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

REVIEW/REVISION DATE: February 5th 2016

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

POLICY NO. RI-02

REVIEWED/REVISION DATE: February 5th 2016

PROGRAMS: ALL

POLICY: It is the policy of RHG a 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 a victim of abuse at any point in his/her life, it must be reported. If a resident reports that they have participated in any type of abuse or neglect, it must be reported. If allegations of abuse or neglect are reported to Admissions Staff during the admissions process, it must be reported.

2. For current residents, the staff member that received the disclosure will call the Program Director and/or Psychotherapist/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 staff member shall notify the Executive 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 staff member 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 Psychotherapist/Therapist regarding the outcome of the call, and (b) IMMEDIATELY DOCUMENT IN THE RESIDENT'S CHART and separate Incident Report. Be sure to include the date, time, and the name and title of the DCF/DCS representative to whom this information was reported.

6. For current residents, the Psychotherapist/Therapist or Program Director shall inform and process the outcome of the call with the resident.

7. For current residents, the Psychotherapist/Therapist and/or Program Director 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

POLICY NO. RI-03

REVIEW/REVISION DATE: February 5th 2016

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 Residents Rights and Resident Responsibilities.

2. As part of the admission process, the Admission staff 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 psychotherapist will ask the resident whether he/she has completed an Advance Directive. If the resident requests, the psychotherapist will assist with sources of help in formulating an advanced directive.

4. If an Advance Directive has been completed, the psychotherapist 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.
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.
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. If a resident’s mental status deems it unsafe or counter-therapeutic to attend services off-campus, the resident 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

REVIEWED/REVISION DATE: February 5th 2016

POLICY NO. RI-06

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 available to all staff.

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 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.

Residents are informed that sexual relationships between residents while in treatment are prohibited. These types of relationships distract from the therapeutic process and are disruptive to the milieu.

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.

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 from 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 STATE LAW.
POLICIES AND PROCEDURES

SUBJECT: RESIDENT SATISFACTION/
RESIDENT ADVOCATE: COMPLAINT RESOLUTION

ISSUE DATE: June 30, 2002

POLICY NO. RI-09

REVIEWED/REVISION DATE: February 5th 2016

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, therapist 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 Resident Advocate within a reasonable amount of time (thirty days) after the person filing the complaint becomes aware of the action.

D. The Resident 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 Resident 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 Resident 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 HIPAA laws apply.

I. The Resident Advocate shall maintain the files and records relating to complaints filed hereunder. The Resident 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 RESIDENT ADVOCATE:

Duties of the Resident 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 Resident Advocate is responsible for submitting a quarterly statistical report of the grievance activity to the governing body.

6. If the Resident 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.
Policies and Procedures

Subject: Resident Telephone Rights

Issue Date: June 30, 2002

Reviewed/Revision Date: February 5th 2016

Policy No. RI-10

Program: All

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.
POLICIES AND PROCEDURES

SUBJECT: SECURITY OF VALUABLES

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: February 5th 2016

POLICY:

It is the policy of RHG to preserve the security of all valuables on the premises and to ensure 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.
POLICIES AND PROCEDURES

SUBJECT: SECURITY OF VALUABLES

ISSUE DATE: June 30, 2002

REVIEWED/REVISION DATE: February 5th 2016

POLICY NO. RI-11T

PROGRAM: All

POLICY:

It is the policy of RHG to preserve the security of all valuables on the premises and to ensure 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.
POLICIES AND PROCEDURES

SUBJECT: OFF CAMPUS JOBS

ISSUE DATE: June 30, 2002

POLICY NO. RI-12

REVIEW/REVISION DATE: February 5th 2016

PROGRAM: ALL

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 Program Director 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.
POLICIES AND PROCEDURES

SUBJECT: RESIDENT ORIENTATION and SELF PRESERVATION

ISSUE DATE: June 30, 2002

REVIEW/REVISION DATE: February 5th 2016

POLICY NO.RI-13

PROGRAM: ALL

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.
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
POLICIES AND PROCEDURES

SUBJECT: CODE OF ETHICS

ISSUE DATE: June 30, 2002

POLICY NO. RI-16

REVIEW/REVISION DATE: February 5th 2016

PROGRAM: All

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 RESIDENTS

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.

