge.

28. The approved admission and other consent forms are to be filed in the medical record.

 a. Authorization for Release of Information shall be filed each time information is released.
 c. Nursing Transfer Summary – completed upon transfer of patient to another facility and filed in the medical record
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   e. Advanced Directives.
   f. Residents Rights and Responsibilities
**Approved Abbreviations for Renaissance Healthcare Group, LLC**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2°</td>
<td>Secondary to</td>
</tr>
<tr>
<td>I8O</td>
<td>Intake and output</td>
</tr>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
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<td>AB</td>
<td>Abortion</td>
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<td>abd</td>
<td>Abdomen/Abdominal</td>
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<td>a.c.</td>
<td>Before meals</td>
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<td>ID</td>
<td>Intradermal</td>
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<td>Advanced cardiac life support</td>
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<td>act</td>
<td>Activity</td>
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<td>ADL</td>
<td>Activities of daily living</td>
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<td>int.</td>
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<td>IOP</td>
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<td>a.m.</td>
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<td>AMA</td>
<td>Against medical advice</td>
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<td>AMI</td>
<td>Acute myocardial infarction</td>
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<td>Altered mental status</td>
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<td>Isolation</td>
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<td>International units per milliliter</td>
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<td>Intravenous</td>
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<td>Joint Commission on Accreditation of Healthcare Organization</td>
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<td>Advanced Registered Nurse Practitioner</td>
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<td>K</td>
<td>Potassium</td>
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<td>kg. KG</td>
<td>kg kilogram</td>
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</table>
KVO  Keep vein open
L    Liter
AU   Both ears
BC   Birth control
BM   Bowl movement
B/P  Blood pressure
bs   Bowl sounds
BS   Breath sounds
B/S  bedside
Lab/Lab Laboratory
Lap. Laparotomy
lat. Lateral
lax. Laxative
lb. LB pounds
LD   Learning disability
lg. Large
liq Liquid
LL   Left leg
Ca   Calcium
cal. Calorie
cap Capsule
CBR  Complete bed rest
CDR  Center for Disease Control
LOA Leave of absence
LOS  Length of stay
LPN  Licensed practical nurse
chg Change
ck   Check
cl   Clear
cm. Centimeter
CNA  Certified Nurse Assistant
M    Male
max Maximum
mcg  Microgram
C/O  Complain of
conf. Conference
cont. Continue
cont’d Continued
CP   Chest pain
CPR  Cardiopulmonary resuscitation MCM/L micromoles per liter
M.D. Doctor of Medicine
Meds Medication
Mg   Magnesium
MG/mg Milligram
C-Section CS-cesarean section
CV    Cardiovascular
CVA   Cerebrovascular accident
CXR   Chest x-ray
MHT   Mental health technician
MI    Myocardial infraction
misc  Miscellaneous
ml    Milliliter
ML    Milliliters per 100 milliliter
MM, mm Millimeter
MOM   Milk of magnesia
MRI   Magnetic resonance imaging
MRI#  Medical record number
MSW   Master of social work
MVA   Motor vehicle accident
MVI   Multivitamin
Na    Sodium
N.A.  Narcotics Anonymous
N/A   Not applicable
DBP   Diastolic Blood pressure
D&C   Dilatation and curettage
D/C   Discontinue, discharge
DCF   Department of children & family
DDS   Doctor of Dental surgery
D.E.A. Drug Enforcement Agency
del.  Delusions
neg   Negative
nml   Normal
NH    Nursing home
NIDDM Non-isulin dependent diabetes mellitus
NKA   No known allergies
Dept/dept Department
detox Detoxification
Diff  Differential count
Dig   Digoxin
DKA   Diabetic Ketoacidosis
DM    Diabetes Mellitus
DNR   Do not resuscitate
D.O.  Doctor of Osteopathy
DOA   Dead on arrival
DOB   Date of birth
DON   Director of nursing
Dr.   Doctor/Physician
dsg   Dressing
NPO   Nothing per os
Nsg   Nursing
NSR  Normal sinus rhythm
NSAID  Non-steroidal anti-inflammatory drug
NTG  Nitroglycerin
N/V  Nausea and vomiting
OB  Obstetrics
O2  Oxygen
OCHD  Orange Co. health Department
DT  Delirium tremens
DVT  Deep vein thrombosis
Dx  Diagnosis
oint.  Ointment
o.k.  Okay
OR  Operating room
Oriented x3 oriented to person, place & time
ECG, EKG  Electrocardiogram
ECT  Electroconvulsive therapy
ED  Emergency department
ed  Education
EEG  Electroencephalogram
EENT  eyes, ears, nose, throat
e.g.  Example
EMS  Emergency Medical System
EMT  Emergency Medical Technician
O.S.  Left eye
OT  Occupational therapist/therapy
OTA  Occupational therapist assistant
OTC  Over the counter
O.U.  Both eyes
P.A.  Physician’s assistant
E.P.A.  Extra-pyramidal side effects
ET  Endotraceal
ETOH  Ethyl Alcohol
p.c.  After meals
P/E  Physical examination
PCM  Patient Care Manger
PERLA  Pupils equal & reactive to light
ex  Exercise
F  Female
fax  Facsimile
FBS  Fasting blood sugar
FB  Foreign body
FDA  Food and drug administration
p.m.  Afternoon
FHx  Family history
fl  Fluid
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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>Freq.</td>
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<td>By mouth</td>
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<td>pos.</td>
<td>Positive</td>
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<td>Post-op</td>
<td>Postoperative</td>
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<tr>
<td>p.r.n.</td>
<td>As necessary</td>
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<td>F/U</td>
<td>Follow up</td>
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<td>Fracture</td>
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<td>Hemoglobin and hematocrit</td>
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<td>H&amp;P</td>
<td>History and physical</td>
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<td>Pasadena Villa at Lake Highland</td>
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<td>Preoperative</td>
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<td>q2*h</td>
<td>Every 2 hours (*3,4,…)</td>
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<tr>
<td>q a.m.</td>
<td>Every morning</td>
</tr>
<tr>
<td>q.d.</td>
<td>QD everyday</td>
</tr>
<tr>
<td>q.h.</td>
<td>Every hour</td>
</tr>
<tr>
<td>q.h.s.</td>
<td>Every night at bedtime</td>
</tr>
<tr>
<td>q.i.d.</td>
<td>Four times a day</td>
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<tr>
<td>q.o.d.</td>
<td>Every other day</td>
</tr>
<tr>
<td>qt.</td>
<td>Quart</td>
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<td>PV</td>
<td>Pasadena Villa</td>
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<tr>
<td>RBC</td>
<td>Red blood cells</td>
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<td>HR</td>
<td>Heart rate</td>
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<tr>
<td>h.s.</td>
<td>At bedtime</td>
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<td>HTN</td>
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<td>r/t</td>
<td>Related to</td>
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<td>Rx</td>
<td>Prescription</td>
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<td>Tsp</td>
<td>Teaspoon</td>
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<td>Tues.</td>
<td>Tuesday</td>
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Tx  Treatment
UA  Urinalysis
UO  Urine output
SA  Pasadena Villa at Summerlin Ave
Sat  Saturday
SBP  Systolic blood pressure
S.I.  Suicide Ideation
SNF  Skilled Nursing Facility
S/O  Significant Other
SOB  Shortness of Breath
UTI  Urinary Tract Infection
vc’s  Verbal Cues
VD  Venereal Disease
V.O.  Verbal Order
V.S.  Vital Signs
WBC  White blood cells
SQ  Subcutaneous
Stat/STAT  at once
STD  Sexually transmitted disease
Sun.  Sunday
supp.  Suppository
Wed.  Wednesday
WNL  Within Normal Limits
W/Wt  Weight
X/x  Times
XR  X-Ray
SW  Social Work
L  Left
R  Right
M  Male
F  Female
Change
tab.  Tablet
TB  Tuberculosis
=  Greater than or equal to
<  Less than
~  Approximate
#  number
@  At
tbsp.  Tablespoon
Thurs.  Thursday
1x  Once
2x  Twice
%  Percent/Percentage
POLICIES AND PROCEDURES

+ Positive/present
- Negative/absent
\* Foot/feet
\" Inches
2o Secondary
w/c With
w/o, s Without
a Before
x Except
p After
q Every
Renaissance Healthcare Group, LLC
Authorization to Release Confidential Information

Patient Name: ______________________________________

Information to be Used or Disclosed includes:
( ) Psychiatric Evaluation   ( ) Consultations
( ) Psychological Evaluation/History   ( ) Treatment Plan
( ) Admission/Discharge Summary   ( ) Physician Orders
( ) Medical Records   ( ) Progress Notes
( ) Vocational Assessment   ( ) Other _____________________

I hereby authorize Renaissance Healthcare Group and its subsidiaries to:

___ Disclose information to:       ___ Receive information from

For the purpose of: _______________________________________________________

Name of person or organization

Address, phone, fax

Expiration Date of Authorization
This authorization is effective for 12 months from the date of signature unless revoked or
terminated by the patient or the patient’s personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to
Pasadena Villa. You should contact any Clinical Staff to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the
person or organization to which it is sent. The privacy of this information may not be
protected under the federal privacy regulations.

Signature

_________________________  _______________________
Signature of Patient        Date

_________________________  _______________________
Signature of Witness        Date

_________________________  _______________________
Signature of Patient
Representative/Guardian    Date
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a residential treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for payment.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of Renaissance Healthcare Group. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapy students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our treatment center. Your information may be disclosed to but are not limited to interns, medical student and anyone else that may be designated as a business associate; who has executed a Business Associate Agreement. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:__________________________  Signature______________________Date_______
REQUEST FOR ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

Consistent with federal regulations, we will provide you with an accounting of certain disclosures of your protected health information. You will not receive an accounting for the following:

- Disclosures of your Protected Health Information for the purposes of treatment, payment, or the day-to-day operation of the medical practice
- Disclosures to law enforcement, correctional institutions, or for any other legally required or permitted disclosure listed on our Notice of Privacy Practices
- Disclosures that occurred prior to April 14, 2003, the effective date of the federal privacy rules
- Disclosures that occurred six or more years prior to the date of this request

We will contact you when the information you have requested is available, generally within 60 days of your request.

Name of Patient (Type or Print)

Signature of Patient       Date

Telephone Number

Street Address

City, State, Zip Code
REQUEST TO AMEND PROTECTED HEALTH INFORMATION

This form is to be used by patients who wish to request that information kept in the records of Renaissance Healthcare Group, LLC be amended. The following summarizes our policies and procedures with respect to amending patient information:

- Requests to amend information must be submitted in writing.
- Your request will be reviewed by the Clinical Director and other staff members as appropriate.
- If the Clinical Director determines that the amendment you have requested should be made, the records will be updated as required by federal regulations.
- If the Clinical Director determines that the information in our records is complete and accurate, your request will be denied. A written notice of this decision will be sent to you as required by federal regulations. You will have an opportunity to send us a written statement explaining your disagreement with this decision. That statement will be included in your records, along with any response that we believe is necessary to help future users of the information understand that information. You will be given a copy of any response that we include in the record.

Information to be Amended

Please identify the information that you believe needs to be amended in the spaces provided below. Identify the source of the information (for example, your medical records or billing records), the specific information that you believe to be incorrect and the reason you believe the information to be incorrect. If no reason is given, your request will be denied.

If you need help with this form, please contact:
Dr. George Kachmarik, Clinical Director
(407) 246-5250

Item to be changed:____________________________________________
Data Source:_________________________________________________
Change:_____________________________________________________
Reason:_____________________________________________________
*Response___________________________________________________
____________________________________________________________

Item to be changed:____________________________________________
Data Source:_________________________________________________
Change:_____________________________________________________
Reason:_____________________________________________________
*Response:__________________________________________________
____________________________________________________________

Attach additional copies of this page as needed.

Patient Signature
Please sign and date this form:

___________________________________________________________
Name of Patient
Decision

Approved amendments
The following requests for amendment of information have been approved:

This information will be corrected and other organizations to which this information has been disclosed will be notified as required by federal regulations.

Requests for Amendment That Have Been Denied
The following requests for amendment of information have been denied for the reasons given section describing the information you have requested:

This information will not be amended in our records. If you disagree with this decision, you may submit a written statement of disagreement. Your statement must be limited to one standard letter-sized page (8 inches X 11 inches) per correction. Your disagreement will be included in our records and it, or an accurate summary of it that we will prepare, will be transmitted to any entity to whom the affected information is disclosed in the future. We also may include own comments on your statements. If we do include such a statement, you will be sent a copy of the statement.

Title of Privacy Official

Signature Date
REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

This form is used by the patient to request an opportunity to examine or copy Protected Health Information in the possession of Renaissance Healthcare Group, LLC.

Information Requested
Please describe the information that you would like to examine or copy:

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Review Procedures
Your request to inspect or copy your Protected Health Information will be reviewed by the Clinical Director, who will determine if the information requested can be made available to you. We may legally prohibited from making certain information available to patients or patient representatives, including:

- Psychotherapy Notes
- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information that is related to medical research in which you have agreed to participate
- Information whose disclosure may result in harm or injury to you or to another person
- Information that was obtained under a promise of confidentiality

Within the limitations of the law, we will make every effort to accommodate your request.

We will complete our review of your request and either arrange for you to inspect your records within 30 days of your request, or provide you with a written explanation of any restriction on the information that we can provide you.

If we deny your request, in whole or in part, you may request that we review that decision.

Name of Patient (Type or Print)

<table>
<thead>
<tr>
<th>Signature of Patient</th>
<th>Date</th>
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</table>

Signature of Patient Representative

Relationship of Patient Representative to Patient
REVOCATION OF RELEASE OF INFORMATION

Revocation of Authorization
This notice revokes the authorization to the use and disclosure of protected health information for:

Patient Name (Please Print or Type)

That was signed on:

Date of Consent

Effect of Revocation
Protected health information that is collected on or after the date on which this form is received by Renaissance Healthcare Group, LLC will not be used or disclosed by Renaissance Healthcare Group, LLC for the purposes specified on the authorization that is revoked.

This revocation of authorization will not limit the ability of Renaissance Healthcare Group, LLC to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services, nor will it affect uses or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Other consequences of revoking authorization include:

Effective Date of Revocation
The revocation of authorization to use or disclose protected health information is effective _____/_____/_____.

