Corporate Compliance and Ethics Manual

Company Name
City, State

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This Corporate Compliance and Ethics Manual consists of policies and procedures. Policies are based on federal requirements established by the Office of Inspector General (OIG), The Centers for Medicare & Medicaid Services (CMS), and the Department of Justice (DOJ). Procedures are based on industry best practices. All policies included in this Manual apply to any and all persons who are affected by the providers risk areas including company employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors/contractors and subcontractors, agents, Chief Executive and other senior administrators, managers, executives, Governing Body Members, corporate officers, 1099 employees, and service contractors.
At Med-Net, we recognize that organizations may have a different process for these practices; how-ever, any changes to policies must be incorporated through the Company Compliance and Ethics Officer and Governing Body through a documented systematic structure and process for drafting, reviewing, revising, and adopting policies and procedures.
This Manual is meant to replace any previous version(s) that may be present in the facility. Archived policies can be obtained by contacting Med-Net. All questions related to the policies in this Manual should be directed to the Company Compliance and Ethics Officer.
This manual has been designed in collaboration with Barmak and Associates, LLC. legal counsel, and as such Med-Net supports those policies excluding customized entries.

Company Name
Corporate Compliance and Ethics Manual
Approval and Indications for Company Use

Compliance is a key component to *Company Name's* day-to-day operations (further referenced as "The Company" throughout this manual). We strive to maintain a good faith effort to comply with all applicable laws, rules, and regulations. In accordance with existing guidance from the U.S. Department of Health and Human Services, Office of Inspector General, as well as the statutory requirements of the Patient Protection and Affordable Care Act, The Company has adopted a Compliance and Ethics Program.

This *Corporate Compliance and Ethics Policy and Procedure Manual,* (hereafter referred to as "Manual"), has been designed to provide guidelines for all affected individuals associated with The Company including company employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors/contractors and subcontractors, agents, Chief Executive and other senior administrators, managers, executives, Governing Body Members, corporate officers, 1099 employees, service contractors. All are expected to comply with applicable federal laws, rules, and regulations provided in this manual as well as state specific requirements referenced through links in Chapter 13 of this manual and The Company's own policies and procedures. Those who fail to comply with the elements of this Program may face disciplinary action, up to and including termination.

This Manual is meant to replace any previous version(s) that may be present in The Company. All questions related to the policies in this Manual should be directed to The Company's Compliance and Ethics Officer.

Manual Adoption: The Governing Body of *Company Name* adopted the policies and procedures outlined in this Manual and these policies and procedures have been reviewed by the QAA/QAPI Committee and found to be adequate to meet the needs of *Company Name* and its residents. The administrator has been delegated the administrative authority, responsibility, and accountability of assuring that all personnel, residents, and the community are made aware of these policies and procedures through an established orientation and in-service training program.

Manual Approved: A group of professional personnel with appropriate representation from administration and the professional disciplines, establishes and annually reviews The Company's Compliance and Ethics Program for use by The Company. The group includes the Compliance and Ethics Officer and at least one member who is neither an owner nor an employee of The Company and may include a member of a third-party compliance company.

Manual Reviewed/Revised: *Date(s) the Manual was reviewed*

Revision Date: *Date(s) the Manual was last revised*

Reviewed by:	**Title:**	**Date:**
Reviewed by:	**Title:**	**Date:**
Reviewed by:	**Title:**	**Date:**

Preface

The electronic version of this Manual is interactive. The *Table of Contents* is hyperlinked to each chapter, and within each chapter is an index with hyperlinks to each policy. Click on the chapter or policy to access it directly.

Throughout the Manual are links in blue text. Click on the blue text to be redirected to a related policy/section/appendix, or to an outside website link containing additional information on the topic being discussed.

Please note: When using the internal hyperlinks of this manual, you will not be able to instantly navigate back to the previous section. To return to the previous section, use the search function by typing in keywords from that section, return to the Table of Contents and click on the section from there, or scroll manually to the section.

Once the Governing Body adopts this Manual, it can be individualized for organization use by inserting the organization name at the *Company Name* grayed areas.

The Governing Body updates the adoption of this Manual on an annual basis.