RESIDENT 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 payer 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
POLICIES AND PROCEDURES

The facility and its employees will disclose to residents any financial interests with other service providers, educational institutions, or payers 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.
Purpose:
Development and implementation of corrective action plans for compliance-related issues.

Policy:
The Chief Compliance Officer and/or Facility Compliance Officers may develop and, in consultation with human resources or outside counsel, impose a corrective action plan upon noncompliant staff or other persons subject to the compliance program as a means of facilitating the overall compliance program goal of full compliance. Corrective action plans should be designed to first assist the noncompliant individual(s) to understand specific issues and reduce the likelihood of future noncompliance. Corrective action, however, shall be developed to effectively address the particular instance or issue of noncompliance and should reflect the severity of the noncompliance.

Procedure:
The basis for corrective action may derive from internal compliance reviews, consultants reports, audits, and other substantiated sources of noncompliant practices in any department by any persons.

The following constitute the minimum action which shall be taken in response to noncompliance with the compliance plan. A corrective action plan for a first violation of noncompliance shall include these elements:

1. a clear statement of the specific problems to be corrected
2. a summary of the method used that discovered the problem
3. a summary of the findings that include an analysis of the noncompliance that will determine the extent and content of the corrective action plan. The analysis may be found to include system or human error, negligence, reckless disregard of policies or procedures, and applicable laws and regulations, or willful misconduct.
4. Remediation, which at minimum, shall include additional education or training by the Chief Compliance Officer, and/or Facility Compliance Officer or their designee if such analysis indicates that education or training is appropriate.
5. A statement that the failure of an individual who is subject to corrective action plan to adhere to the plan shall be grounds for further corrective action that may include disciplinary procedures and/or actions.
6. A statement that corrective action shall be in response to noncompliance during a given audit period, but noncompliance and previous audit periods can be considered in deciding upon appropriate corrective action.
7. A statement that if an analysis shows that the source of the problem was a reckless disregard of facility policies or applicable laws and regulations, or willful misconduct, the compliance corrective action shall yield to all appropriate provisions of the applicable human resources corrective action plans or policies.
Purpose:
To establish training requirements for all employees concerning the corporate and facility compliance program and policies.

Policy:
All new employees will review the corporate compliance manual and the organization’s code of conduct as part of the new employee orientation process.

Procedure:
1. All staff members will review the organization’s code of conduct as part of their annual performance review evaluations.
2. The Chief Compliance Officer, or Facility Compliance Officer, will inform staff members of specific ongoing compliance issues that pertain to their job duties at regularly scheduled staff meetings.
3. All staff members will participate in ongoing compliance in service presentations and competency-based trainings.
4. Regular publication of reporting mechanisms will occur throughout the organization’s communication systems. These will include but not be limited to email notification, internal memos, and postings on bulletin boards and staff and public areas.
5. Upon review of the corporate compliance manual, employees will sign an acknowledgment that they have received and understood the compliance program requirements.
6. Employee exit interviews may include compliance-related questions.
Purpose:
Procedures for conducting internal compliance investigations.

Policy:
Odyssey Behavioral Health is committed to full compliance with all applicable state, federal and local laws. The Chief Compliance Officer shall have the responsibility and authority to conduct and oversee independent compliance investigations to detect possible violations of the law, with legal guidance of outside counsel as appropriate. The extent of the investigation will vary depending on the matter investigated.

Procedure:
1. The Chief Compliance Officer shall commence and/or oversee investigations on all compliance-related matters within seven (7) days following receipt of the report indicating a matter warranting investigation.