Signature

Name of Patient (Print or Type)

Signature of Patient Date

Signature of Patient Representative/Guardian
Policy and Procedure Manual

Leadership
(LD)

Table of Contents

LD-01  Confidentiality
LD-02F  External Inspections, Reviews and Evaluations
LD-02T  External Inspections, Reviews and Evaluations
LD-03  Utilization Review

Utilization Review Form
Visitor Sign-in and Confidentiality Statement
POLICY: It is the policy of RHG to assure that the confidentiality of residents’ identities shall be protected in all Utilization Review/Medical Records activities in accordance with Federal HIPAA regulations.

PROCEDURES:

1. All records shall be subject to the same confidentiality procedures as applies to any other protected document.

2. Staff and interns will be required to attend an annual inservice on HIPAA laws and agency policies regarding patient confidentiality.

3. Staff will be required to have a HIPAA disclaimer on all clinical emails and faxes from the program. Fax numbers will be verified prior to transmission.

4. Staff will not discuss clients with identifying information via cell phone as this is not a secure form of communication.

5. Staff will be assigned a computer password to protect information when working at a computer station. Staff will sign out off prior to leaving the area.

6. Staff will use the clean desk protocol and clear the desk area of files and paperwork prior to leaving the area unattended by staff.

7. Verbal communications regarding clients will take place in offices or in a tone of voice that protects patient information from other clients and visitors.

8. The use of clients’ names or other identifying information, with the exception of the medical record number, in any final utilization review report which is not a portion of a resident’s clinical record is prohibited.

9. Visitors to RHG will be required to sign a Notice of Confidentiality, stating that they cannot release the names or identities of any resident at the facility for any reason.

10. RHG will not post signage on the outside of the building which identifies the facility as a treatment facility, nor will there be signage on any company vehicle which could compromise resident confidentiality.
POLICY:
It is the policy of RHG to assist with and facilitate a well organized and smooth inspection, review or evaluation from certain agencies, including the Agency for Health Care Administration (AHCA), the Alcohol, Drug Abuse and Mental Health (ADM) Program Office, and the Occupational Safety and Health Administration (OSHA). Such inspections may occur at any time and without warning, but can be anticipated annually to determine compliance with rules and standards. RHG shall afford these agency representatives with access to the facility and the documentation necessary to conduct inspections, reviews and evaluations. When a representative from these agencies presents himself to the Facility and requests permission to perform the inspection, the following procedure shall be followed.

PROCEDURE:

1. Immediately notify: Managing Director
   Clinical Director
   Program Manager

2. Representative verification:
   Review and copy identification presented. If there is any doubt, contact local office to verify that this is an authorized inspection.

3. Notify key staff as necessary.

4. Assemble staff requested.

5. Ask if there are photos to be taken. If there are, be prepared to have staff with camera accompany inspection team.

6. Have staff member arrange for a conference room where team can be reassembled for a closing conference.

7. Designated staff will accompany the agency representative.

8. If photos are taken, duplicate with facility camera.
9. If necessary, make a room available for the representatives to privately interview any employees selected.

   
   A. Review with representative any deficiencies, if any have been found.
   B. "Serious Deficiency," may indicate monetary penalties that will accompany citations. Ask questions for complete clarification.
   C. Ask representative specifically to indicate standards being referenced.
   D. Offer any additional information that could eliminate or reduce a citation or penalty.
   E. Request information concerning current procedures for appeal, if appropriate.
POLICY:
It is the policy of RHG to assist with and facilitate a well organized and smooth inspection, review or evaluation from certain agencies, including the Department of Mental health and Developmental Disabilities Office of Licensure and the Occupational Safety and Health Administration (OSHA). Such inspections may occur at any time and without warning, but can be anticipated annually to determine compliance with rules and standards. RHG shall afford these agency representatives with access to the facility and the documentation necessary to conduct inspections, reviews and evaluations. When a representative from these agencies presents himself to the Facility and requests permission to perform the inspection, the following procedure shall be followed.

PROCEDURE:

1. Immediately notify: Managing Director
   Clinical Director
   Program Manager

2. Representative verification:
   Review and copy identification presented. If there is any doubt, contact local office to verify that this is an authorized inspection.

3. Notify key staff as necessary.

4. Assemble staff requested.

5. Ask if there are photos to be taken. If there are, be prepared to have staff with camera accompany inspection team.

6. Have staff member arrange for a conference room where team can be reassembled for a closing conference.

7. Designated staff will accompany the agency representative.

8. If photos are taken, duplicate with facility camera.
9. If necessary, make a room available for the representatives to privately interview any employees selected.


   A. Review with representative any deficiencies, if any have been found.
   B. "Serious Deficiency," may indicate monetary penalties that will accompany citations. Ask questions for complete clarification.
   C. Ask representative specifically to indicate standards being referenced.
   D. Offer any additional information that could eliminate or reduce a citation or penalty.
   E. Request information concerning current procedures for appeal, if appropriate.
POLICY: It is the policy of RHG to monitor the allocation of facility resources in order to provide optimal achievable resident care in the most effective manner. All resident records will be subject to review, without regard to payment source, to evaluate the necessity and appropriateness of services and allocated resources to assure that the services are necessary, cost effective and effectively utilized.

PROCEDURE:

Each quarter, 20% of the current resident records will be chosen for extensive Utilization Review. The Managing Director will assign designated staff to perform a Utilization Review to ensure that at a minimum:

1. Resident admissions are appropriate;
2. Services are delivered in the least restrictive environment possible;
3. Resident rights are protected;
4. When permitted by the resident, the resident’s family or significant others are involved in resident assessment, treatment planning and discharge planning;
5. Treatment plans are comprehensive and relevant to resident needs;
6. Minimum standards for resident records are met;
7. Minimum therapeutic dosages of medication are prescribed and appropriately administered;
8. Specialty cases such as suicides, death, violence, staff abuse, and resident abuse are reviewed;
9. All major incident reports are reviewed;
10. The length of stay for each resident is appropriate;
11. Continuity of care is provided; and
12. Delay in receiving services is minimal.

Summary reports of Utilization Review will be reported quarterly to the CQI Committee, Management Team and Governing Board.

The quarterly summaries will be used as one tool to conduct an annual review of program effectiveness, program goals, policies, procedures and treatment provision.
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<th>INDICATOR</th>
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VISITOR SIGN-IN AND CONFIDENTIALITY STATEMENT

By signing below, I acknowledge that every aspect of care at Renaissance Healthcare Group, LLC is strictly confidential. The names and descriptions of residents, clients and visitors within the facility shall be held in confidence, and shall not be discussed with any other person outside of the facility. I shall adhere to all Federal and State confidentiality laws, rules, regulations and guidelines.

Visitors must sign this Confidentiality Statement upon their visit, but are not required to sign during each visit to Renaissance Healthcare Group, LLC.

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Incident Report

Use Black Ink Only

Name: __________________________

Circle:    Resident    Visitor    Employee

Pasadena Villa      CRH      TLLC      Smoky Mountain Lodge

Date of event or issue: ________________  Time: ____________________

Describe Event or Situation:

Attending Physician (if applicable)

Was Physician Called?  □ Yes  □ No  Time: ____________________

Physician Responding: ____________________  Time: ____________________

Staff Intervention/Action:

Result/Outcome/Next Step:

Signature and Title of Person Initiating Report  Date/Time

Signature of Clinical Services Manager  Date /Time

Risk Manager  Date/Time
Post – Occurrence Follow-Up

I. Reporting to State Agency

Was this an adverse incident or unusual occurrence that prompted reporting to the State:
  Y   N

If Yes, who was called: ______________________________________________________

Time and Date of Report: ____________________________________________________

Outcome of Report: ________________________________________________________

II. Internal Response

Steps taken to prevent reoccurrence of similar incidents:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Staff/Persons Involved in Determining Preventative Steps:

<table>
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<tr>
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Policy and Procedure Manual

Performance Improvement (PI)

Table of Contents

PI-01 Policy & Procedure
PI-02 Risk Management Program
PI-03 Contact with Media
PI-04 Designated Drivers
PI-05 Incident Reporting
PI-06 Clinical Privileging
PI-07 Quality Improvement Plan
PI-08 Chart Auditing

Incident Report
POLICY:
A formal organized system for the procurement and review of policies and procedures of RHG is essential to preserve the safety of our residents, personnel, visitors, and property, and to ensure the integrity of all services provided by the facility.

PROCEDURE:
1. All policies and procedures of RHG will be maintained in a Policy and Procedure Manual. The Manual will be reviewed on an annual basis and revised as the needs of individual residents or the living group change. The current Policy and Procedure Manual shall be available to staff and residents.

2. Designated staff are responsible for the review and revisions to existing policies or development of new policies/procedures.

3. Information relating to the policy/procedure review, revision or development of new policy/procedure will be documented in appropriate committee meeting minutes.

4. New/revised policies will be forwarded to the Managing Director.

5. Managing Director will submit a list of policies/procedures that were reviewed and copies of any new policies at the next regularly scheduled meeting of the management team.

6. The management team will note the discussion related to policy/procedure review process in meeting minutes and report this activity at the next governing board meeting.

7. With approval from management team and governing board, the reviewed, revised or newly developed policy/procedure will be signed by Managing Director, Clinical Director and Department Director, if applicable.

   A. Exception: In the instance a policy is required to be immediately effective, provisional approval may be given by the Managing Director and/or Clinical Director prior to the next regularly scheduled meeting of the management team.

8. The governing board meeting minutes will reflect the review of policies and procedures.

9. Original copies will be kept by Administration for inclusion in the master manual. Copies will be forwarded to designated departments for inclusion in their respective department manuals.
POLICIES AND PROCEDURES

SUBJECT: RISK MANAGEMENT PROGRAM

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

POLICY: Recognizing its duty to protect RHG’s assets from loss and to protect clients, employees and visitors from potentially unsafe equipment, facilities, systems or processes, RHG establishes a Risk Management Program.

PROCEDURE: The program shall contain the following components:

1. To investigate and analyze the frequency and causes of general categories and specific types of adverse incidents causing injury to residents, to prevent recurrence and to assist in preparation for defense of Pasadena Villa should an action be brought.

2. To develop appropriate measures to minimize the risk of injuries and adverse incidents to residents through the cooperative efforts of all personnel.

3. To analyze resident grievances which relate to resident care and the quality of medical services and, if possible, to resolve them without resort to legal action.

4. To develop and implement an incident reporting system based upon the affirmative duty of all health care providers and agents and employees of RHG to report injuries and adverse incidents to the Risk Manager.

5. To continually inspect RHG’s premises to discover and correct deficiencies in the physical plant that may present unacceptable risks to residents and others.

6. To continually review the performance of all persons providing care to residents within RHG, including physicians and employees of RHG, with the objective of discovering and correcting practices that may present unacceptable risks to residents.

   In order to achieve these goals, participation and cooperation of all physicians and facility personnel is required.

7. To analyze critical incidents with a Root Cause Analysis.

8. To utilize the Incident Reporting System (PI-05) as a means of reporting, tracking and analyzing relevant data.

9. To provide quarterly reports to the CQI Committee, and subsequently to the Management Team and Governing Board.
POLICY:
It is the policy of RHG to ensure that any and all media contacts are handled by only: the Managing Director or Clinical Director.

A media inquiry in any event has the potential to create a negative image of the facility within our community. Skillful handling can turn a media crisis into a positive public relations opportunity.

PROCEDURE:
1. Any media inquiry whether it be television, radio or print must be responded to as soon as possible.

2. Facility employees authorized to speak with the media shall be limited to the Managing Director and Clinical Director.

3. Should a media inquiry occur after hours or on the weekend, the Managing Director or Clinical Director must be contacted immediately.

4. Should the media (photography/TV crews) arrive at the facility unannounced, they should not be allowed within the facility for any reason by any staff other than the Managing Director or Clinical Director. Staff shall request that any unannounced media persons await the Managing Director or Clinical Director in the adjacent parking lot. NO photography, video or camera shall be operational during this process. Staff must resist making any statements and shall ensure that patient confidentiality and patient rights are upheld. Strict adherence to patient confidentiality policies and procedures, federal regulations and state statutes must be enforced.
POLICIES AND PROCEDURES

SUBJECT: DESIGNATED DRIVERS

ISSUE DATE: June 30, 2002

POLICY NO. PI-04

REVIEWED/EVISION DATE: March 31, 2011

PROGRAMS: ALL

POLICY:

It is the policy of the facility to obtain information regarding the driving records of all designated drivers. The following information is required:

- Employee’s Motor Vehicle Report
- Copy of Employee’s effective license
- For those employees who drive their own vehicles on Company time, a copy of the employee’s insurance policy declaration page (the first page of the policy which shows effective dates and limits of liability).

PROCEDURE:

The definition of a designated driver is:

Any employee who is specifically assigned to drive any facility owned or leased vehicle, which is garaged at the facility and used solely for the facility’s use;

Any employee who drives their personal vehicle on Company time, for the purpose of transporting residents to and from the facility;

1. The Human Resources Department will obtain the Motor Vehicle Report from the State of Florida, Department of Transportation on all employees, and shall maintain the Motor Vehicle Reports, a copy of the driver’s license and a copy of the Declaration page (if applicable) in the employee’s personnel file.

2. A list of the facility’s designated drivers will be forwarded to Risk Management and kept in Administration.

3. An employee should be considered for Designated Drivers only if the following conditions are met;

   A. Any and all moving violations recorded on the MVR must be reviewed by the Administration to determine the continued employ of the person involved.
   
   B. There is not more than one accident recorded on the MVR in five years.
   
   C. Employee’s license is in effect.
   
   D. For those employees driving their own vehicles, valid physical damage and liability insurance is in effect.
POLICY: The Incident Reporting System is a component of the Risk Management function of RHG’s Quality Improvement Program. Through this system, all events/occurrences involving clients, staff and/or visitors will be promptly identified and reported by facility staff.

EVENT/OCCURRENCE: An Incident Report is completed when an unusual event with potentially harmful outcome occurs which is not consistent with the routine care of a resident and/or the desired operation of the facility.

DEFINITIONS:

A. Events/occurrences for the purpose of INCIDENT REPORTING are defined as, but not limited to, the following:

1. Physical harm to residents, staff or third parties (visitors, workers, students, etc.).

2. Levels of unauthorized leaves:
   (a) unauthorized leave by residents, (elopement) - more than 24 hours,
   (b) runaway - less than 24 hours, or
   (c) left campus without permission - less than 30 minutes.

3. Use of drugs/alcohol on or off campus, possession of contraband.

4. Damage to property.

5. Medication errors.

6. Accidents such as burns, falls, lacerations, fractures, contusions, sprains, etc.

7. Serious threats, dissatisfaction complaints or lawsuits by residents or families.

8. Residents leaving Center against medical advice (AMA).


10. Death(s).
11. Sexual involvement/charges.


13. Suicidal gesture, suicidal attempt.

Occurrences which are not reportable as incidents, include resident behaviors which may be expected at a level of emotional or social development which result in no injury, complaint of injury, or property damage. These behaviors would be recorded in clinical notes, not in incident reports.