CORPORATE COMPLIANCE AND ETHICS MANUAL
TABLE OF CONTENTS

1. COMPLIANCE AND ETHICS PROGRAM (CP)

1. COMPLIANCE AND ETHICS PROGRAM (CP)

Policy Number	Policy
CP 1.0	COMPLIANCE AND ETHICS PROGRAM: REGULATORY COMPLIANCE
CP 1.0.1	CORPORATE COMPLIANCE AND ETHICS PROGRAM ADMINISTRATION, OVERSIGHT, AND RESPONSIBILITY
CP 1.1.0	GOVERNING BODY A. DUTIES AND RESPONSIBILITIES B. CHARTER AND ADOPTION AGREEMENT
CP 1.1.1	POSITION DESCRIPTION: COMPLIANCE AND ETHICS OFFICER A. ROLE OF THE PRIVACY OFFICER B. ROLE OF THE INFORMATION SECURITY MANAGER C. ROLE OF THE VIOLENCE PREVENTION MANAGER D. ROLE OF THE SAFETY AND RISK MANAGER E. APPOINTMENT OF A COMPLIANCE AND ETHICS OFFICER
CP 1.1.2	COMPLIANCE AND ETHICS COMMITTEE CHARTER
CP 2.0	COMPANY COMPLIANCE AND ETHICS PLAN: STANDARDS, POLICIES, AND PROCEDURES A. COMPLIANCE INQUIRY SYSTEM B. COMPLIANCE REPORTING SYSTEM C. SCREENING AND EVALUATION OF ASSOCIATES D. PROTECTION OF EMPLOYEES E. COMPLIANCE HOTLINE F. COMPLIANCE CONFIDENTIALITY G. COMPLIANCE AUDITING AND MONITORING H. COMPLIANCE RESPONSE AND PREVENTION I. COMPLIANCE INVESTIGATION J. EXTERNAL COMMUNICATIONS AND LITIGATION K. COMPLIANCE CORRECTIVE ACTION L. COMPLIANCE AND ETHICS TRAINING AND EDUCATION M. COMPLIANCE REASSESSMENT/ANNUAL REVIEW
CP 2.1	CODE OF CONDUCT
CP 2.2	CONFLICT OF INTEREST
CP 2.3	GENERAL LEGAL DUTIES AND ANTITRUST LAWS

CP 2.4	RISK MANAGEMENT A MEDICAL RECORDS REQUEST REVIEW

Policy Number: CP 1.0

Policy Title: Compliance and Ethics Program: Regulatory Compliance (§ 483.85 Effective November 28, 2017)

Policy Statement/Purpose: The organization's *Compliance and Ethics Program* is designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Social Security Act in promoting quality of care; and includes, at a minimum, the required components specified below.

Policy Interpretation and Implementation:

Definitions:

High-level personnel - individual(s) who have substantial control over The Company or who have a substantial role in the making of policy within The Company.

Required Program components - The Company develops, implements, and maintains an effective Program that contains, at a minimum, the following components:

(1) Written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Social Security Act and promotes quality of care, including but not limited to:

- The designation of an appropriate Program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution, retaliation, or intimidation.
- Disciplinary standards that set out the consequences for committing violations for The Company's entire staff; individuals providing services under a contractual arrangement; and individuals providing services on a volunteer basis.

(2) Assignment of specific individuals within the high-level personnel of The Company with the overall responsibility to oversee compliance with The Company's compliance and ethics program's standards, policies, and procedures, such as, but not limited to:

- The chief executive officer (CEO)
- Members of the Governing Body
- Directors of major divisions in The Company

(3) Sufficient resources and authority to the specific individuals designated to oversee compliance to reasonably ensure compliance with such standards, policies, and procedures.

(4) Due care not to delegate substantial discretionary authority to individuals who have a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.

(5) The Company takes steps to effectively communicate the standards, policies, and procedures in the compliance and ethics program to:

- The entire staff
- Individuals providing services under a contractual arrangement
- Volunteers, consistent with the volunteers' expected roles

Requirements include, but are not limited to:

- Mandatory participation in training:
  - As set forth at policy WM 2.4 D
  - Orientation programs
  - Disseminating information that explains in a practical manner what is required under the Compliance and Ethics program

(6) The Company takes reasonable steps to achieve compliance with the compliance and ethics program's standards, policies, and procedures.

- Utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Social Security Act by any of The Company's staff, individuals providing services under a contractual arrangement, or volunteers
- Having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within The Company without fear of retribution
- Having a process for ensuring the integrity of reported data

(7) Consistent enforcement of The Company's standards, policies, and procedures through appropriate disciplinary mechanisms.

- Appropriate discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in The Company's compliance and ethics program.

(8) After a violation is detected, The Company must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to The Company's program to prevent and detect criminal, civil, and administrative violations under the Social Security Act.

Additional required components for operating organizations with five or more facilities- In addition to all of the other requirements of this Compliance and Ethics Plan, organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program:

(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the training requirements identified at policy WM 2.4 D

(2) A designated Compliance and Ethics Officer for whom the organization's compliance and ethics program is a major responsibility. This individual must report directly to the organization's Governing Body and not be subordinate to the general counsel, chief financial officer, or chief operating officer.

(3) Designated compliance liaisons located at each of the organization's facilities.