2. The Chief Compliance Officer may delegate the investigation responsibilities, but will retain ultimate supervision and responsibility for all compliance investigations.

3. The investigation may include, but is not limited to:
   a. reviewing and preserving documents related to the matter;
   b. interviewing appropriate individuals;
   c. reviewing policies and procedures applicable to the matter;
   d. collaborating with facility or program management as needed and
   e. engaging outside legal counsel or consultants or other authorities to assist in an investigation, as needed.

4. If a significant compliance violation is found, the Chief Compliance Officer shall develop and implement a corrective action plan, in consultation with facility compliance officer, management, and, if needed, with other departments within the facility or within Odyssey corporate.

5. All investigation methods and findings pursuant to the investigation must be documented. Copies of all supporting documents should be attached to all reports.
   a. If the investigation findings do not substantiate the allegation or matter, the investigation will be closed by the Chief Compliance Officer.
   b. If they compliance violation is found, all documentation related to the investigation will be maintained as an “open” investigation and tell a corrective action plan has been completed and the matter has been resolved, at which time the investigation will be closed by the Chief Compliance Officer. Once closed, the investigation file will be filed and maintained by the Odyssey corporate compliance officer and the appropriate facility compliance officer for a minimum of seven (7) years after the investigation has been closed.

6. For investigations implicating the facility compliance officer, the Chief Compliance Officer
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shall notify the CEO of the facility and will conduct and coordinate the investigation. For investigations implementing the Chief Compliance Officer, will be handled by outside counsel at the direction of the Board of Directors.

SUBJECT: CONFLICTS OF INTEREST

ISSUE DATE: March 1, 2016

POLICY NO. RI-20

REVIEW/REVISION DATE: March 1st 2016

PROGRAM: ALL

Purpose:

To provide a policy for facility personnel concerning the identification, disclosure, and management or elimination of potential and actual conflicts of interest. Activities of facility personnel involving other businesses, organizations or individuals must not interfere or conflict with their duties to the facility or cause loss or embarrassment to the facility, or Odyssey. Accordingly, facility personnel must identify and disclose such situations to the facility so that the situation can be managed or eliminated.

Policy:

Facility personnel should not place themselves in a position where their actions or the activities or interests of others with whom they are with whom a member of their family may have a financial, business, professional, family or social relationship that may be in conflict with the interests of the facility or program. Employees shall not enter into any transaction or activity in which their interests are advanced at the expense of Odyssey, the facility or program, or any transaction or activity which may interfere with the proper performance of their duties or which may cause loss or embarrassment to the facility, program or Odyssey.

• Employees shall not have any direct or indirect interest or relationship with any transaction which might in any way affect their objectivity and independent judgment or conduct and carrying their responsibilities for the facility.

• Employees shall not conduct any business or perform any services for another professional or business venture or enterprise while on company time nor shall they use any company resources for such activities.

• Employees shall refrain from transactions which might in any way embarrass the facility, program, or Odyssey, because such interest or relationships might reasonably be misunderstood by others. Such transactions, while not including routine business transactions such as reasonable meals, specifically include the receipt of gifts.

• A waiver of a conflict shall be allowed only when full disclosures and appropriate reviews are made and approval has been granted by the applicable facility Executive Director and Chief Compliance Officer. The obligation to disclose is a continuing duty, which requires disclosure at any time any such conflicts may arise.

Examples of Conflict Situations:

Because each case may involve special circumstances, each case will be generally judged on its own merits. Accordingly, it is not feasible to specify all possibilities which may give rise to a potential conflict of interest that must be disclosed by the employee. Any employee who believes that he or she may have an actual or potential conflict of interest shall report all pertinent information to the facility executive, or facility compliance officer. The following, however, illustrate certain types of more serious potential conflicts which must be disclosed:

1. Involvement, directly or indirectly, in outside commercial interests, such as with vendors, physicians, patients, competitors or others having a business relationship with the facility which
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could influence the decisions or actions of an employee in the performance of his/her job.