RESPONSIBILITY:

A. All employees and medical staff members will participate in the Incident Reporting System. All events that are not consistent with routine care and treatment of a resident or desired operations of facility are considered reportable, and completion of the Incident Report (IR) is mandatory (attached). Visitors who are injured on center property will be subject to reporting within the system.

1. It is the responsibility of each staff member completing a IR to review the form for completeness and accuracy, and to provide the completed IR to the Risk Manager within 24 hours of the incident.

B. Quality Improvement Program assumes overall responsibility for the Incident Reporting System to ensure the following:

1. Confidentiality of information.

2. Monitoring of corrective action.


The Risk Manager will submit summary reports to the Governing Board which may include incidents, trends/patterns of events and summaries of evidence and recommended/accomplished corrective actions.

C. Risk Management has primary responsibility for the administrative functions of the Incident Reporting System, and for coordination and interaction of its operation within the facility.

PROCEDURE:

A. Any employee or medical staff member who discovers, is directly involved in or is responding to an event/occurrence is to complete or direct the completion of a Incident Report.
B. The facility Risk Manager is notified IMMEDIATELY of a serious event.

**SERIOUS EVENTS:**

1. Serious events include but are not limited to: (1) resident or visitor sustains serious injury, (2) fire, or (3) threats of litigation.

2. Risk Manager confers with Clinical Director immediately when indicated.

3. Risk Manager coordinates steps of internal investigation and coordinates the completion of a Root Cause Analysis with other staff.

4. In the event of receipt of claim notification, center Risk Management immediately forwards copies the Managing Director, who reviews all documentation and completes an investigative file.

C. Incident Reports are to be signed by the individual preparing the report and the Risk Manager.

1. The IR is to be completed at the time of event.

2. The Nurse on duty at time of event is notified of any IR incident, reviews IR for completeness, making suggestions or additions as necessary from nursing perspective.

D. The event is documented in the medical record by the person most closely associated with the event and includes:

   Confidentiality of the IR is maintained as follows
   
   1. There is only ONE copy of the IR. NO COPIES ARE MADE OF THIS DOCUMENT.

   2. Until review is made by the Risk Manager the report is kept in a confidential envelope in a secure area of the nurse's station.

   3. The IR is not part of the resident's chart. It is not left on the Chart for ANY reason.

E. Risk Manager Designee will refer all appropriate events for further review; request results of follow-up and actions taken through the involved department's quality review process.

1. Directors/chairpersons of appropriate committees will initiate and effect corrective action.

2. Report of corrective action and staff education follow-up is made periodically through the quality review process.
3. Risk Manager ensures appropriate review of all events through the QI process.

**Risk Management Summary Reports/Analyses**

A. Risk Management will maintain summary reports of events/occurrences on a quarterly basis. These summary reports will be forwarded to the CQI Committee.

B. Risk Management will provide the Managing Director with an annual summary of events/occurrences by January 31 of the year following annual report due date.

C. Additionally, any periodic analysis of trends and events may be requested of Risk Management at any time by the Managing Director or Clinical Director.
POLICY: It is the policy of RHG that all members of the medical staff and consultants providing services to residents will be clinically privileged in accordance with the Privileging Plan adopted by the Governing Board. Individuals not clinically privileged will not perform at the facility. Individuals who are employees of RHG will receive periodic supervision.

PROCEDURE:

1. The original privileging file will be maintained by Administration, which is responsible for the safekeeping, maintenance, and completeness of the files.

2. The Risk Manager will receive and process all applications for clinical privileges, reapplications, and those for temporary privileges.

3. Individuals who do not provide services on-site at RHG do not have to be clinically privileged.

4. The Risk Manager is responsible for providing the completed file to the Managing Director for review and appropriate signatures.

5. The Risk Manager is responsible for presenting the recommendations for privileging to the Governing Board and obtaining required signatures.

6. Under no circumstances will the original credentialing application, file, or documents contained therein leave the grounds of RHG.
Policy: It is the policy of RHG to maintain and follow an active Quality Improvement Plan that is designed to provide an ongoing process by which to objectively and systematically monitor and evaluate the quality and appropriateness of resident care, identify acceptable levels of risk, find and implement opportunities to improve care, and resolve problems and/or submit proposals for the resolution of problems to Administration and/or the Governing Board.

Procedure:

1. The Governing Board charges the facility Administration (Managing Director and Clinical Director) with the development of the Quality Improvement Plan and organization of the Quality Improvement Team.
2. The Quality Improvement Team consists of the Managing Director, Clinical Director, Administrator, Clinical Services Manager, Compliance Manager, Nurse Designee, a therapist, and any other staff member or facility professional who either wishes to participate in the Team or is requested to participate due to a specific issue to be addressed by the Team.
3. The Quality Improvement Team will provide quarterly and annual reports to Administration and the Governing Board, as outlined in the Quality Improvement Plan.
4. The Administration will review the Quality Improvement Plan, revise the plan as needed, and make recommendations to the Governing Board upon annual review.
Policy: It is the policy of RHG to audit the clinical content and frequency of charts on a quarterly basis to ensure accuracy and clinical quality.

Procedure:

The Compliance Manager will complete a quarterly audit thirty (30) percent of all open charts and charts closed in the last quarter. Deficiencies will be addressed directly with staff and they will have ten (10) days to complete and/or correct. After ten days, deficiencies will be addressed with the direct supervisor and subject to the disciplinary process.
We believe in, and are committed to, a Person-Centered Approach to continuous quality improvement in all areas of our operations, including leadership, management, service delivery, human resources, and relationship-building with clients, families, referents, outside professionals, and other stakeholders.

Our Person-Centered Approach is rooted in the belief that our company’s most important assets are our employees – team members who work collaboratively to provide the best mental health services in the country. Our Person-Centered Approach provides an environment for our employees to help our residents improve their quality of life through improvement in mental, emotional, spiritual and physical health. It is our belief that improvements in quality of life are measured by the quality of social functioning and familial relationships that emerge from successful treatment.

Given these beliefs, we pride ourselves in the development of creative and prompt solutions to issues, as we strive to meet the dynamic and changing needs of our clients, families and referents. This theme is central to our Quality Assurance/Quality Improvement Plan.

I. Purpose

The purpose of the Quality Assurance/Quality Improvement Plan is to provide an ongoing process by which Pasadena Villa objectively and systematically monitors and evaluates the quality and appropriateness of resident care, identifies acceptable levels of care, finds and implements opportunities to improve care, and resolves and/or submits proposals for the resolution of problems to the Administration and/or Governing Board.

II. Objectives

Objectives of the Quality Assurance/Quality Improvement Plan are:
• To emphasize the role of the leaders of the organization in improving quality
• To routinely use assessment and improvement activities that move beyond the strictly clinical and on to the interrelated governance, managerial, support and clinical processes that affect resident outcomes
• To use other sources of feedback, other than ongoing monitoring, in order to trigger evaluation and improvement of care activities
• To establish the organization of assessment and improvement activities around the functions of patient care services
• To focus on the processes of care and service, rather than on the performance of individuals
• To emphasize continuous improvement rather than merely identifying and solving problems

• To continuously improve over time
  To operationalize and monitor Peer Review and Utilization Review activities conducted under policy LD-03.

III. Authority and Responsibility

  **Governing Board** - The Governing Board charges the leadership of Pasadena Villa and the professional staff with the obligation of operating and implementing this Plan.

  **Administration** - The responsibility for monitoring and evaluating resident care services is the responsibility of the Administration (Administrative Program Manager and Clinical Program Manager), but may be delegated to various facility staff on the Quality Improvement Team, consisting of the Managing Director, Clinical Director, a nurse, a therapist and one PCM, at a minimum.

  **Quality Improvement Team** - The Quality Improvement Team shall report areas for improvement and/or problems identified by staff members, professional staff, residents, families, visitors or vendors.

IV. Quality Improvement Activities

  The Quality Improvement Team is responsible for the monitoring and evaluation of activities. At a minimum, this includes monitoring these key functions: clinical and medical records.
review through chart audits; utilization review; infection control; incident report/risk management review; and peer review functions.

The channels through which the Quality Improvement Team may receive recommendations for improving services and/or reports of actual or potential problems may be formal or informal. Formal channels include meeting minutes, routine reports, findings from QI indicators, and resident and family surveys. Informal channels may include unsolicited suggestions or complaints from staff, residents, family, visitors or vendors.

In the selection of service functions for monitoring and evaluation, the following considerations shall be used:
POLICIES AND PROCEDURES

High Volume: most frequently rendered services, assessments, procedures or modalities
High Risk: activities, medications or procedures having the potential to harm or injure residents, staff, visitors or property
Problem Prone: activities often associated with resident or staff difficulties, complaints, errors or incidents
Response to Untoward Event: a Root Cause Analysis is conducted for all facility-defined sentinel events and near misses, addressing opportunities for prevention of future events.

V. Evaluation of Monitored Data

Initial Evaluation: areas of consideration during the evaluation of data shall include the following:

- Appropriateness of care or clinical performance
- Impact on resident care
- Identification of problems and/or opportunities for improvement of care delivery systems or clinical performance
- Potential sources of problems, including staff knowledge, behaviors or attitudes.

Re-Evaluation: a status report of succeeding data shall be submitted to the appropriate authority and shall include the following:

- Demonstration that performance/conditions have met or have not met standards
- Statement of cause when actual performance/conditions have met or have not met standards
- Recommendations for further action when initial action did not reduce or resolve the problems
- Plan for follow-up and re-evaluation
Annual Appraisal: the effectiveness of the Plan shall be assessed on an annual basis. This annual review shall measure program effectiveness, program goals, policies, procedures, and service treatment goals. Also, in applicable, a summary of QIP activities shall be submitted.

VI. Methodology

Important functions throughout the organization are continuously measured, assessed and improved. The successful outcome of improvement activities is accomplished through:

\[P = \text{PLAN process changes designed to improve outcomes}\]
\[D = \text{DO take action pilot the process changes}\]
\[C = \text{CHECK the effects, study results, measure changes}\]
\[A = \text{ACT to improve the process by implementing changes}\]

VII. Confidentiality and Immunity

Any and all documents and records that are a part of the internal Quality Assurance/Quality Improvement Plan and quality management program, as well as proceedings, reports, records of any of the activities identified
in this Plan, shall be confidential and not subject to subpoena or discovery or considered admissible in a court of law under Florida Statutes.

Access to data is restricted to the Governing Board and CQI Team.

Summary reports and Team meeting minutes shall be provided for necessary meetings and activities, but are not to be removed from the facility. All copies of reports or minutes will be collected after each meeting and destroyed. Original reports and minutes shall be maintained in Administration and shall be produced upon request on a need to know basis. Program evaluation and review information shall be made available to the Department of Children and Families and the Agency for Health Care Administration, upon written request or during licensure surveys, within the limits of confidentiality pursuant to 394.459(9), F.S. Requests for release of Quality Assurance/QI data from individuals not otherwise authorized for review must be made to the Managing Director. Such requests are to be specific and are to describe the purpose and intended use of information requested. The authority for such review may be granted only by the Managing Director in association with facility legal counsel, when appropriate, or courts of appropriate jurisdiction.

APPROVAL:

_____________________________  __________
Administrator     Date

_____________________________  __________
Clinical Manager     Date

_______________________________          __________
Governing Board – Managing Director Date
We believe in, and are committed to, a Person-Centered Approach to continuous quality improvement in all areas of our operations, including leadership, management, service delivery, human resources, and relationship-building with clients, families, referents, outside professionals, and other stakeholders.

Our Person-Centered Approach is rooted in the belief that our company’s most important assets are our employees – team members who work collaboratively to provide the best mental health services in the country. Our Person-Centered Approach provides an environment for our employees to help our residents improve their quality of life through improvement in mental, emotional, spiritual and physical health. It is our belief that improvements in quality of life are measured by the quality of social functioning and familial relationships that emerge from successful treatment.

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Objectives of the Quality Assurance/Quality Improvement Plan are:

- To emphasize the role of the leaders of the organization in improving quality
III. Authority and Responsibility

**Governing Board** - The Governing Board charges the leadership of Pasadena Villa and the professional staff with the obligation of operating and implementing this Plan.

**Administration** - The responsibility for monitoring and evaluating resident care services is the responsibility of the Administration (Administrative Program Manager and Clinical Program Manager), but may be delegated to various facility staff on the Quality Improvement Team, consisting of the Managing Director, Clinical Director, a nurse, a therapist and one PCM, at a minimum.

**Quality Improvement Team** - The Quality Improvement Team shall report areas for improvement and/or problems identified by staff members, professional staff, residents, families, visitors or vendors.

IV. Quality Improvement Activities

The Quality Improvement Team is responsible for the monitoring and evaluation of activities. At a minimum, this includes monitoring these key functions: clinical and medical records review through chart audits; utilization review; infection control;
incident report/risk management review; and peer review functions.

The channels through which the Quality Improvement Team may receive recommendations for improving services and/or reports of actual or potential problems may be formal or informal. Formal channels include meeting minutes, routine reports, findings from QI indicators, and resident and family surveys. Informal channels may include unsolicited suggestions or complaints from staff, residents, family, visitors or vendors.

In the selection of service functions for monitoring and evaluation, the following considerations shall be used:
High Volume: most frequently rendered services, assessments, procedures or modalities **High Risk:** activities, medications or procedures having the potential to harm or injure residents, staff, visitors or property **Problem Prone:** activities often associated with resident or staff difficulties, complaints, errors or incidents **Response to Untoward Event:** a Root Cause Analysis is conducted for all facility-defined sentinel events and near misses, addressing opportunities for prevention of future events.

V. Evaluation of Monitored Data

**Initial Evaluation:** areas of consideration during the evaluation of data shall include the following:

- Appropriateness of care or clinical performance
- Impact on resident care
- Identification of problems and/or opportunities for improvement of care delivery systems or clinical performance
- Potential sources of problems, including staff knowledge, behaviors or attitudes.

**Re-Evaluation:** a status report of succeeding data shall be submitted to the appropriate authority and shall include the following:

- Demonstration that performance/conditions have met or have not met standards
- Statement of cause when actual performance/conditions have met or have not met standards
- Recommendations for further action when initial action did not reduce or resolve the problems
- Plan for follow-up and re-evaluation
Annual Appraisal: the effectiveness of the Plan shall be assessed on an annual basis. This annual review shall measure program effectiveness, program goals, policies, procedures, and service treatment goals. Also, in applicable, a summary of QIP activities shall be submitted.