Elements of an effective compliance and ethics program: (Identified at §483.85)

- Standards, policies, and procedures
- Compliance and ethics program administration
  - Designating a Compliance and Ethics Officer and Compliance and Ethics Committee
- Screening and evaluation of employees, physicians, vendors, and other agents

- Conducting effective training and education
  - Developing effective lines of communication
- Enforcing standards through well publicized disciplinary guidance
- Monitoring, auditing, and internal reporting systems
  - Responding promptly to any detected offense and developing corrective action
- Investigations and remedial measures

(Reference inclusive Compliance and Ethics Program Components at policy CP 1.0)

Compliance risk areas:

- Quality of Care (Appendix CP 1. Section A)
- Resident Rights (Appendix CP 1. Section B)
- Billing and Cost Reporting (Appendix CP 1. Section C)
- Employee Screening (Appendix CP 1. Section D)
- Kickbacks, Inducements, and Self-Referral (Appendix CP 1. Section E)
- Creation and Retention of Records (Appendix CP 1. Section F)
- Privacy and Security Rules (Appendix CP 1. Section G)

Reference Appendix CP 1 *Compliance Risk Assessment*

Annual review- The Company must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within The Company and its facilities to improve its performance in deterring, reducing, and detecting violations under the Social Security Act and in promoting quality of care. (Policy CP 2.0 Section M *Compliance Reassessment/Annual review*)

Policy Number: CP 1.0.1

Policy Title: Corporate Compliance and Ethics Program: Administration, Oversight, and Responsibility

Mission: The mission of The Company is to provide quality, cost effective healthcare in a positive and productive work environment. In fulfilling this mission, The Company is dedicated to adhering to the highest ethical standards and, accordingly, recognizes the importance of compliance with all applicable state and federal laws.

Policy Statement/Purpose: To ensure that The Company adheres to all applicable Medicare and Medicaid laws, rules, and regulations related to the submission of claims. This includes proper documentation of services, billing, coding, and claims submission, and the prevention, prompt detection, and appropriate corrective action to detect, address, and prevent fraud, waste, and financial abuse.

Policy Interpretation and Implementation: The Company Compliance and Ethics Program is intended to be part of the fabric of The Company's routine operations. The Company endeavors to communicate to all Associates The Company's commitment to accurate and lawful documentation and submission of all claims for services to Medicare, Medicaid, and other third-party payers and to comply with applicable laws and regulations. In addition, the Compliance and Ethics Program will:

1. assess The Company's business activities and minimize any potential loss to the government from erroneous claims as well as reduce The Company's potential exposure to legal risks, damages, and civil and criminal penalties through early detection and reporting, that may result from noncompliance;
2. promote the prevention, detection, and resolution of any acts that do not conform to applicable federal and/or state laws, rules, and regulations;
3. implement monitoring and reporting functions to measure the effectiveness of the Program and to address problems in an efficient and timely manner;
4. educate all associates to meet legal and ethical standards that govern Company business of providing resident care, and train personnel to conduct their job activities in compliance with the policies and procedures of the Compliance and Ethics Program; and
5. include enforcement and discipline components that ensure that all personnel take their compliance responsibilities seriously.

The Company will take steps to investigate all reported violations and will endeavor to ensure that the Compliance and Ethics Program is effective in preventing, detecting, and eliminating violations of the law in accordance with Policy CP 2.0 Section I – *Compliance Investigation*

Compliance and Ethics Program Components:
To ensure The Company remains consistent with applicable legal and ethical requirements and standards of practice, The Company Compliance and Ethics Program includes the elements of a Compliance Program identified at §483.85 (Policy CP 1.0 *Compliance and Ethics Program*) and incorporates the *Federal Sentencing Guidelines for Organizational Defendants*. These guidelines detail policies and practices for the federal criminal justice system that prescribe the appropriate sanctions for organizations convicted of federal crimes.

Strategic Risk Reduction Elements:

- Element 1: Standards, Policies, and Procedures
- Element 2: Program Administration
- Element 3: Screening and Evaluation of Employees, Physicians, Vendors and Other agents
- Element 4: Communication, Education, and Training
- Element 5: Monitoring, Auditing, and Internal Reporting Systems
- Element 6: Counseling and Discipline
- Element 7: Investigations and Remedial Measures

Element 1: Standards, Policies, and Procedures

Standards, Policies, and Procedures [42 CFR § 483.85(c)(1)]

Written policies and procedures that describe compliance expectations, identify how to communicate compliance issues with appropriate personnel, and describe how potential compliance problems should be investigated and resolved. Compliance standards and procedures must be followed by Company employees and other agents that are reasonably capable for reducing the prospect of criminal conduct.

This Compliance and Ethics Program Manual contains many of the compliance policies and procedures that apply to Medicare-certified skilled nursing facilities and Medicaid-certified nursing facilities. It specifically addresses compliance with federal reimbursement and operational requirements and identifies potential fraud and financial abuse issues related to relationships between The Company and other referral sources, vendors, and providers.