2. Acceptance by an employee, or member of his/her family, of gifts, entertainment or favors which go beyond common courtesies usually associated with accepted business practice and which could place the employee under obligation to a vendor, physician, patient or other persons having a business relationship with the facility.

3. Solicitation by an employee, or member of his/her family, of gifts, contributions, gratuities, tickets or entertainment from vendors, physicians, patients or others having business relationship with the facility, regardless of dollar value.

4. Maintenance of an interest by an employee, or member of his/her family, in a business with which the facility has, or is about to have, dealings, including the sale or lease of real or personal property or supplying services to the facility. It is incumbent upon the employee to disclose such an interest to their supervisor and/or the Facility Compliance Officer so that the facility’s business decision can be made by someone who clearly has no self-interest in the matter.

5. Performance of work, even part-time, by an employee of the facility in any other commercial enterprise is generally not allowed. This includes but is not limited to any circumstance or arrangement whereby an employee would be compensated for services performed or provided. However, an employee may seek approval from their supervisor as long as any outside employment, investment or other source of income is secondary and subordinate to the employee’s position with the facility and must not interfere in any way with the performance of duties for the facility. In particular, no employee should work for or provide services to any competitor, vendor, physician, patient, or others having a business relationship with the facility. The petition must be in writing and authorization for outside employment requires approval by the supervisor and either the Chief Compliance Officer or the applicable facility CEO.

6. Use of facility employees, material, equipment or other company property for personal purposes.

7. Borrowing by an employee, or member of his/her family, of money, material, equipment, or personnel from any competitor, vendor, physician, patient, or others having a business relationship with the facility, except transactions with banks or other institutions in accordance with normal business practices.

8. At any time during or after employment with the facility, using or revealing outside the facility any confidential or proprietary information concerning the facility, or using for personal gain confidential or “insider” information obtained as a result of employment with the facility. All employees working with confidential information should guard against its intentional or inadvertent disclosure to outsiders.

Corrective Action:
Any employee intentionally violating this policy is subject to appropriate corrective action including immediate dismissal, and if appropriate, Odyssey may seek to recover damages or any improperly received gains and/or encourage prosecution for any possible criminal offenses.
Purpose:
Description and reporting responsibility of facility compliance officers.

Policy:
All Odyssey facilities and programs shall designate a facility compliance officer (“FCO”). The FCO will be considered a member of the management of the facility and will report regarding compliance program related matters to the chief executive officer, and Chief Compliance Officer.

Procedure:
In coordination with the Chief Compliance Officer, the FCOs shall have the following duties and responsibilities:

• Coordinate resources to ensure proper implementation and ongoing effectiveness of the compliance program at the facility and program level.
• Organize and maintain facility compliance policies and procedures. Assure that the facility compliance program effectively prevents and/or detects violations of law, regulations, facility policies, the code of conduct and the compliance manual.
• At the direction of the Chief Compliance Officer conduct compliance education/training programs for facility employees and other related persons working with the facility or program.
• At the direction of the Chief Compliance Officer conduct and/or provide assistance with investigations including, when requested, conducting or participating in the investigation and/or review of compliance related reports to the Chief Compliance Officer involving the facility, including the oversight of resolution to any investigations which may involve disciplinary measure against facility employees for instances of noncompliance.
• Work with the Chief Compliance Officer in developing and implementing corrective action plans and compliance remediation plans in accordance with the compliance program.
• Develop, coordinate and oversee other audit procedures for the purpose of monitoring and detecting any potential misconduct, noncompliance or failure to follow facility policies.
• Develop a yearly audit work plan.
• Provide assistance at the facility or program level with other compliance program matters and initiatives as directed by the Chief Compliance Officer.
Purpose:
To provide a mechanism for employees to report any known or suspected ethical violations or other activity that may be inconsistent with any provisions of the code of conduct, compliance program, or Odyssey or facility policies, or that an employee believes may otherwise violate any law or regulation, including a mechanism for anonymous reporting.