VI. Methodology

Important functions throughout the organization are continuously measured, assessed and improved. The successful outcome of improvement activities is accomplished through:

\[ P = \text{PLAN process changes designed to improve outcomes} \]

\[ D = \text{DO take action pilot the process changes} \]

\[ C = \text{CHECK the effects, study results, measure changes} \]

\[ A = \text{ACT to improve the process by implementing changes} \]

VII. Confidentiality and Immunity

Any and all documents and records that are a part of the internal Quality Assurance/Quality Improvement Plan and quality management program, as well as proceedings, reports, records of any of the activities identified
in this Plan, shall be confidential and not subject to subpoena or discovery or considered admissible in a court of law under Florida Statutes.

Access to data is restricted to the Governing Board and CQI Team. Summary reports and Team meeting minutes shall be provided for necessary meetings and activities, but are not to be removed from the facility. All copies of reports or minutes will be collected after each meeting and destroyed. Original reports and minutes shall be maintained in Administration and shall be produced upon request on a need to know basis. Program evaluation and review information shall be made available to the Department of Children and Families and the Agency for Health Care Administration, upon written request or during licensure surveys, within the limits of confidentiality pursuant to 394.459(9), F.S. Requests for release of Quality Assurance/Quality Improvement data from individuals not otherwise authorized for review must be made to the Managing Director. Such requests are to be specific and are to describe the purpose and intended use of information requested. The authority for such review may be granted only by the Managing Director in association with facility legal counsel, when appropriate, or courts of appropriate jurisdiction.

APPROVAL:

_____________________________  __________
Administrator     Date

_____________________________  __________
Clinical Manager     Date

_____________________________          __________
Governing Board – Managing Director Date
Policy and Procedure Manual

Rights, Responsibilities and Ethics
(RI)

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POLICIES AND PROCEDURES

SUBJECT: DEFINITIONS OF ABUSE AND/OR NEGLECT

ISSUE DATE: June 30, 2002

POLICY NO: RI-01

REVIEW/REVISION DATE: March 31, 2011

PROGRAM: ALL

POLICY: The purpose of this policy is to define abuse and neglect as is applicable to RHG.

PROCEDURE:

1. Abuse:
   Abuse can be separated into three (3) categories. They are as follows:

   A. Sexual: defined by RHG as any sexually physical act from sexual intercourse to fondling, sexual assault, molestation, rape and exploitation.

   B. Physical: defined by RHG as any act which could cause physical harm to an individual.

   C. Emotional: defined by RHG as any act which is designed to humiliate an individual, such as name calling, verbal humiliations, any act which would call negative attention to a resident to set them apart from the daily routine.

2. Neglect: defined by RHG as any act that does not facilitate an active effort to ensure all basic needs and rights are available for an individual.
POLICIES AND PROCEDURES

SUBJECT: REPORTING ALLEGATIONS/DISCLOSURES
OF ABUSE AND/OR NEGLECT

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

POLICY NO. RI-02

PROGRAMS: ALL

POLICY: It is the policy of RHG that all employees are required to report all allegations of abuse (sexual, physical or verbal and/or neglect) to The Department of Children and Families immediately per State of Florida Statute 415.504-1 through 2(a) and/or the Department of Human Services per State of Tennessee Statute 71-6-101 through 122.

PROCEDURE:

1. If a resident states that he/she has been abused at any point in his/her life, it must be reported.

2. An incident report must be filled out by the staff whom received the complaint, who will call the Attending Physician and Family Therapist in order to verify whether or not the abuse has been reported and/or investigated.

3. If the abuse has not been previously reported or investigated, the Therapist shall notify the Clinical Director that The Department of Children (and Families) Services (FL) or TN Department of Human Services will be called.

4. If the abuse has not been reported previously, the Therapist, shall call The FL Department of Children (and Families) Services/TN Department of Human Services to report the incident.

5. The person making the report to The FL Department of Children and Families/TN Department of Human Services shall: (a) notify the Nurse regarding the outcome of the call, and (b) IMMEDIATELY DOCUMENT IN THE RESIDENT'S CHART. Be sure to include the date, time, and the name and title of the DCF/DCS representative to whom this information was reported.

6. The Therapist or Nurse shall inform and process the outcome of the call with the resident.

7. The Therapist and/or Nurse shall:

   A. Assist the resident and FL DCF/DCS or TN DHS representative with the interview.

   B. Process the effects of the FL DCF/DCS or TN DHS representative's visit with the resident.

   C. Immediately document the outcome of A and B in the resident's chart. Be sure to include the date, time, name and title of the representative who interviewed the resident.
POLICIES AND PROCEDURES

SUBJECT: ADVANCED DIRECTIVES

ISSUE DATE: June 30, 2002

REVIEW/REVISION DATE: March 31, 2011

POLICY NO. RI-03

PROGRAM: All

POLICY:

It is the policy of RHG to comply in all ways with the Patient-Self Determination Act (the “Act”), as contained in the Omnibus Budget Reconciliation Act of 1990. The purpose of the Act is to protect each adult resident’s right to participate in health care decision making to the maximum extent of his or her ability and to prevent discrimination based on whether the resident has executed an advance directive for health care. (Durable Power of Attorney for Healthcare, Declaration to Physician, Living Will).

PROCEDURE:

1. Adults (18 and above) admitted to RHG will be provided with a Patient’s Right Brochure, ADVANCE DIRECTIVES: Legal Documents to Assure Future Health Care Choices as required by the Act.

2. As part of the admission process, the Admission Director or designee shall provide the adult resident with information regarding the resident’s right to make decisions concerning health care, which includes the right to accept or refuse medical or surgical treatment, even if that treatment is life-sustaining.

3. During the admission process, the facility staff will ask the resident whether he/she has completed an Advance Directive.

4. If an Advance Directive has been completed, the Admissions Director will ask for a copy of the Advance Directive so that it may be placed in the resident’s medical record. If a copy is not immediately available, the resident will be informed that it is his or her responsibility to provide a valid copy of the Advance Directive to the facility as soon as possible.

5. If an Advance Directive has not been completed, or if the resident is unfamiliar with Advance Directives, the facility staff will have the resident complete the Advance Directive Acknowledgment. The acknowledgment will be placed in the resident’s medical record.
POLICY:

It is the policy of RHG to identify and record those areas pertaining to the rights of parents/guardians of residents.

PROCEDURE:

Parents and Guardians are entitled to:

1. Respect and treatment, which respects the dignity of all family members.

2. Freely write to and receive letters from residents.

3. Make and receive telephone calls from the resident, unless this right is suspended as a reasoned and integral part of the treatment plan.

4. Visit the resident, at reasonable times, and take the resident for visits away from the facility, unless this right is temporarily abridged by reasons clearly stated in the treatment plan, and which are shown to be detrimental to the treatment process of the resident.

5. Be informed concerning the treatment of the resident, and to be allowed to participate in planning of the treatment, and receive treatment services, if desired, which may contribute to the resident's treatment.

NOTE: In the instance of conflict between the wishes of the parents and/or guardian and those of the resident, RHG reserves the right to observe the wishes of the resident. Such conflicts are addressed through the complaint/grievance procedure.

6. Be advised of, and give informed consent (if guardian), to all aspects of the resident's treatment, and risks, side effects, and benefits of medications.

7. Register or file a complaint or grievance concerning any aspect of the resident's treatment or care and to have a Resident Advocate, who is not directly responsible for the day-to-day care of the resident, who is capable of objectivity regarding the complaint and any staff involved.

NOTE: The staff of RHG will aid the parent in the registering of such a complaint and shall hold parents, guardians, and the resident free from restraint, coercion, discrimination, and reprisal.

8. Independent review of the resident's treatment program at their own expense.
9. Request an internal review of the resident's treatment program.

10. Be informed of any transfer of the resident.
POLICY: It is the policy of RHG to facilitate pastoral services to residents upon request.

PROCEDURE:

1. Religious services are provided through community churches, synagogues, temples, or other places of worship, or may be provided at the facility.

2. Transportation to religious services may be provided by the staff, when appropriate.

3. Those resident’s whose mental status deems it unsafe or counter-therapeutic to attend services off-campus will be given the option of receiving pastoral services or visits on campus.

4. In the event the milieu would be clinically compromised by the absence of staff to transport residents, an alternate plan to attend to spiritual needs will be discussed with the residents.
POLICIES AND PROCEDURES

SUBJECT: PHOTOGRAPHING, VIDEOTAPING, OR AUDIOTAPING OF RESIDENTS

ISSUE DATE: June 30, 2002

POLICY NO. RI-10

REVIEWED/REVISION DATE: March 31, 2011

PROGRAM: All

Policy: It is the policy of RHG that residents in the program will not be photographed, videotaped, or audiotaped without specific written consent.

- Program staff will be informed of this policy upon employment and required to attend an in-service reviewing confidentiality policies at least once per year.

- Visitors to the program who have resident contact will be informed of this policy and required to sign a statement acknowledging their agreement not to photograph, audiotape, or videotape residents.

- Disposal of any photographs, audiotapes, and videotapes shall be in accordance with the procedures in this policy.

PROCEDURE:

1. Prior to photographing, audiotaping, or videotaping, a signed (written specific) consent for the procedure used will be obtained from the resident by staff. (See Attached required Consent Form)

2. Blank copies of the form will be kept in the staff office for accessibility.

3. Photographs, audiotapes, and videotapes of residents will be permitted for the following purposes (with signed consent) and disposal will be as specified below:

   A. Photographs may be taken upon admission for internal use for identification or for emergency utilization needed by law enforcement or emergency personnel.

   B. Photographs, audiotapes, and videotapes may be made as a part of the therapeutic process. These will be maintained for a period of time specified on the consent form and then incinerated.

4. Visitors to the program who will have resident contact will be required to sign a statement acknowledging prohibition of photographing, videotaping, or audiotaping of residents, and agreeing to abide by the prohibition.
POLICY:

It is the policy of RHG to allow home visits by the residents, in concert with treatment team meetings and resulting recommendations.

PROCEDURE:

1. Permission for home visits must be granted by the treatment team and Attending Physician.

2. Frequency and duration of home visits are evaluated according to the individual needs of the resident and the existing family dynamics.

3. Passes for home visits, which include overnight Therapeutic Absences are to be approved by the Attending Psychiatrist.
POLICY:

It is the policy of RHG to recognize each resident's right to be treated with dignity and respect as an individual. The following will be observed and protected for each resident. The resident's rights will be posted in common areas within the facility. Upon admission, the admitting staff will give each resident/family/guardian a copy of the Resident Rights and Resident Responsibilities (attached).

PROCEDURE:

The following identifies areas pertaining to the rights of the resident.

1. Treatment, which respects the personal dignity of the resident in all aspects of care.

2. Services without discrimination as to race, color, age, sex, religion, disability, national origin, or regardless of source(s) of financial support.

3. Ability to practice individual spiritual and cultural beliefs which do not interfere with individual treatment or the rights of others. *Attendance at religious services must be requested through the treatment team and will depend upon the availability of staff.*

4. Treatment, which is confidential.


6. Receive an individualized treatment plan which will be reviewed at major key decision points through the course of treatment or, at minimum, every 30 days.

7. The provision of an adequate number of competent, qualified, and experienced professional clinical staff to supervise and implement the treatment plan.

8. When, in judgment of a physician, a resident is restricted to bed rest or is prohibited access to the outdoors, the physician's order is reviewed at least every three days.

9. RHG will not utilize one-way vision mirrors, tape recorders, television, movies, photographs, or research without first obtaining a signed and dated "Informed Consent" form from the resident and family or legal guardian.

10. Actively participate in treatment planning.
POLICIES AND PROCEDURES

11. Receive treatment in the least restrictive environment possible.

12. Be informed of the unit rules and regulations in which he/she resides.

13. Write and receive mail. Any limitations on mail will be overseen by the Therapist and input from the family and resident will be solicited. Limitations shall be ordered by the Attending Physician and a progress note entry shall be made as to why mail cannot be sent or received.

14. Receive prearranged visits from family and significant others. Arrangements are made through the Therapist. Visits that are contraindicated will be addressed in the treatment plan.

15. Place and receive telephone calls to/from family members or significant others. The call will be at the convenience of the staff, in accordance with the resident's treatment plan. If married residents reside in the facility, privacy for visits by spouses must be insured.

This right may only be limited when the limitation is an integral part of the treatment plan. Restrictions are fully explained to resident and family. The Attending Physician and Therapist will review at least every seven days. Continuation of the limitation will be done in consultation with family and resident.

16. Freely make phone calls to his/her attorney at their own expense. No staff shall attempt to abridge this right in any manner, nor harass or punish any resident exercising this right.

17. Wear his/her own clothing, of own choice, suitable to the season and in good repair, unless such right be abridged by reasonable and clear standards set forth in the treatment plan. The resident may keep and use personal grooming aides and articles, unless it is clinically indicated to restrict use of such potentially dangerous materials. In the case of a clinical restriction, staff will fully explain the reasons for the restriction and review the effectiveness of the restriction weekly. The resident also has the right to assistance by staff with clothing and grooming.

18. Read material of his/her own choosing, within his/her leisure time, and to engage in other cultural pursuits, unless reasonable and adequate rationale for altering this right is contained in the treatment plan. The harm caused by the exercise of this right must be documented and should not be based on anticipated harm.

19. Be informed of the effects of any medication, including anticipated benefits and side effects. Parents or guardians must be informed of same.

20. Have an independent, internal, or external review of the individual treatment plan. External reviews will be at the expense of family/guardian.

21. Residents may be assigned tasks related to facility operation, including but not limited to cooking, laundering, housekeeping and maintenance, only if such tasks are in accordance with the treatment plan, consented by patient/guardian and are done with staff supervision.
POLICIES AND PROCEDURES

22. Residents have high speed broadband access to the internet via cable and wireless networks. The right to have internet access may be restricted by the treatment team. Such restrictions shall be reviewed by the Attending Physician and Primary Therapist at least every seven days.

23. RHG expressly prohibits all illegal internet activities, and such uses could result in suspension form the program. RHG reserves the right to monitor internet activity of residents while in the program; but neither RHG, nor its staff, are responsible for the internet activities of the residents/clients. Furthermore, RHG shall report to the proper authorities, any illegal internet activities of residents/clients.