In addition to the policies and procedures set forth in this Compliance and Ethics Program Manual, The Company maintains other corporate policies governing standards of care, ethics, and criminal wrongdoing. Such additional corporate policies may be specifically incorporated by reference throughout the Manual. (Reference policy CP 2.0 *Policies and Procedures)*

Element 2: Program Administration

Oversight and Responsibility

Every employee and associate at The Company is responsible for participating in Company efforts to comply with federal, state, and local laws and regulations and ethical standards. Everyone associated with The Company is encouraged to share with the Compliance and Ethics Officer their comments and suggestions for improving the Program or for correcting errors or mistakes.

Overall responsibility for operation and oversight of the Compliance and Ethics Program belongs to the Governing Body. The day-to-day responsibility for operation and oversight of the Compliance and Ethics Program rests with the Compliance and Ethics Officer. The Compliance and Ethics Officer is assisted by the Compliance and Ethics Committee, which is comprised of persons appointed by the Governing Body, in collaboration with the Compliance and Ethics Attorney.

No Corporation Representative has authority to act contrary to any provision of the Compliance and Ethics Program or to condone any violation by others. Any Associate with knowledge of information concerning a suspected violation of law or violation of a provision of the Compliance and Ethics Program is required to report promptly such violations.

Ultimate authority to approve changes to the Compliance and Ethics Program rests with the Governing Body. The Governing Body acts within its discretion, upon the receipt of recommendations from the Compliance and Ethics Committee in relation to any Amendment or Modification of Policies and Procedures, the Compliance and Ethics Program, and/or the Manual.

Delegation of Authority

Material Changes. The Governing Body may not delegate its authority to approve or reject material changes to Policies and Procedures, the Compliance and Ethics Program and/or the Manual. A material change is one that would substantially affect the integrity of the Compliance and Ethics Program or that would result in a change, modification, revision, deletion, or addition to the Compliance and Ethics Program in its entirety, or a policy or policies, or any component of a policy or policies, and that pertains to the authority of the Compliance and Ethics Committee or any subcommittee thereof to act, the authority of the Compliance and Ethics Officer to act, the existence of the Compliance and Ethics Program, or the deletion, addition, change, modification, or revision of any of the essential elements required by the Compliance and Ethics Program. Any material change shall be effective on the date referenced in the resolution of the Governing Body adopting the change.

Technical Changes. The Governing Body may delegate its authority to approve an amendment or modification to the Compliance and Ethics Committee or the Compliance and Ethics Officer if the change is a technical change. A technical change is one that is procedural in nature and has the effect of improving the overall operational aspects of the Compliance and Ethics Program. Examples of technical changes include, but are not limited to, increasing or decreasing the number of charts during an audit, increasing or decreasing the number of educational sessions, changing the manner or method of providing educational sessions, topics addressed at educational sessions, amending the monitoring criteria utilized, etc.

Any technical change shall be effective on either: (a) the date referenced in the resolution of the Governing Body adopting the change; or (b) the date the Compliance and Ethics Committee or Compliance and Ethics Officer implements the change in writing based upon a delegation of authority.

The Company reserves the right to change, modify, or amend the Compliance and Ethics Program or the Policy Manual as deemed necessary by The Company without notice to Associates or other persons.

The Company's Governing Body adopts, develops, and implements The Company's Compliance and Ethics Program. (Reference policy CP 1.1.0 *Governing Body*.)

Discretion in Assigning Positions of Responsibility

The Company must use due care not to assign positions of substantial discretionary authority to individuals whom The Company knows, or should know, are inclined to engage in illegal activities. "Exercising due care" means that The Company diligently inquired about the employment contacts and other relevant history of employees and agents to avoid improperly giving such discretionary authority.

Compliance and Ethics Officer* [42 CFR § 483.85(c)(2)]

Appointment of a Compliance and Ethics Officer who is responsible for day-to-day operations of The Company Compliance and Ethics Program. Pursuant to 42 CFR § 483.85(c)(2), the Compliance and Ethics Officer is someone who has substantial control over the operating organization or who has a substantial role in the making of policy within the organization. The Compliance and Ethics Officer reports regularly to the Compliance and Ethics Committee and senior management on implementation progress and to the Governing Body on the operation of the Program and any significant developments. The Compliance and Ethics Officer makes available a copy of the Compliance and Ethics Program to all affected individuals. The Compliance and Ethics Officer is responsible for:

- Recommending to the Compliance and Ethics Committee all appropriate revisions to Policies and Procedures, the Compliance and Ethics Program, and/or the Manual.
- Providing all proposed changes to the Compliance and Ethics Program to the Governing Body and Compliance and Ethics Attorney for The Company, as necessary.
- Ensuring that the appropriate authority approves or rejects in writing all amendments or modifications of Policies and Procedures, the Compliance and Ethics Program, and/or the Manual in accordance with this policy and procedure. (Reference policy CP 1.1.1. *Position Description: Compliance and Ethics Officer*)*