Policy:
Odyssey Behavioral Health is committed to complying with all applicable laws and regulations including those designed to prevent internal fraud, waste and abuse. The organization desires a climate that discourages improper conduct and facilitates open communication of any compliance concerns and/or questions. If any employee including facility and corporate employees have knowledge of, or in good faith, suspect any wrongdoing in the documenting, coding, or billing for services, equipment or supplies; in the organization’s financial practices; involving any violation of any law or regulation; or involving a violation of facility policy, they should promptly report it so that an investigation can be conducted and appropriate action taken.

There are many ways to report suspected improper conduct. In most cases any concerns should be brought to the attention of a supervisor. However, if this does not result in appropriate action, or if an employee is uncomfortable discussing these issues with their supervisor, they should take their concerns to another member of management, or use the reporting methods available through the Odyssey compliance program. Failure to report any known illegal conduct can have consequences. Retaliation or reprisal against anyone for making such a report, in good faith, is strictly prohibited by law and is a violation of Odyssey compliance policy.

Making an allegation of ethical wrongdoing or compliance violations, whether made in good faith or not, does not exempt an employee, at any level, from performance improvement or disciplinary corrective actions stemming from identified job-related performance issues.

Supervisors receiving a complaint that raises a potential compliance issue shall report the complaint to the Facility Compliance Officer. Complaints that do not raise a potential compliance issue should be referred to the appropriate department. Facility Compliance Officers shall report all complaints with potential compliance issues to the CEO and to the Chief Compliance Officer.

Sometimes, employees may become suspicious of innocent activities due to insufficient information. To prevent this understanding, we encourage all employees to immediately bring any concerns or questions forward using the established internal channels.

Employees may be reluctant to discuss wrongdoing with their employers out of fear of retaliation.
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However, no retaliation will be permitted against an employee who, in good faith, brings forward concerns. Only where it has been clearly determined that someone has made a report of wrongdoing maliciously, frivolously, or in bad faith will disciplinary action be considered.

Procedure:

1. If at any time an employee becomes aware of or suspects illegal or unethical conduct or a violation of facility policies by another employee, board member, vendor, contractor, medical staff member or a volunteer, the employee must report it immediately to the appropriate individual. Such individuals may include the employee’s immediate supervisor, management, risk management, Facility Compliance Officer, Human Resources Director, Chief Compliance Officer.

2. An employee may also make a report using the anonymous compliance email (compliance@OdysseyBH.com), or by sending in an anonymous letter to the compliance department:
   Odyssey Compliance Department
   100 Winners Circle, Suite 420
   Brentwood, Tennessee, 37027

3. Self-reporting is encouraged. Anyone who self-reports their own potential wrongdoing or potential violation of law will be given due consideration and any potential mitigation of any disciplinary action that may be taken.

4. Once a report is received, and appropriate individual will then be assigned to conduct an investigation into the allegations to determine the nature, scope and duration of wrongdoing, if any. Odyssey investigates all non-frivolous claims of wrongdoing.

5. If the allegations are substantiated, a plan for corrective action will be developed. Appropriate corrective action may include restitution of any overpayment amounts, notifying an appropriate governmental agency, disciplinary action or making changes to policies and procedures to prevent future occurrences.

6. Retaliation in any form against anyone who makes a report of wrongdoing, or cooperates in an investigation, is strictly prohibited. If any employee feels that they have been retaliated against, the employee should report it immediately, using any of the reporting methods referred to in this policy.

7. Our commitment to compliance and ethical conduct depends on all employees. Should any employee find themselves in an ethical dilemma or suspect inappropriate or illegal conduct, they should remember the internal processes that are available for guidance or for reporting suspected unethical conduct.
Purpose:
To establish procedures for facility employees regarding government inquiries, investigations and audits from government officials, insurance companies, representatives, investigators, or other individuals acting on behalf of the government, so as to assure that they act appropriately in cooperation with the investigation or audit, as well as to enable Odyssey to lawfully protect its interests.