24. Appeal the denial or abridgement of any of these rights by filing a formal grievance through the Administration and to have a Patient Advocate, who is not directly responsible for the day-to-day care of the resident, who is capable of objectivity regarding the complaint and any staff involved. No center staff may interfere with a grievance or punish the resident in the fulfillment of this right.

25. The rights of residents may be modified or limited under the following conditions:
   a. It is demonstrated and documented that a legitimate program purpose cannot reasonably be achieved without such modification or limitation;
   b. No modification or limitation may be made solely for the convenience of staff or be more stringent than is necessary to achieve the demonstrated purpose;
   c. Facility rules, policies or procedures which modify or limit resident rights will be in writing and posted in a conspicuous place.

All staff of the center are responsible for the resident's welfare and are subject to all relevant and pertinent to State laws regarding child abuse and/or neglect.

ALL STAFF ARE SUBJECT TO MANDATORY REPORTING OF CHILD ABUSE, AS REQUIRED BY FLORIDA LAW.
POLICIES AND PROCEDURES

SUBJECT: RESIDENT SATISFACTION/
PATIENT ADVOCATE: COMPLAINT RESOLUTION

ISSUE DATE: June 30, 2002

POLICY NO. RI-15

REVIEWED/REVISION DATE: March 31, 2011

PROGRAMS All

POLICY:
It is the policy of RHG to ensure fair consideration and timely resolution of complaints. Residents, parents, guardians of residents or individuals acting on behalf of a resident, who believe a resident has been mistreated in any manner, that the resident's rights have been denied, or who have concerns related to facility policies and procedures, have the right to file a complaint or grievance with the facility through the Administration. The resident and/or family will be represented by a patient advocate who is not directly responsible for the day-to-day care of the resident, who can be objective regarding the complaint and any staff involved.

Residents and other individuals involved in the filing of a complaint/grievance are free from restraint, coercion, discrimination, or reprisal.

PROCEDURE:

HOW TO FILE A GRIEVANCE:

A. Obtain a complaint/grievance form from the nurse or other staff.

B. With the help of the staff, write the complaint on the form and include your suggestions for resolution of the problem. Where possible, a complaint should state the name and address of the person filing it, briefly describing the alleged action prohibited by the laws and regulations and the date it allegedly occurred.

C. A complaint should be filed with Patient Advocate within a reasonable amount of time (thirty days) after the person filing the complaint becomes aware of the action.

D. The Patient Advocate shall investigate the complaint to determine its validity. These rules contemplate informal but thorough investigations, affording all and their representatives, if any, an opportunity to submit evidence relevant to the complaint.

E. Understand resident rights and responsibilities, facility policies and rules, as well as licensure requirements and be able to communicate these to residents.

F. The Patient Advocate will be the liaison with the clinical team of health care providers and not let little issues get blown out of control and grow into large problems or obstacles.
POLICIES AND PROCEDURES

G. The Patient Advocate shall issue a written decision determining the validity of the complaint no later than thirty (30) days after its receipt and issue a corrective action plan where necessary.

H. All advocacy communications need to be held in highest confidence and all confidentiality and HIPPA laws apply.

I. The Patient Advocate shall maintain the files and records relating to complaints filed hereunder. The Patient Advocate may assist persons with the preparation and filing of complaints, participate in the investigation of complaints and notify the Governing Board of the resolution of the complaints.

J. The right of a person to the prompt and equitable resolution of a complaint filed hereunder shall not be impaired by the person’s pursuit of other remedies, such as filing a complaint with the Office for Civil Rights of the United States Department of Health and Human Services and/or any other federal or state agency.

K. These rules shall be liberally construed to protect the substantial rights of interested persons, to meet appropriate due process standards and assure compliance with laws and regulations.

DUTIES OF THE PATIENT ADVOCATE:

Duties of the Patient Advocate shall include but are not limited to the following:

1. Receipt of written complaints from residents, families of residents, or others.

2. Give proper notice to all individuals involved with the complaint.

3. Monitor complaint process and ensure that time limits are met; maintain a Grievance Log and associated files.

4. Logs shall contain copies of complaints, both active and inactive. The information in the log shall reflect, at a minimum, the complaint number, the resident, and the current status of the complaint.

5. The Patient Advocate is responsible for submitting a quarterly statistical report of the grievance activity to the governing body.

6. If the Patient Advocate determines that a complaint may be satisfactorily resolved by changing policy and procedure or requires budgetary consideration, he/she shall immediately route the complaint to the next level of appeal.
POLICY:

It is the policy of RHG to allow residents free access to local telephone calls.

PROCEDURE:

1. The number of phone calls received or made by residents can be restricted by the treatment team when such calls are in conflict with treatment issues.

2. Long distance calls made on the resident phone are at the expense of the facility (domestic long distance only). The resident may establish with the local phone company (with assistance of Administration) a personal telephone account for his/her own telephone number. In such instances, the costs of the service will be the sole responsibility of the resident/family. The resident may receive calls directly into his/her room, without the calls being first received and screened by RHG staff.
POLICY:

It is the policy of RHG to preserve the security of all valuables on the premises and to insure the safety of residents possessing those valuables. In accordance with these objectives, the following procedures will be enacted.

PROCEDURE:

1. All articles in the possession of the prospective resident will be inspected for suitability by staff at the time of admission.

2. Staff will strongly encourage residents to withhold from the facility those articles that are deemed to be sufficiently valuable as to cause an undue enticement to other residents.

3. If a resident expresses an unwillingness to part with the valuables in his/her possession, the staff will inform the resident that RHG cannot guarantee the security of these articles and will not accept liability for articles that are lost, stolen or misplaced.

4. RHG will provide, upon request, a locked storage compartment for each resident that is to be used at the resident’s discretion to contain articles of value for safe-keeping.

5. In the event that a valuable article is discovered to be missing, all reasonable attempts will be instituted to recover that article, including a search of the residence and consultation with the residents therein.

6. All residents and guardians, if applicable, upon admission will sign Acknowledgment and Waiver of Liability which is included in the Consent for Treatment. The executed form will be placed in the medical record and a copy provided to the guardian.
It is the policy of RHG to preserve the security of all valuables on the premises and to insure the safety of residents possessing those valuables. In accordance with these objectives, the following procedures will be enacted.

PROCEDURE:

1. All articles in the possession of the prospective resident will be inspected for suitability by staff at the time of admission and a list of personal property valued at one hundred ($100.00) or more, including its disposition if no longer in use.

2. Staff will strongly encourage residents to withhold from the facility those articles that are deemed to be sufficiently valuable as to cause an undue enticement to other residents.

3. If a resident expresses an unwillingness to part with the valuables in his/her possession, the staff will inform the resident that RHG cannot guarantee the security of these articles and will not accept liability for articles that are lost, stolen or misplaced.

4. RHG will provide, upon request, a locked storage compartment for each resident that is to be used at the resident’s discretion to contain articles of value for safe-keeping.

5. In the event that a valuable article is discovered to be missing, all reasonable attempts will be instituted to recover that article, including a search of the residence and consultation with the residents therein.

6. All residents and guardians, if applicable, upon admission will sign Acknowledgment and Waiver of Liability which is included in the Consent for Treatment. The executed form will be placed in the medical record and a copy provided to the guardian.
POLICY: It is the policy of RHG to facilitate off campus jobs to eligible adult residents.

PROCEDURE:

1. Residents interested in exploring off campus employment shall discuss this option with his/her therapist.
2. The Therapist will review this intervention with the Clinical Services Manager and treatment team members.
3. RHG staff will evaluate resident's ability to work through:
   A. Behavior in milieu
   B. Previous work experience
4. RHG will assist resident in finding work by providing support, education, advocacy - directly contacting employers, and referral to State Vocational Rehabilitation. Resident will be encouraged to be as self-reliant as he/she is able.
5. Work hours need to be approved by Treatment Team as psychiatric treatment is a priority. Resident may increase amount of time at work as he/she nears discharge date.
POLICY:

The employees of RHG will conduct their activities in an ethical manner. Services provided to residents and the community will be delivered in an honest and open manner.

HONESTY

Honesty will be the guiding principle of all clinical and business affairs of the facility and its staff.

MARKETING

Marketing activities will honestly represent the capabilities of the facility. Under no circumstances shall any inducement for referrals be offered.

ADMISSION PRACTICES

Admission practices shall represent the needs of the resident. To the extent possible, residents shall be informed of any financial liabilities associated with decisions regarding care.

TRANSFER AND DISCHARGE OF PATIENTS

Transfer and discharge decisions shall be based upon the clinical needs of the resident. Where financial issues are involved, all available information will be provided to the resident, parent, or guardian, as appropriate, to facilitate care decisions.

PATIENT CARE SERVICES

All clinical care services will be provided based on resident needs. Staff will honestly represent services, expectations, and information provided to residents. All care will be provided on a non-discriminatory basis.

BILLING

Residents will be billed in an accurate and timely manner. When billing conflicts are identified, the facility Managing Director will take action to provide information to the resident and/or payor and ensure corrective measures are applied as appropriate. Such action will be taken in a timely manner, generally not more than thirty (30) days.

FINANCIAL INTEREST DISCLOSURE
The facility and its employees will disclose to residents any financial interests with other service providers, educational institutions, or payors to which the resident is referred. Facility clinicians will not refer to themselves without documented approval by the Treatment Team. Conflicts of interest shall be avoided in all referral and contractual relationships.

ETHICS AD HOC COMMITTEE

Employees shall take ethical concerns to the facility Managing Director for resolution. The facility Managing Director may call an Ad Hoc Ethics Committee meeting if appropriate. If immediate action is required, the Managing Director shall respond as appropriate.
POLICY: It is the policy of RHG to give each resident, on admission, essential information, which allows for effective participation in the program and promotes personal safety in the event of an emergency.

PROCEDURE:

1. Each resident, within twenty four (24) hours of admission, shall be provided an orientation which includes minimally the following:
   
   A. Explaining of Facility services, activities, performance expectations, rules and regulations, including providing written Facility rules;
   
   B. Familiarizing the resident with the Facility’s premises, the neighborhood and public transportation systems;
   
   C. Scheduling the resident’s activities; and
   
   D. Explaining resident rights and grievance procedures.

2. A basic program and safety information.

3. Verbally discuss at time of orientation and document patients understanding of material presented during orientation.

4. Discuss individual issues openly during community meetings.

5. Obtain a signed statement from the resident or guardian that the resident has received an orientation.

6. Obtain a signed statement indicating that the resident has either read or has been explained Facility rules.

7. Obtain a signed statement indicating the resident’s or guardian’s financial obligations to the Facility and the person responsible for meeting such obligations.
POLICIES AND PROCEDURES

SUBJECT: STAFF BOUNDARY VIOLATION PREVENTION GUIDELINES/SEXUAL MISCONDUCT

DATE ISSUED: June 30, 2002
Policy No.: RI-22

REVIEWED/REVISED: March 31, 2011
PROGRAM: All

POLICY:

The ability of the resident to rely on facility staff as concerned and caring individuals who remain objective in their guidance is one of the tenets of a safe, therapeutic relationship. When staff interact with patients in a personal manner, the relationship may no longer be objectively therapeutic. Accepting gifts, financial transactions, and romantic entanglement could lead to various negative consequences for the facility, staff and resident.

Thus, enforces a policy of non-fraternization with current and former residents. While there are conceivably exceptions, the general expectation is that hospital staff and employees are not to establish a personal relationship with a current or former resident.

RHG recognizes that there are times when peers, friends, families or neighbors of employees seek treatment for emotional well-being. In these circumstances, it is the policy of the company that the relationship remains of the nature it was prior to admission, assuming that it is in the resident’s best interest. However, it is RHG’s policy that the staff member not be allowed involvement in the direct treatment process of a peer, friend, family member or neighbor. Furthermore, it is the staff member’s responsibility to notify his or her supervisor when an individual with whom he or she has a relationship is admitted for treatment.

RHG has established the following guidelines to assist in the prevention of staff to resident boundary violations.

PROCEDURE:

Hiring Practices

The first step in preventing staff: resident boundary violations are to institute strict hiring practices with appropriate reference checks. All prospective employees should undergo appropriate human resources screening, which may include but is not limited to, effective job interview, clinical background screenings and reference checks.

Staff Orientation/Education

A. All staff should be provided an initial orientation, upon hire, to the concept of therapeutic boundaries and potential boundary issues and violations. All staff should receive policy related to abuse, neglect reporting and policy related to sexual misconduct.

B. Clinical staff should receive ongoing education, at least annually, regarding therapeutic boundaries. This can be done in various forums - formal inservices, staff meetings, individual supervision, etc. Supervisors should provide a forum for staff to feel comfortable in discussing transference issues.

Staff should be encouraged to openly discuss questions or concerns they may have regarding staff/patient relationships with their supervisor or other professional and to report any concerns regarding potentially inappropriate staff/patient relationships.

Patient Education
Clinical staff should educate the patient on an as-needed basis regarding the staff/patient relationship. When specific boundary issues arise, staff should explain the ethical obligations of the professional relationship and the parameters in which he/she must work. This should be done in a matter-of-fact, but caring, manner and in such a way as not to make the resident feel “put down” or abandoned.

Supervision

Staff supervision should include identification of early signals that a staff member may be crossing therapeutic boundaries and institution of appropriate interventions. Staff should be provided a forum in which to confidentially report concerns that a peer may be in danger of potential boundary violations (peer “policing”). Employee behavior which may be misunderstood by a patient should be openly discussed with the involved employee in a nonadversarial manner.

Staffing Considerations

A. Programs should provide for adequate supervision of staff and availability of supervisor resources as needed.

B. Staff members of the opposite sex from the patient should be advised not to enter resident rooms unless accompanied by another staff person, if possible. The patient’s door should never be closed when a staff member is in the patient’s room.

Investigation of Alleged Boundary Violations

At the preliminary/pre-investigation stage, the Risk Manager will review the available information and may conduct a cursory investigation to determine whether to:

A. place accused employee on immediate leave (paid or unpaid),

B. take further action related to any safety concerns,

C. procure consultation from legal counsel, and/or

D. assign someone from outside the involved unit/department to conduct the investigation. This person should have a reputation for trustworthiness and must be objective.
POLICY: It is the policy of RHG to protect the rights of all residents. If a resident’s behavior poses a risk to their progress in treatment or the progress of others, the treatment team may temporarily restrict all or part of a resident’s right until the risk passes. Restrictions are assessed by the medical director and treatment team based upon reduction of the above mentioned risk factors and at least 3 days consistency and compliance. Residents will be notified as to the purpose and benefit of the restriction and develop a goal list to work toward reinstatement of privileges. Rights restrictions and reinstatement will be reflected in treatment plan/plan of care.