  * *Although components of compliance management can be delegated as defined in role descriptions, the Compliance and Ethics Officer retains administrative oversight for Fraud and Abuse, Ethics, Privacy, Information Security, and Safety Compliance as appointed by the Governing Body.*

Compliance and Ethics Committee [42 CFR § 483.85(c)(3)]

Appointment of a Compliance and Ethics Committee, which has overall responsibility for oversight of compliance activities. The Committee meets no less than quarterly to review reports on The Company's compliance activities. The Compliance and Ethics Committee is responsible for making recommendations to the Governing Body with respect to any amendments or modifications of Policies and Procedures, the Compliance and Ethics Program, and/or the Manual that the Compliance and Ethics Committee has approved. (Reference policy CP 1.1.2 *Compliance and Ethics Committee)*

Element 3: Screening and Evaluation of Employees, Physicians, Vendors and Other agents

Screening and Evaluation of Associates

Screening and evaluation are conducted for all employees, executives, Governing Body members, and all other affected persons associated with The Company, including vendors, consultants, students, and interns. (Reference policy CP 2.0 Section C, and WM 2.0.

Element 4: Communication, Education, and Training

Compliance Training and Education [42 CFR § 483.85(c)(5)]

The Company takes steps to effectively communicate the standards and procedures it has set by requiring all employees and other agents to participate in compliance training programs or by disseminating information that explains the requirements of compliance policies in a practical manner. As such, compliance training and education is provided for all employees, executives, Governing Body members, and all other affected persons associated with The Company, including vendors, consultants, students, and interns. Training includes Company specific regulatory compliance issues, and compliance responsibilities.

The Company attempts to communicate changes to, or modification of, the Compliance and Ethics Program concurrent with, or prior to, the implementation of such changes or modifications.

Should Associates have questions or uncertainties regarding compliance with applicable state or federal law, or any aspect of the Compliance and Ethics Program, including related policies or procedures, they should seek immediate clarification from the Compliance and Ethics Officer, management, Compliance and Ethics Attorney, or through the Compliance Hotline. (Reference policy WM 2.4 Section D *Compliance and Ethics Training and Education* and VC Appendix 1.0 sections C and D *Vendor/Contractor Compliance and Ethics Plan*)

Element 5: Monitoring, Auditing, and Internal Reporting Systems

Reporting System [42 CFR § 483.85(c)(6)]

The Company takes reasonable steps to respond appropriately and to prevent future events when an offense is detected, including making needed changes to its Compliance and Ethics Program or procedures. The reporting system supports the ability of The Company's personnel to communicate issues of concern openly and freely to their supervisors through all lines of communication including a method of anonymous reporting to detect, address, and prevent compliance issues. (Reference policy CP 2.0 section B on *Reporting Systems*)

Auditing and Monitoring [42 CFR § 483.85(c)(6)]

The Company takes reasonable steps to detect violations of its standards. The routine auditing and monitoring system identifies compliance risk areas through self-evaluation and is designed to detect criminal, civil, and administrative violations. Reasonable steps include: (a) use of monitoring and auditing systems to detect criminal conduct within The Company, and (b) establishing a reporting system that encourages the reporting of suspected criminal conduct without fear of retribution. The Company has developed systems to meet these requirements presented in Policy CP 2.0, Section G on *Compliance Monitoring and Auditing* and Section E on the *Compliance Hotline*.

Element 6: Counseling and Discipline

Response and Prevention [42 CFR § 483.85(c)(8)]

Reasonable steps to respond are taken when potential compliance issues arise. The Company will respond appropriately to the offense including to investigate and develop remedial measures and corrective action to prevent future similar offenses. (Reference policy CP 2.0 section H on *Response and Prevention*)

Disciplinary Standards [42 CFR § 483.85(c)(7)]
The Company consistently enforces appropriate disciplinary mechanisms through a well-publicized disciplinary guidance. Noncompliant behavior may result in disciplinary action, up to and including termination. Associates who violate any provision of the Compliance and Ethics Program, including the duty to report suspected violations, shall be subject to disciplinary measures. Promotion of and adherence to the Compliance and Ethics Program is part of the job performance evaluation criteria for all Associates. The enforcement and discipline standards that apply under the Compliance and Ethics Program are discussed in Policy WM 2.9 *Disciplinary Standards*.