Policy:
It is the policy of Odyssey behavioral health to cooperate fully with any lawful government investigation or audit. Odyssey expects all employees to extend the same cooperation within the guidelines of this policy. Accordingly, this policy covers:

1. Telephone calls or letters from a licensure or regulatory representative, investigator or other individual acting on behalf of the government, or payer.

2. Prevention of demand letters, subpoenas, or search warrants.

3. On-site visits to or inspections of Odyssey facilities or programs including corporate and/or facility premises, by a government official, representative, investigator or other individual acting on behalf of the government.

4. Visits to the homes or other locations of current employees by a government official, representative, investigator or other individual acting on behalf of the government.

5. Other contacts with a government official, representative, investigator or other individual acting on behalf of the government.

Procedure:

If a facility or Odyssey employee is contacted at an Odyssey workplace by an official, representative, investigator or other individual acting on behalf of the government, the employee should: (1) immediately contact the Chief Compliance Officer or Facility Compliance Officer and (2) ask to see the credentials or proper identification, including a business card, before speaking further with the person.
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Upon receipt of notice of or information regarding a government investigation, the Chief Compliance Officer, and or Facility Compliance Officer may contact legal counsel, as appropriate.

Requests for Interviews
An interview of a facility or Odyssey employee may be requested by a government official, representative, investigator or other individual acting on behalf of the government. Legal counsel may be immediately notified and may be consulted regarding any such request. If an employee decides to be interviewed by the government official, representative, investigator or other individual acting on behalf of the government, the employee should always be truthful, cooperative and polite. If the employee does not know with certainty the answer to any question, it is appropriate for the employee to say that he or she does not know the answer to the question. In addition, the employee may stop the interview or conversation at any time.

Demand for Documents
A government official, representative, investigator or other individual acting on behalf of the government may arrive at an Odyssey facility or premises with written authority seeking documents. This authorization may come in the form of a demand letter, subpoena, or search warrant.

Once there has been notice of an investigation, the destruction portion of any policy on record retention is suspended and no documents may be destroyed until notified otherwise by the Odyssey Chief Compliance Officer.
Purpose:
To give guidance in the event a facility or program is served with a lawful search warrant or subpoena.

Policy:
It is the policy of Odyssey and its facilities and programs to cooperate with any lawfully executed search warrant or subpoena.

Procedure:
Demand Letters and Subpoenas
1. If the authorization is either a demand letter or subpoena, the employee must request that the government official, representative, investigator or other individual acting on behalf of the government wait until either the Chief Compliance Officer, legal counsel, or other facility official “in charge” is notified.
2. The employee should ask the government official, representative, investigator or other individual acting on behalf of the government for proper identification, including their business cards, and the employee should list the names and positions of all the investigators along with the date and time of the demand.

Search Warrants
1. If a government official, representative, investigator or other individual acting on behalf of the government presents a valid search warrant and identification, employees must understand that they have the authority to enter the premises, to search for evidence of criminal activity, and to seize those documents or items listed in the warrant. No employee shall interfere with the search and must provide the documents or items sought in the warrant.
2. All employees should request an opportunity to consult with the Chief Compliance Officer before a search commences. Note, however, that this request may not be granted by the investigators. However, employees (1) should request copies of the warrant and the affidavit providing reasons for the issuance of the warrant, and (2) should provide the Chief Compliance Officer with a copy of the warrant immediately if possible. If legal counsel for the facility can be reached by telephone, the employee should put counsel directly in touch with the lead investigator.
3. To the extent possible, employees should keep track of all documents and the general information in any documents taken by the investigators. Note in as much detail as
circumstances allow the precise areas and files searched, the time periods when each of them was searched, the manner in which the search was conducted, the government official, representative, investigator or other individual acting on behalf of the government who participated, and which files were seized.