PROCEDURE:
Residents may be restricted from rights for any of the following criteria:
- Risk of harm to self
- Risk of harm to others
- Return from a baker act
- Use of drug or alcohol during treatment
- Non compliance with treatment plan
- Interfering with the treatment of others
- Medication non-compliance
- Overall instability of mood, behaviors, or psychosis
- Risk of elopement
- Medical issues
- Impulsivity
- Refusal to adhere to program rules
- If it is determined that the right is negatively impacting sleep cycle, isolative behaviors, or exacerbating symptoms
- If communication or visits need to be supervised or limited due to inappropriate or harassing communication, or communication that is otherwise detrimental to treatment.

Rights and Privileges that may be partially restricted or use limited based upon clinical assessment:
- Telephone
- Computer
- Clothing (if provocative or containing alcohol or drug references)
- Caffeine
- Cigarettes
- Visitors
- Home passes
- Personal items that interfere with treatment needs of self or others
- Any additional privileges reflected in individual treatment plans/plan of care
Complaint/Grievance Follow-Up

Name of Person Expressing Grievance: __________________________ Date Reported: _______________

Phone Number (or method to contact): ________________________ Relationship to Patient: ___________

Patient Name: ___________________________________ Date of Admission: ______________________

Nature of Complaint: ____________________________________________________________________

______________________________________________________________________________________
______________________________________________________________________________________
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Pertinent Investigational Information: _______________________________________________________

______________________________________________________________________________________
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Problem Resolution/Follow Up: ____________________________________________________________

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Staff Person Addressing Grievance/Title __________________________________ Date Resolved ____________

*Please forward to the Patient Advocate when complete.

Reviewed by: ____________________________
Renaissance Healthcare Group, LLC

NOTICE OF NON DISCRIMINATION

This is to notify all persons that Renaissance Healthcare Group, LLC does not discriminate against any person because of his/her race, color, religious creed, national origin, sex, sexual orientation, which shall not include persons whose sexual orientation involves children as the sex object, age, ancestry, disability, marital status or political affiliation in the provision of or access to services, employment and activities.

This is in accordance with all applicable federal and state law, including, but not limited to, Section 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, as amended, the Tennessee Administrative Code and all relevant Tennessee Statutes.

David Nissen is designated to administer compliance with the law and regulations.

For further information about our policies and grievance procedures for the resolution of complaints contact:


George Kachmarik, PhD, for Programmatic Access and ADA issues.

______________________________  ______________________
Managing Director                              Date
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_________________________________________  _________________________
Managing Director                                    Date
Resident Responsibilities

You have most of the same rights, benefits and privileges at Pasadena Villa as you have anywhere. You also have the same responsibilities...

1. You may be held legally responsible for breaking the law. You may be civilly or criminally liable if you...
   - Intentionally or unintentionally damage property or hurt another patient, an employee or any other person.
   - Destroy or steal property.
   - Smoke inside of the building, or disable a smoke detector or other any fire protection device.

2. You may keep personal property, but you are responsible for taking care of it and for protecting it from theft or less.
   - Most valuable property should not be brought to the facility.
   - You may not bring or use any weapons, alcoholic beverages, drugs or paraphernalia or unauthorized substances into the facility.
   - You may use your own personal safe for safekeeping of valuables you choose to keep.

3. You should not interfere with the care or treatment of others.
   Remember that you are here, as are others, for care and treatment. You should respect the rights of others just as you want them to respect your rights. Safety concerns are the priority of Pasadena Villa. Residents who continue to place themselves or others at risk may be referred to higher levels of care. Some examples of behaviors that are considered interfering with the treatment of others include, but are not limited to; sexual contact or gestures with other clients, breach of confidentiality, harassing, bullying, or aggressive behaviors toward staff or clients, or requesting other clients for medications, non compliance with medications, or elopement issues.

4. Persons may be suspended from Pasadena Villa if any of the following exist:
   - Major medical condition requiring ongoing 24 hours per day, 7 days per week nursing services.
   - Chronic inappropriate behavior which disrupts, or could potentially disrupt, the facility's activities or is harmful to self or others;
   - Any prior diagnosis, determination or legal charges categorizing the person as a sexual offender, sexual perpetrator or sexual predator.
   - Patterns of non-compliance with the treatment plan, and policies of the facilities may result in termination.

- Your confidentiality is a priority, you are responsible for ensuring that you do not violate the confidentiality of others.
  - You are not required to make public statements about the facility or their treatment.
  - You are not required to perform in public gatherings.
  - You are not responsible for the care or supervision of others.
  - You are not permitted to access the confidential information of others.
  - You are not permitted to communicate the names, or any other identifying information of other residents by telephone, writing, or by any means of electronic communication, including e-mails and social networking sites.
  - You are not permitted to take photographs or videos of others nor post photos or videos of residents on public/social networking sites.

- It is your responsibility to work with our treatment team and to be active in your own care. This includes following facility rules and treatment protocols, as well as participating in program activities. The following policies are in place to encourage participation in treatment:
• Be actively involved in all areas of your treatment, which includes chemical dependency groups, psychotherapy groups, individual psychotherapy, and family therapy sessions. It is strongly advised that individuals who have chemical dependency issues refrain from attending locations that serve alcohol.

• You have the right to refuse activities but cooperation and participation is strongly encouraged to maintain a cohesive milieu. It must be noted that consistent refusal or patterns of noncompliance with attending groups may result in increasing level of care or increased supervision and/or level of care.

I have read and understand my responsibilities as a patient at Pasadena Villa.

Resident Signature: ___________________________ Date: __________

Staff Signature: ___________________________ Date: __________
Resident Rights

While you are at Pasadena Villa you have the following rights:

1. To be safe from harm and neglect.
2. To be treated with dignity and respect; free from abuse, retaliation, humiliation, financial or other exploitation.
3. To be informed of the Rules and Regulations.
4. To not be discriminated against because of race, sex, national origin, sexual orientation or handicap.
5. To have treatment for your mental and physical problems in the least restrictive environment possible.
6. To actively participate and have an independent review of your treatment planning.
7. To have available an adequate number of qualified staff.
8. To have information about you kept private.
9. To see your clinical records.
10. To see your own doctor.
11. To be informed of the effects of any medication.
12. To visit with, telephone or write your lawyer or others about legal problems.
13. To complain if you think your rights have been violated.
14. To practice your religion.
15. To attend school or obtain a job.
16. To read material of your own choosing.
17. To refuse to be photographed.
18. To see visitors you want to see; including privacy for spouses.
19. To send and receive mail without anyone else reading it.
20. To talk on the phone in private.
21. To spend your money as you want.
22. To wear your own clothing.
23. To free use of the common areas while observing the privacy and rights of others.
24. To have access to restroom facilities at all times.

Note: Some of these rights may be restricted by your physician if determined to be in the best interests of your care and treatment Restrictions are reviewed at least every 3 days.

I have read and understand my rights as a patient at Pasadena Villa.

Resident Signature: _____________________________________________ Date: ___________

Staff Signature: ________________________________________________ Date: ___________
RESIDENT NAME: _______________________

DATE: _______________________________

CONSENT FOR AUDIO/VIDEOTAPING

This is to certify that I, ______________________________, a resident at _____________________ give my consent to be audio-video taped or photographed.

For the purpose of: ________________________________________________________________

______________________________________________________________________________.

I acknowledge that the cassette will become the property of Renaissance Healthcare Group, LLC and will be kept confidential. The cassette will be kept in Medical Records for a period not to exceed five (5) years at which time it will be incinerated.

Signed:

_________________________________________  __________________________
Resident                                Date

_________________________________________
Legal Guardian (if applicable)             Date

_________________________________________
Witness                                Date
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Resident Therapeutic Pass
Emergency Care and Transfer Procedure
POLICY: It is the policy of RHG to provide a clear and concise description of Adjunctive Therapy Services. Adjunctive Therapy at RHG encompasses the areas of Activity Therapy, Equine Therapy, Art Therapy, Music Therapy and Recreational Therapy.

PURPOSE:

The Adjunctive Therapy Department is based on the belief that a sense of competence and social efficacy are fundamental to being able to cope and adapt and that such a sense of self is achieved in large part through successful “doing” experiences that verify achievement, mastery, and self worth.

The primary goal of the Adjunctive Department is to assist each individual to improve the physical, psychological, cognitive and social functions that are fundamental to acquisition of daily living skill.

To achieve this goal, the therapist must meet the following objectives:

1. Evaluate the individual’s performance, strengths, and deficits. Assessment of each resident must be completed within seven days of admission.
2. Identify the functional living skills required of the individual in his/her home environment.
3. Select therapeutic interventions appropriate to the defined need or goal.
4. Facilitate individual participation and investment.
5. Evaluate progress and response to interventions.
6. Document findings and make appropriate recommendations to the treatment team.

PROCEDURE:

OCCUPATIONAL/ACTIVITY THERAPY

Occupational Therapy provides an environment where a resident can gain better understanding of how he/she relates to objects and others. Many residents are not aware of their abilities, disabilities, negative attitudes, or problems until they are experienced in structured, task oriented therapeutic modality.

The occupational activity therapy includes activities of daily living and independent living skills. These groups and activities include time management, stress management, budgeting/money management, interpersonal skills, cooking skills and public transportation.
The occupational/activity therapist also conducts task oriented activities such as arts and crafts. The goal of these activities are:

1. Teach problem solving abilities
2. Improve frustration tolerance
3. Improve self-image, building self confidence
4. Structure age appropriate tasks
5. Build success oriented projects by enabling residents to feel positive about themselves.

Through assessing sensorimotor and cognitive skills, the therapist is able to:

1. Evaluate distractibility
2. Ability to follow directions
3. Attention span deficits
4. Anxiety
5. Coping skills

RECREATIONAL THERAPY

The recreational therapist offers weekly recreational outings, a multitude of sports and games, active exercise groups and leisure skill counseling.

The goal for each recreational group is to teach leadership skills, relationship skills, provide an outlet for fun and relaxation and to teach the residents to laugh and enjoy life. The exercise groups provide an opportunity for physical conditioning and to enhance physical wellness. The leisure skills counseling helps the resident to develop better use of leisure time through hobbies and other interests. These groups help the resident to decrease isolation, withdrawal and alienation.

EQUINE THERAPY

Equine Assisted Psychotherapy (EAP) is the field in which horses are used as a tool for emotional growth and learning. EAP is a collaborative effort between a licensed therapist and a horse professional. EAP is experiential in nature and the focus is not horsemanship. The focus of EAP involves the use of activities involving horses which requires the client or group to apply certain skills; non-verbal communication, assertiveness, creative thinking, problem solving skills, leadership, taking responsibility, teamwork, relationships and confidence.
POLICY: The purpose of this policy is to define the clinically approved methods of dealing with a resident who becomes physically aggressive or assaultive.

It is not used to "make" a resident do something he or she does not want to do, but to ensure a safe and effective resolution to the situation.

PROCEDURE:

When a resident acts out his/her anger by becoming physically aggressive or combative, the following procedure is the acceptable means of control.

1. Begin all VERBAL intervention techniques FIRST. Exhaust possible verbal de-escalations techniques prior to any physical intervention.

2. If the resident continues to be a danger to himself or others begin using physical C.P.I procedures.

3. If C.P.I interventions fail or if the resident should continue to be a danger to self or other residents, 911 should immediately be called. The Attending Physician should also be contacted, and a Baker Act shall be initiated.

3. An Incident Report shall be completed on each holding session resulting in injury or complaint of injury.
POLICY: It is the policy of RHG to facilitate dental services to its residents for initial screening, routine and emergency care. RHG does not have on-site dental services. Services are provided by a cooperative agreement with a community based dentist, or family dentist.

PROCEDURE:

1. All residents who have a need for dental services, either routine or emergency, shall be afforded the opportunity to see a dentist.

2. Emergency dental services are available through community based dentists.

3. Annual dental screenings are offered to those residents who have not had dental care for one year.

4. Personal hygiene monitoring shall include evaluation of the resident’s attention to oral hygiene and instruction, when necessary, in basic preventive dentistry.

5. Referrals for dental services shall be initiated by therapist, nurse, or guardian and requires a written physician’s order.
POLICIES AND PROCEDURES

SUBJECT: ELOPEMENTS

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: March 31, 2011

POLICY NO. TX-04

PROGRAM: ALL

POLICY: The purpose of this policy is to define the policies and procedures to determine if a resident is absent without permission and the notification requirements to be followed.

PROCEDURE:

1. Determination of runaway is defined by the following criteria:
   
   A. The resident has left the campus without staff permission.
   
   B. The resident's whereabouts are unknown for a period of 15 minutes after a thorough search has been made and the notification process will commence at this time.
   
   C. The only exception to the above is when a resident has been placed on close observation, in which case the notification and search will commence on discovery of the resident's absence.

2. Elopement is defined as being off campus for 24 hours or more.

3. Notification Requirements:

   The following persons should be notified in this order immediately upon determination of a runaway:

   A. Local Police, if it is believed that the resident poses a threat to himself or others
   
   B. Administrator or Clinical Services Manager
   
   C. Staff will notify parent or guardian
   
   D. Attending Psychiatrist

5. For the police report, the following information will be made available:

   File photograph, physical description (including clothing worn), medical problems (seizures, diabetic, etc.) and resident's present mental condition and expected behavior.

6. The runaway, preliminary events, interventions, etc. should be charted as well as the documentation of those notified.

7. An Incident Report shall be completed before the end of the shift.

8. On return the resident is placed on close observations until evaluated by the attending physician.

9. Notification requirements of resident's return:
POLICIES AND PROCEDURES

The same people notified of the runaway shall be notified of the return, especially the Local Police Department, all of which shall be documented.

10. On return, staff shall do:
   A. An assessment of the resident's condition
   B. A contraband search
   C. Obtain a specimen for drug screening
   D. Obtain a breatalizer

All of the above shall be documented in the resident's medical record.
POLICY: It is a RHG policy that emergency services for acute medical/surgical/psychiatric conditions are provided through local hospitals. Non-acute or routine medical care, not provided at this facility are obtained through contract with service providers in the community.

PROCEDURES:

Referral Services:

1. Medical, dental and other special professional services needed by residents and not available from RHG shall be secured through consultation with providers in the community.

2. Professional consultation shall be secured from the community sources including, but not limited to, hospitals, medical specialists, laboratories, dental clinics, and professional dietitians.

3. Conditions for which outside referrals may be initiated shall include the following:
   A. Examinations, assessments, or consultations that are not within the professional domain or expertise of the staff at RHG.
   B. Special treatment services.
   C. Assistance from providers who can contribute to the resident's well being.