Non-Intimidation and Non-Retaliation

The Company has a policy of non-intimidation and non-retaliation for good faith participation in the Compliance and Ethics Program including, but not limited to, reporting potential issues, cooperating or participating in the investigating of issues, participating in self-evaluations, audits, and remedial action, and/or making reports to appropriate officials of inappropriate conduct. (Reference policy CP 2.0 Section D on *Protection of Employees*)

Reassessment

The Company performs a periodic reassessment of the Compliance and Ethics Program to evaluate its effectiveness and to make any necessary adjustments [42 CFR § 483.85(e)] (Reference policy CP 2.0 Section M on *Compliance Reassessment/Annual Review*)

Element 7: Investigations and Remedial Measures

External Communications

Contact with Government Agents and Investigators. It is The Company's policy to cooperate with Government Authorities/Agents/Investigators. (Reference policy CP 2.0 Section J on *External Communications and Litigation*)

Contact with the Media. All contacts concerning The Company with anyone from the media shall be referred to the Compliance and Ethics Officer and the Administrator.

Contact with Attorneys. All contacts concerning The Company with anyone claiming to be an attorney shall be referred immediately to the Compliance and Ethics Officer and the Administrator.

Contact with Competitors. All contacts with anyone representing a competitor of The Company or employed by a competitor shall be reported to your immediate supervisor.

Investigations and Litigation

Subpoenas, Summonses, and Legal Complaints involving The Company shall be given to the Compliance and Ethics Officer and the Administrator immediately. (Reference policy CP 2.0 Section J on *Compliance External Communications and Litigation*)

Policy Number: CP 1.1.0 A

Policy Title: Governing Body Duties and Responsibilities

Policy Statement/Purpose: The Company must have a Governing Body that assumes full legal responsibility for establishing and implementing policies regarding the management and operation of the facility.

Policy Interpretation and Implementation:

1. GOVERNING BODY DUTIES AND RESPONSIBILITIES

   A. **Policies and Procedures**: The Governing Body is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The Governing Body, in conjunction with regular reporting by the Administrator, should assess on a regular basis that services are being provided in accordance with facility policies, that policies are current and reflect an acceptable standard of care, that care is coordinated among the professional staff, and that there is efficient use of resources.

   B. **Disclosure of Ownership:** The Governing Body is legally responsible for ensuring that the facility is in compliance with Title 42 Part 420, Subpart C "Program Integrity: Medicare-Disclosure of Ownership and Control Information" including, but not limited to, ensuring that all requisite CMS forms have been completed and signed regarding the following:
      a. Determination of ownership or control percentages, including indirect ownership interest, pursuant to 42 C.F.R. Section 420.202
      b. Disclosure of hiring of intermediary's former employees pursuant to 42 C.F.R. Section 420.203
      c. Disclosure of principals convicted of a program-related crime pursuant to 42 C.F.R. Section 420.204
      d. Disclosure by providers and part B suppliers of business transaction information pursuant to 42 C.F.R. Section 420.205
      e. Disclosure of persons having ownership, financial, or control interest pursuant to 42 C.F.R. Section 420.206

   C. **Appointment of Administrator:** The Governing Body is responsible for appointing an Administrator who shall:
      a. Be licensed by the state, where licensing is required.
      b. Be responsible for the overall management of the facility under the authority delegated by the Governing Body.
      c. Report to and be accountable to the Governing Body.
         i. Facility will determine a means and schedule for regular reporting to the Governing Body and how the Governing Body will respond to the Administrator.
         ii. Administrator and Governing Body will determine which types of problems and information (e.g., survey results, allegations of abuse or neglect, complaints, compliance concerns, overpayments and underpayments, and other risk areas) should be reported to the Governing Body and method of communicating.

d. Implement and enforce the facility's policies and procedures.
e. Designate, in writing, an individual who, in the absence of the Administrator, acts on behalf of the Administrator.
f. Retain professional and administrative responsibility for all personnel providing facility services.
g. Have a thorough working knowledge of the overall operation of the facility, including the scope of services provided, policies governing these services, budgetary and fiscal matters, and the utilization and qualification of personnel.

D. **Group of Professional Personnel**: The Governing Body, in conjunction with the Administrator, is responsible for ensuring that the facility has a group of professional personnel associated with the facility that:
   a. develops and periodically reviews policies to govern the services provided by the facility;
   b. consists of at least one physician and one professional representing each of the services provided by the facility; and
   c. advocates for the allocation of sufficient funding, resources, and staff for the compliance officer to perform their responsibilities.

E. **Institutional Budget Plan**: The Governing Body is responsible for directing and ensuring that a committee consisting of representatives of the Governing Body and the Administrative staff prepares an institutional budget plan that provides for:
   a. An annual operating budget prepared according to generally accepted accounting principles.
   b. An institutional budget plan that meets specified conditions including a compliance and ethics budget.
   c. A 3-year capital expenditure plan if expenditures in excess of $100,000 are anticipated, for that period, for the acquisition of land; the improvement of land, buildings, and equipment; and the replacement, modernization, and expansion of buildings and equipment.
   d. Annual review and update by the Governing Body.