4. The attending physician will determine residents in need of special professional consultation or treatment not offered at RHG.

5. Staff or parents will be responsible for making the arrangements necessary for the resident to be seen by a consultant, if the medical situation is non-emergent.

6. The nurse shall document each visit to a consultant in the individual resident record, including specific reason for consultation, date and time, and the consultant's recommendation.

7. Continuity of care is assured for the resident through the following methods:
   A. Records to other facility
B. Consultation request form to outside consultant with consultant recommendations documented on the consult form.

8. The resident and/or his parents may request a referral by talking to the nurse or the attending physician.

9. The nurse has the major responsibility of assisting in the referral of individuals who are seeking services that the facility does not provide. There are elective and non-elective referrals.

   A. In the case of elective referrals (e.g., dermatological exam for acne), the families of the residents are notified so that they can make the choice of whether they want the referral and whether they are able to cover the financial expenses. We encourage the parents to take care of these referrals on their own terms.

   B. In the case of non-elective referrals (e.g., ENT specialist), the nurse or the parents will make the proper arrangements to schedule and arrange transport for the resident to the referred service provider as soon as possible. The families and/or legal guardians are notified of the need for the non-elective referral so that they are aware of the situation.

   C. The family is notified of the results of any referrals made by the physician.

*Emergency Services:*

1. Emergency services are provided through local hospitals. The nature of the emergency may be medical/dental or psychiatric. Police or Ambulance will transfer all residents who are dangerous to self or others.

   A. The nurse on duty is available and authorized to provide necessary emergency medical evaluations.

   B. RHG vehicles may be used to transport the resident to the outside facility. In life-threatening situations, an ambulance is called. In non life-threatening emergencies, staff will accompany the resident to the outside facility.

   C. The nurse will complete a transfer summary with all pertinent data relative to the resident's medication and treatment which accompanies the resident for admission to an outside facility. For a routine or non-acute emergency, the request for consultation form will be completed by the nurse and will accompany the resident to the outside service provider.

2. Acute Emergencies:

   Acute Emergencies include but are not limited to the following and require immediate action:

   A. Poison ingestion
   B. Overdose
POLICIES AND PROCEDURES

C. Electrical shock
D. Stabbing
E. Hanging
F. Severe loss of blood
G. Loss of consciousness
H. Burns (2nd, 3rd degree)
I. Severe EPS or allergic reactions
J. Any life-threatening condition
K. Fall that results in bleeding
L. Chest pain

3. The following steps should be taken immediately:

A. Assess the immediate situation.
B. First aid intervention as needed, (in case of poisoning, call Poison Control Center at 800-222-1222.)
C. Call emergency paramedics at 911 or make arrangements for transport to the hospital as indicated.
D. Notify physician and parents.
E. Gather the following to facilitate Emergency Room or hospital admission processing:

1. Resident's insurance information: insurance company name, group name, policy number, certificate holder and insurance company phone number to contact to verify benefits.
2. Signed parental consent to treatment form.
3. Name of medications currently taking the time of last dose.
4. Pertinent medical information such as allergies, recent lab values physical condition, etc.

4. RHG shall maintain a registry of all transfers to acute care facilities (and shall notify the referring court in the case of forensic residents, if appropriate).
POLICY NO. TX-06
PROGRAMS: PV, SML, CRH

POLICY:
RHG will provide direct care residential staff on site/on duty; available for residents 24 hours a day. Treatment and rehabilitation services will be provided by mental health professionals or mental health personnel and under the direct clinical supervision of a licensed mental health professional. At least one staff member will be CPR and First Aid certified at all times.

PROCEDURES:
1. Smoky Mountain Lodge will maintain a waking and sleeping staffing ratio of 1 direct care staff member for every 10 residents.

2. Pasadena Villa Level II Residential will maintain a waking staffing ration of 1 direct care staff member for every 15 residents and a sleeping staffing ratio of one direct care staff member for every 22 residents.

3. Pasadena Villa Level IV Residential may have less than 24 hour on-site/on duty staff but will have on-call staff available 24 hours, 7 days a week.
POLICY:
RHG will provide procedures for on-call, back-up and staff mobilization in case of emergency.

PROCEDURE:
On-Call

RHG will make available administrative personnel to assist working staff whenever needed. The Clinical Services Manager, Administrator or assigned staff shall be on-call at all times, and staff shall have access to their respective home and cellular telephone numbers.

Back-Up

RHG will cross-train staff to perform various functions and to assist and back-up each other in the event back-up support is required. Also, the On-Call staff will have the numbers available to contact cross-trained staff, if needed.

Emergency Staff Mobilization

Although RHG’s staffing pattern exceeds state guidelines, there may be times when extra staff are needed to handle an emergency situation at the facility. In these cases, the facility staff will call the On-Call person. The On-Call person will determine if emergency staff mobilization is needed. If it is determined that staff mobilization is required, the following staff will all be immediately called in: Administrator, Clinical Services Manager, Therapist, Recreational Therapist, Nurse, and Mental Health Technicians.
POLICY:
Illegal drug use is not permitted on the premises of any RHG property by staff or residents. Alcohol use is not permitted on the premises of any RHG property by staff or residents. Drug and Alcohol use is not permitted while in treatment.

PROCEDURES:
Any resident found with drugs or alcohol on property or have used while in treatment may have rights or privileges restricted and/or be Administratively Discharged based on the recommendation of the treatment team.

Staff found with drugs or alcohol on property will be subject to termination.
POLICY: It is the policy of RHG to allow residents to participate in off-campus activities or recreational outings unsupervised and supervised by RHG staff. Activities do not require document unless a particular outing would result in a resident being off campus overnight. Such outings are subject to any special restrictions that be placed on the resident.

PROCEDURE:

1. The opportunity for off-campus, unsupervised outings/recreational activities is written into a resident's individualized treatment plan.

2. The resident must meet the qualifications established by the treatment team, of which the resident is part.

3. When there is a question of suitability for an outing, the Nurse and/or Therapist will assess the resident, document the results, and the have the final say in regards to a resident's participation in an off-campus outing or recreational activity.

4. All off-campus, supervised outings and recreational activities will be supervised by qualified staff.

5. Staff coverage on such outings will be adequate for the type of outing and the size of the group. There will be at least a ratio of one staff per eight (8) residents.

6. After the outing:
   A. When there is a suspicion of contraband, the resident may be searched.
   B. The results of the search will be documented in the resident's medical record.
POLICY:

It is the policy of RHG that no pets are allowed on any campus, including indoor and outdoor pets.
POLICY: It is the policy of RHG to assist the resident to gain control of his behavior in the least restrictive manner possible. If this proves ineffective, "Time Out" procedures may be utilized.

In no circumstances will seclusion or restraint be utilized. For the purposes of this policy, “seclusion” and “restraint” shall be defined pursuant to Chapter 65E-4.016 FAC. Bed rails may be used under the direction and supervision of a physician.

PROCEDURE:

1. Whenever a resident becomes agitated and requires staff intervention, staff shall allow the resident the opportunity for alone time in his/her room, or other quite area of the residence.
2. If the resident requires continual staff observation, the resident will be asked to take this alone time within visual eye distance of a staff member.
3. If the resident becomes further agitated, staff will follow the procedures of CPI intervention.
4. If the resident continues to be further agitated, and becomes a danger to him/herself or others, the police will be contacted; the Clinical Services Manager and physician notified for possible Baker Act procedures and transfer to an acute care facility.
POLICIES AND PROCEDURES

SUBJECT: SEXUAL CONTACT BETWEEN RESIDENTS

ISSUE DATE: June 30, 2002

POLICY NO. TX-13

REVISION DATE: March 31, 2011

PROGRAM: ALL

POLICY: It is the policy of RHG that sexual contact between residents is prohibited. Sexual contact is defined as consensual or nonconsensual kissing, fondling of another person’s body and/or breasts and genitals, mutual masturbation of one another, oral sex, digital penetration, simulated and actual intercourse.

PROCEDURE:

1. If it is suspected that there has been sexual contact between residents, the Clinical Services Manager shall be notified.

2. Staff will notify the attending physician.

3. The nurse, therapist and/or the attending physician will assess the emotional and physical status of the resident(s) involved.

4. The physician will order one or more of the following as appropriate to the resident(s) and the situation:
   A. Vaginal exam (OB/GYN consult)
   B. Pregnancy test
   C. Initiate resident to birth control measures
   D. HIV and STD testing

5. If the resident has a legal guardian, such guardian will be notified of occurrence and counseled regarding the possibility of sexually transmitted disease, as well as pregnancy and the need for medical follow-up.

6. The documentation by the nurse or therapist will include statements made by the resident, occurrence as observed or reported, physician notification, medical and nursing care provided.

7. The nurse or therapist will notify the police in the event a resident states the sexual act was nonconsensual.

8. The nurse or therapist will complete an Incident Report, which will be forwarded to the Risk Manager.

9. The nurse or therapist will notify the Clinical Services Manager and Administrator that the police will be on campus.

11. Interviews with law enforcement personnel will be limited to staff who were initially informed by resident of the nonconsensual sexual act.
A. A staff member will accompany the resident during interviews with law enforcement as a support to the resident.

B. The perpetrator is to be separated from the victim during interview.

C. After any interview with law enforcement, the staff member will document that the interview took place. This documentation will include the time of the interview, resident’s emotional status, the name of the interviewer and any requests for follow-up.
POLICY: It is the policy of RHG to allow for TLOA's (Therapeutic Leave of Absence) for the purpose of assessing the resident's progress toward accomplishment of the goals in his/her individualized treatment plan. TLOA's are time specific, medically appropriate, recommended by the therapist, Clinical Services Manager and Attending Psychiatrist.

PROCEDURE:

1. For the first 30 days, a resident is not allowed TLOA's, with the exception of medical.

2. It is the responsibility of the Therapist to check with the Clinical Services Manager and/or the chart for the resident's eligibility for TLOA.

3. Should the family situation, as assessed by the Family Therapist, be counterproductive to the treatment plan, the TLOA will not be granted. Should behavioral indicators, such as attitude toward treatment, the TLOA will not be granted.

4. The Therapist is responsible for reviewing the objectives for the TLOA with the resident and the parent prior to departure.

6. The nurse will provide medication education for the resident and family prior to departure and document on the Resident Therapeutic Pass.
POLICIES AND PROCEDURES

SUBJECT: TREATMENT PLANS or PLAN OF CARE

ISSUE DATE: June 30, 2002

REVISION DATE: March 31, 2011

POLICY NO. TX-15

PROGRAM: ALL

POLICY: It is the policy of RHG to provide a guideline for policies, procedures, and requirements regarding the development of treatment plans.

PROCEDURE:

1. Each resident shall have a written, individualized treatment plan/plan of care that is based on assessments from a multi-disciplinary team, which will meet the resident's clinical needs.

2. The overall development and implementation of the treatment plan/plan of care is assigned to the therapist under the direct supervision of the Clinical Services Manager.

3. Within seventy two (72) hours of admission, the nurse shall initiate an initial treatment plan. This initial treatment plan shall be based on an assessment of the resident's presenting problems, physical health, emotional status, and behavioral status.

4. A Master Treatment Plan is developed within thirty (30) days of admission at a full meeting of the treatment team. The report includes data gathered through the first-hand treatment team observation, evaluations, and the assessments. The treatment plan/plan of care is documented by the Therapist, with Psychiatrist having final approval.

   A. The multi-disciplinary team shall develop a treatment plan/plan of care that is based on a comprehensive assessment of the resident's needs, and shall contain objectives and methods for achieving them. Treatment goals or objectives shall be achievable, have a reasonable time frame for achievement, and be stated in terms of measurable and observable changes.

   B. At the treatment team meeting, the Therapist presents the family, social, and educational/vocational history, presenting problems, and other relevant background on how the resident has been adjusting to the group in terms of peer relationships, skill development, and behavioral aspects. Nurse shall present the medical history. The Recreational Therapist shall discuss the resident's recreational, occupational, and activity needs.

   C. The treatment plan/plan of care shall specify the services necessary to meet the resident's needs, as well as referrals for needed services that are not provided directly by RHG.

   D. The treatment plan/plan of care shall contain specific objectives that relate to the goals, written in measurable terms, and will include expected achievement dates.
E. The treatment plan/plan of care shall delineate the specific criteria to be met for termination of treatment.

F. A specific plan for involving the family or significant other shall be included in the treatment plan whenever possible.

G. The treatment plan/plan of care shall be developed with and signed by the resident or guardian. If the resident or guardian refuses to sign, the reason for this, if determinable, must be documented in the resident record.

H. If treatment interventions, as stated in the treatment plan, require restriction of communication or visits, treatment staff shall evaluate these restrictions at least weekly for their effectiveness and continuing need. Such restrictions shall be documented and signed by the Clinical Director and placed in the resident’s record.

5. Every thirty (30) days thereafter, a review of the treatment plan/plan of care is accomplished by the treatment team and documented by the Therapist with the Clinical Service Manager having final approval. The treatment team will complete a treatment plan/plan of care update every sixty (60) days.

The reviews of treatment are based upon information from the various disciplines and evaluate each resident's treatment plan/plan of care and his/her progress in attaining the stated treatment goals and objectives. This information is gathered through Team Meetings, daily charted notes, and specially call staffings.

Any unusual occurrence or major change in treatment, such as, but not limited to, transfer to an acute care facility, elopement, lack of individual resident progress toward treatment goals, medical complications, family complications such as death, divorce, etc., will provoke an immediate review and/or update of the treatment plan/plan of care. In addition, the treatment team will review the treatment plan/plan of care for specific residents resulting from the quality assessment/quality improvement, utilization review, and resident care monitoring studies. Also, in accordance with residents’ rights, a resident may request a review of his/her treatment plan at any time.

6. Psychiatric Discharge Summary: This written summary is due fifteen (15) days after dismissal.

7. If an Authorization to Release Confidential Information is signed by the guardian, copies of reports may be forwarded, upon request, to private physicians, psychologists, or psychiatrists who referred the resident for treatment. Copies of reports may be requested by insurance companies who are funding a particular resident's treatment, as well as other funding sources. Copies will be forwarded to these funding sources upon request.

8. Information regarding the progress of the resident is shared with the parent(s) or guardian through family conferences and telephone conferences with the Therapist or the Attending Psychiatrist. Any time there are revisions in the plan, it will be discussed with the parent(s) or guardian in the next
POLICIES AND PROCEDURES

scheduled family conference. An Authorization to Release Confidential Information will be signed prior to sharing this information.

9. On an exceptional basis, parent(s) may receive copies of the treatment plan/plan of care and the periodic Reviews of Treatment. The sharing of these professional, confidential reports with parent(s) or guardian(s) must be approved by the Attending Psychiatrist.
POLICY: It is RHG a policy to utilize the support measure termed "Visuals" when a resident becomes upset and staff has reason to believe the resident may engage in "acting out" behavior such as; elopement, self harm or suicidal ideation.

When a resident is on "Visuals," he/she must be within staff's eye-sight at all times. It is instituted by a staff member, when a resident is upset and gives staff reason to believe he/she might engage in acting-out behavior. The therapeutic aim is to reassure resident that we are aware of the situation and their anguish and that we care about them. It is used as a way to "take a resident's emotional temperature." It is also used to provide a resident the reassurance that if they require immediate adult intervention, they are assured they will receive it. This provides them the opportunity to feel safe while dealing with painful emotional issues.
POLICY:
The Nurse and Consultant pharmacist shall provide individual patient drug counseling if requested. Counseling shall include written or verbal instructions to the patient on the importance and correct use of drugs to be taken during treatment and following discharge.

PROCEDURE:
Drug counseling may be requested by resident, family or treating professional. Only nurses, pharmacists, or practitioners responsible for the patient may counsel patients on drugs to be taken following discharge. As necessary, the pharmacy shall provide drug related information to personnel who provide discharge counseling.

WHO MAY PROVIDE INDIVIDUAL PATIENT DRUG COUNSELING
Only pharmacists or other qualified personnel may counsel patients on drugs.

GOALS OF INDIVIDUAL PATIENT DRUG COUNSELING
The goals of individual patient drug counseling include:

• Educating patient’s concerning the need to take drugs as ordered
• Improving patient compliance
• Facilitating discharge planning by encouraging attitudinal adjustments about drugs
• Assessing side effects that interfere with the patient’s ability to function
• Assisting the patient in tolerating unavoidable effects.

INFORMATION INCLUDED IN INDIVIDUAL PATIENT DRUG CONSELING
Counseling shall include written or verbal instruction on the importance of correct use of drugs to be taken during the patient’s stay and following discharge. Counseling may include but shall not be limited to:

• Identity of the drug (s) and how it works
• Intended benefits
• How and when to administer the drug
• Side effects
• Allergies
• Precautions
• Contraindications
• Food-drug and drug-drug interactions
• Storage requirements

PRESCRIPTION MEDICATION NOT TAKEN HOME AT DISCHARGE
Prescription medication not taken with the resident upon terminating residence shall be returned to a responsible relative or a guardian, or if none exists, given to a pharmacist to destroy. Notation of drug disposition shall be entered in the resident’s record.

**DOCUMENTATION**
Counseling shall be documented in the patient’s medical record, on the Therapeutic Aftercare Plan and shall include the signature of the counselor and the date of counseling.
POLICY:
Pursuant to state regulations, facility management has determined that medications could be a safety hazard to residents in the program, therefore drugs and devices shall be centrally stored to ensure their stability and integrity.

Centrally stored medications shall be kept locked. These medications shall be accessible only to those staff responsible for distribution of medications. Narcotic medication will be double locked.

PROCEDURE:

Drug Storage Areas

Drug dispensing, administration and storage areas shall be well lighted and located where personnel preparing drugs for dispensing or administration will not be interrupted.

Storage Conditions

Drugs shall be stored under the proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

Official Compendia and Manufacturer’s Recommendations

Drugs shall be stored according to the provisions of the official compendia (USF/NF) and/or the specifications of the manufacturer so that their integrity, stability and effectiveness are maintained.

When in conflict, the consultant pharmacist shall ascertain whether the provision of the US/NF or the specifications of the manufacturer take precedence.

Labeling

Each container of medication shall be labeled according to state law.

Separation of Internals from Externals

Antiseptics, poisons, test reagents, other drugs for external use (i.e. otics, ophthalmics, etc.) and disinfectants shall be stored on separate shelves or in separate containers from internal and injectable drugs.

Food Storage and Consumption

Food shall be stored only in designated areas. Food shall not be consumed in areas designated for drugs.
Special Storage Conditions

Ensure that drugs requiring special storage conditions, such as, refrigeration or protection from light, are so stored.

Orderly Storage

Store drugs in an orderly manner to facilitate inventory control and minimize errors.

Clean Storage

Keep storage areas clean, uncluttered and free from trash, insects, rodents and vermin. If lowered shelves are not sealed to the floor, allow sufficient space underneath to permit access for cleaning.
POLICY:
Break-ins, theft or unexplained loss of drugs shall be reported in accordance with applicable federal and state laws.

PROCEDURE:
Theft or Break-ins

If there is a theft or break-in, the Clinical Services Manager shall be notified immediately. The consultant pharmacist shall ascertain the loss, if any.

Reports

The Nurse shall make reports to:

- Administrator or a designee using the Quality Review Report
- DEA Regional Office, if appropriate
- The State agency responsible for controlled drug regulation, if appropriate
- The State Board of Pharmacy, if appropriate
- Pharmacy
POLICY:
All controlled drugs will be counted by the nurse to ensure the security of controlled drugs, as well as the safety of staff, residents and visitors.

PROCEDURE:

1. Nurse on duty will count controlled drugs at the beginning of each shift with another staff.

2. The total number of pharmacy cards/bottles will be counted then logged on the Controlled Drug Use Record by the nurse and verified by the other staff.

3. The Nurse and other staff will verify the total number of pills remaining in each pharmacy card/bottle against the Controlled Drug Use Record.

4. Any unresolved discrepancy will be reported to the Administrator and then Risk Manager through an Incident Report.
POLICY:
Excess controlled drugs shall be disposed of according to this policy. The disposition of a controlled drug remaining in the ampule, vial, syringe, etc. must be documented.

PROCEDURE:
Destruction/Disposition of Controlled Drugs
Unusable or excess controlled drugs shall be given back to the pharmacist for disposal.

Controlled drugs shall be destroyed or disposed of in accordance with current destruction or disposition procedures of the DEA and the State Agencies.

Documentation
Documentation of disposition shall be on a report of wastage or destruction.

Witnesses
A licensed person, such as, the nurse or a Clinical Services Manager must witness and co-sign for all returns to the pharmacy for destruction.
POLICY:

Administration of drugs shall be in accordance with all state laws, federal laws, rules and regulations that govern such acts. Administration of prescribed medications shall be recorded on a Medication Administration Record (MAR). Medication shall be administered only to the person for whom it is prescribed.

PROCEDURE:

Compliance with Drug Orders

Drugs shall be prepared and administered in accordance with the orders of the prescriber or practitioner responsible for the patient’s care and accepted standards of practice.

Persons Who May Administer Drugs

Drugs shall be prepared and administered by or under the supervision of appropriately licensed personnel who have been approved by the medical staff. Drugs may also be self-administered by the resident, in compliance with policy and state law.

Standard Drug Administration Times

Unless the prescriber directs otherwise, drugs shall be administered at standard times.

Entries

- The date and time of administration to the resident.
- Resident’s last name, first name.
- Drug name, dosage.
- Signature and title of person who administered the drug or adjusted the stock.

Entry Notes

- Use a separate line for each drug issued or administered.
- Correct errors with a single line and initial all corrections

Completed MARs are to be placed in the resident’s chart.
POLICY:
Orders for drugs shall be written on a Physician’s Order Form or other authorized document.

PROCEDURE:
Maintenance of Original Orders
Original orders shall be a permanent part of the patient’s medical record.

Legitimate Orders – Authorized Prescribers
Orders shall be written by MDs or ARNPs, provided the individual is legally authorized by federal, state and local authorities to write such orders.

Authentication of Entries
Entries in medical records, including standing routine orders, must be authenticated and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing or evaluation the service furnished.

Written Drug Orders
Each drug order shall include the following:

- Patient name and location
- Time and date of order.
- Drug name, strength and dosage form, if necessary.
- Directions for use, including route of administration.

- Prescriber’s signature or that of his/her authorized agent.

The prescriber or prescribers responsible for the care of the patient shall sign written drug orders.
POLICY:
Verbal orders, including telephone or other oral orders, shall be processed in accordance with this policy.

PROCEDURE:
Recording Verbal Orders

Verbal orders shall be immediately entered on the physician’s order form or other authorized document. In addition to the information required for a written order, verbal orders shall include the following:

- Date and time of entry.
- Prescribing practitioner’s name.
- Signature and title of the person who accepted the order.

Authentication Verification of Verbal Orders

Orders that are not written by prescriber, such as, verbal orders, shall be subsequently authenticated verified and countersigned by the prescribing practitioner or other responsible practitioner.

Persons Who May Transmit Verbal Orders

Verbal orders shall be accepted only from authorized prescribers and only consistent with federal laws and the state laws and regulations.

Person Who May Accept Verbal Orders

Verbal orders for drugs and verbal clarification of drug orders shall accepted and written in the patient’s record by nursing staff.
POLICY:
Self-administration of medication may be facilitated by staff.

PROCEDURE:
Staff not licensed by the state to administer medication may assist a resident in the self-administration of medication by:

(1) Obtaining the medication from the centrally stored or other location;
(2) Reminding the resident that it is time for the medication to be administered;
(3) Preparing the necessary paraphernalia such as water, juice, cups, spoons, and medicine cups;
(4) Steadying arm, hand or other parts of the resident’s body;
(5) Returning to the medication container unused doses of solid medication not used by the resident; and
(6) Returning the medication container to the centrally stored or other location.

Patient Access Drugs

Drugs shall not be left at the patient’s bedside or in the patient’s room accessible to the patient unless specifically authorized by the responsible practitioner. Unauthorized drugs shall be returned to the centralized medication storage.

Labeling Drugs for Self-Administration

Drugs supplied for self-administration shall be labeled as such and shall include the patient’s name.

Supervision by a Member

A member of the staff shall supervise the pouring of medications for the self-administration of drugs.

Patient Instruction
Patients shall be instructed in proper administration techniques.

**Recording Self-Administered Drugs**

The following shall be recorded in the patient’s medical record:

- Quantity of drug.
- Date and time of delivery.
- Dosage administered.
- The MAR shall reflect self administration of the medication by documenting staff.
POLICY:

The nurse shall dispense temporary leave drugs to patients to assure continuity of care during temporary leave from the facility.

PROCEDURE:

**Resident Education**

The nurse shall conduct and document resident education about the medications to be used during the leave on the Resident Therapeutic Pass, to include:

1. Name and dosage of medication
2. Dosage schedule
3. Quantity dispensed
4. Date of Leave

**Labeling of Temporary Leave Drugs**

Temporary leave drugs shall be properly labeled for outpatient use. Labels shall contain:

- Name, address and phone number of pharmacy
- Date and pharmacy’s identifying number for the prescription
- Name of the patient
- Name, strength, dose form and quantity of the drug dispensed. (SEE NOTE)
- Directions to the patient for use
- Name of the prescribing practitioner
- Name or initials of the dispensing individual.
- Any required DEA cautionary label on controlled drugs
- Refill limitation and instructions, when applicable

**Note:** Include the manufacturer’s name or initials if a generic name is used. List principal active ingredients for combination or compounded products not having a brand name.

**Administration Records**

The patient’s medical record should note (as close as possible) the amount administered while absent from the facility.

**Disposition of Unused Drugs Upon Return To The Facility**

Upon return to the facility, unused drugs (if any) shall be returned to the pharmacy. The nurse shall ensure the destruction of unusable drugs.
POLICY:
All suspected adverse drug reactions should be reported to the Nurse immediately, and to the Risk Manager using the Incident Report. The attending physician should be informed immediately if the reaction is deemed serious or life threatening.

PROCEDURE:
Guidelines for Reporting Adverse Drug Reactions

Causality or proof a drug caused an undesirable patient effect is NOT a requirement for reporting an adverse drug reaction. If an adverse event is suspected of being drug-related, particularly if the event is unusual in context of the illness, it should be reported.

- all suspected adverse reactions to drugs which are unexpected. An unexpected adverse drug reaction is an undesirable patient effect, which is not consistent with product information or labeling.
- all suspected adverse reactions to drugs which are serious. A serious adverse drug reaction is an undesirable patient effect, which contributes to significant disability or illness. All adverse drug reactions, which result in hospitalization, prolong hospitalization or require significant medical intervention should be considered serious.
- all suspected adverse reactions to recently marketed drugs regardless of their nature or severity. A recently marketed drug is considered to be commercially available for less than five years.

Facility Review of Adverse Drug Reactions

ADR’s will be reviewed by Administration and the consultant pharmacist.
POLICY:
Authoritative, current charts or information and the telephone number of a regional poison control center shall be readily available and posted on the employee information board.

PROCEDURE:
In case of poisoning, overdose, or other exposure to a harmful substance facility personnel shall:

- Notify a physician immediately.
- Ascertain the
  - Chemical composition of the substance
  - Name of the substance
  - Manufacturer
  - Amount ingested
  - Route of entry or area of exposure
  - Time of entry or exposure
  - Patients vital signs and symptoms
- Examine the label and consult references for antidote and treatment.
- Contact the poison control center.
Emergency Care and Transfer Protocol

1. Assess the situation immediately

2. Apply first aid as needed – first aid kits are available in the kitchen, the staff office and in the administrative office

3. Call poison control if needed (800-222-1222)

4. Call emergency paramedics or ambulance by activating 911

5. Notify attending physician

6. Notify parents, guardian or emergency contact listed in resident record

7. Gather the following to facilitate transfer to the Emergency Room:
   a. Resident insurance and/or payer information: copy of insurance card should be in the resident record for emergency purposes
   b. Copy of signed consent for emergency treatment (Consent for Treatment form)
   c. Pertinent medical information such as allergies, recent lab values, physical condition, etc.

8. Be sure to remove other residents from the emergency area

9. Call the administrator on call, who may activate the emergency staff mobilization plan.
Resident Therapeutic Pass

Name: ______________________________________________________

Medication Schedule

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<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Time</th>
<th>Reason for taking</th>
<th># of pills sent home</th>
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I have read and understand the information given to me about my medication administration.

________________________________________________________  ______________________________
Signature of Resident or Significant Other                                            Date

______________________________________________     ______________________________________________
Nurse Signature                                                                                      Date
Resident Therapeutic Pass

Name:__________________________________________________________________

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I have read and understand the information given to me about my medication administration.

______________________________________________     ______________________________________________
Signature of Resident or Significant Other                                            Date

______________________________________________     ______________________________________________
Nurse Signature                                                                                      Date