F. **Patient Care Policies**: The Governing Body is responsible for ensuring that the facility has written patient care policies that are current and responsive to the needs of residents. The Governing Body must verify the input of the group of professional personnel in policy development and review that govern the services it furnishes. The Governing Body must ensure that the policies include the following:
   a. A description of the services the facility furnishes through employees and those furnished under arrangements.
   b. Rules for and personnel responsibilities in handling medical emergencies.
   c. Rules for the storage, handling, and administration of drugs and biologicals.
   d. Criteria for patient admission, continuing care, and discharge.
   e. Procedures for preparing and maintaining clinical records on all residents.
   f. A procedure for explaining to the patient and the patient's family the extent and purpose of the services to be provided.
   g. A procedure to assist the referring physician in locating another level of care for residents whose treatment has terminated and who are discharged.
   h. A requirement that residents accepted by the facility must be under the care of a physician.

i. A requirement that there be a plan of treatment established by a physician for each patient.
j. A procedure to ensure that the group of professional personnel reviews and takes appropriate action on recommendations from the utilization review committee regarding patient care policies.

G. **Delegation of Authority**: The Governing Body is responsible for ensuring that the responsibility for overall administration, management, and operation is retained by the facility itself and not delegated to others. However, the facility, under direction of the Governing Body, may permit the below services (a) through (e) to be delegated provided that: 1) there is a written contract for the services; 2) the term of the contract is not for a term longer than five (5) years; 3) the contract must be subject to termination within sixty (60) days of written notice by either party; 4) the contract must contain a clause requiring renegotiation of any provision that CMS finds to be in contravention to any new, revised, or amended federal regulation or law; 5) the contract must state that only the facility may bill the Medicare program; and 6) the contract may not include clauses that state or imply that the contractor has power and authority to act on behalf of the facility, or clauses that give the contractor rights, duties, discretions, or responsibilities that enable it to dictate the administration, management, or operations of the facility:
   a. Bookkeeping
   b. Assistance in the development of procedures for billing and accounting systems
   c. Assistance in the development of an operating budget
   d. Purchase of supplies in bulk form
   e. The preparation of financial statements

H. **Quality Assurance and Performance Improvement (QAPI) Program**: The Governing Body and/or executive leadership and/or an organized group or individual who assumes full legal authority and responsibility for operation of the facility is responsible for the Quality Assurance and Performance Improvement (QAPI) program in accordance with federal and state laws including, but not limited to, ensuring that:
   a. an ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities;
   b. the QAPI program is sustained during transitions in leadership and staffing;
   c. the QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;
   d. the QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information;
   e. corrective actions address gaps in systems and are evaluated for effectiveness; and
   f. clear expectations are set around safety, quality, rights, choice, and respect.

I. **Facility-wide Assessment**: The facility must conduct and document a facility-wide assessment to determine what resources are necessary to competently care for its residents during both day-to-day operations and emergencies. To ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include:
   a. The Administrator
   b. A representative of the Governing Body

c. The Medical Director
d. The Director of Nursing
e. The Environmental Operations Manager and other department heads

J. **Program Integrity**: The Governing Body has a duty to be knowledgeable of and have regular interaction with the facility's Compliance and Ethics program and program integrity.
   a. The Compliance and Ethics Officer shall have a direct line of communication to the Governing Body to discuss and report compliance and ethics issues.
      i. Regularly scheduled executive board sessions should be scheduled with the Compliance and Ethics Officer and the Governing Body to encourage the free flow of information regarding compliance without potential for conflict.
   b. The Governing Body must participate in regularly scheduled training, at a minimum annually, on the basic elements of a compliance program;
   c. The Governing Body should participate in a meaningful and rigorous conflict-of-interest process and self-disclosure process.
   d. The Governing Body is responsible for holding the facility accountable for program integrity and shall take appropriate actions to ensure program integrity as necessary;
   e. The Governing Body is responsible for delivering a clear and consistent message about compliance, ethics, and program integrity;
   f. The Governing Body shall regularly review the existing compliance plan documents against existing requirements;
   g. The Governing Body shall regularly conduct or receive the results of a comprehensive self-assessment of the entire compliance program and its implementation.

Policy Number: CP 1.1.0 B

Policy Title: Governing Body Charter and Adoption Agreement

Policy Statement/Purpose: The Governing Body directs management in the development and implementation of The Company's formal Compliance and Ethics Program that includes continuing efforts to improve quality and performance while remaining compliant with applicable laws, rules, and regulations and avoiding violations of law.

Policy Interpretation and Implementation: The development and implementation of a Company Compliance and Ethics Program is an element in its continuing effort to improve quality and performance and remain compliant with applicable laws, rules, regulations, and standards.

WHEREFORE, BE IT RESOLVED ON THIS DATE:

1. The scope of this Resolution applies to: (A) The Company; and (B) all directors, officers, clinical staff, employees, and all other affected individuals working for The Company ("Associates").
2. Company management is directed to dedicate the necessary resources toward development of an effective Compliance and Ethics Program designed to prevent and detect violations of federal or state law in the conduct of Company operations by employees and agents.
3. The Program will meet or exceed the elements of a Program, which require an organization to:
   a. establish compliance standards and procedures reasonably capable of reducing the prospect of wrongful conduct;
   b. *appoint* a specific, *high-level individual* with overall responsibility to oversee compliance with such standards and procedures;
   c. exercise due care not to delegate substantial discretionary authority to individuals with a propensity to engage in unlawful activities;
   d. take steps to effectively communicate the compliance standards and procedures to all employees and agents by, for example, mandatory training sessions or the dissemination of publications;
   e. take reasonable steps to achieve compliance by, for example, utilizing monitoring and auditing systems, and by publicizing a reporting system whereby employees and agents can report perceived wrongful conduct by others within the organization without fear of retribution;
   f. consistently enforce its standards through appropriate disciplinary mechanisms (WM 2.9), including, as appropriate, discipline of individuals for failure to detect noncompliance; and
   g. take responsible steps to respond appropriately to noncompliance after detection and to prevent recurrence, which may require modifications to the Compliance and Ethics Program.
4. The development and implementation of specific standards, educating and training employees with respect to those specific standards, and reviewing and enhancing internal controls and monitoring systems. This process may be time consuming. Accordingly, management is directed to proceed in phases, but management should make steady progress toward the creation and implementation of specific standards and systems relating to all material areas of The Company's operations where there are compliance obligations. Management shall provide periodic progress reports to the Governing Body.

_____

Date Adopted

_____

Signature

Policy Number: CP 1.1.1

Policy Title: Position Description: Compliance and Ethics Officer

Policy Statement/Purpose: The Compliance and Ethics Officer provides general oversight to all aspects of the Compliance and Ethics Program. Working in collaboration with the Compliance and Ethics Committee, the Compliance and Ethics Officer is directly involved with the creation, implementation, education, and enforcement of the Compliance and Ethics Program. The Compliance and Ethics Officer maintains the responsibility for the day-to-day compliance issues, which stem from effectively incorporating the intention and design of the Compliance and Ethics Program with The Company's operations, including any delegated functions pertaining to fraud and abuse, privacy, information security, quality, safety, and integrity management. The Compliance and Ethics officer:

- May be assigned other duties, provided that such other duties do not hinder the carrying out of their primary responsibilities. *The provider must demonstrate that they have assessed this.*
- Is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day-to-day operation of the compliance program. *The provider must demonstrate that they have assessed this.*
- Along with appropriate compliance personnel have access to all records, documents, information, facilities, and any affected individuals.
- Has a signed letter of appointment and executed contract. The Organizational chart identifies if the chief executive has designated that the CO reports to another senior manager, if applicable.

Policy Interpretation and Implementation:

The Compliance and Ethics Officer is a *high-level individual* appointed by the Governing Body and is accountable to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the Governing Body. The designation of the CO reporting to another senior manager should not hinder the CO in carrying out their duties and accessing the chief executive and governing body. The Compliance Officer has the following specific responsibilities:

1. Coordinate resources to ensure the ongoing effectiveness of the Compliance and Ethics Program.
2. Participate in the development of compliance and ethics policies and standards.
3. Participate in the development, presentation, and the documentation of educational programs for all employees, agents, and affiliated providers that focus on the elements of the Compliance and Ethics Program and risk areas specific to The Company.
    a. Provide adequate information on compliance and ethics to employees and vendors.
    b. Ensure that ongoing training of employees is conducted and documented.
    c. Make sure that training is frequent enough so new employees receive training promptly.
    d. Ensure that all affected individuals have read the Code of Conduct and signed an acknowledgement of their understanding of its requirements; (Reference CP 2.1 *Code of Conduct* and Appendix WM 2.4 Section E, and VC 1.2)
    e. Participate in the presentation of policies that encourage reporting of suspected fraud and other improprieties without fear of retaliation or intimidation.
    f. In some cases, the Compliance and Ethics Officer, in conjunction with the Compliance and Ethics Committee, may determine that it is appropriate to share the results of a compliance inquiry among all Company employees to educate them on such issues and attempt to ensure

consistency. If the advice or inquiry is published in any form, the questioner's confidentiality must be protected.

4. Implement and operate retaliation- and intimidation-free reporting channels, including an anonymous telephone hotline service available to all employees and vendors.
5. Develop productive working relationships with all levels of management.
6. Work with individuals responsible for personnel decisions to ensure that The Company does not delegate substantial discretionary authority to individuals whom The Company knows, or has reason to know, have the propensity to engage in criminal, civil, and/or administrative violations.
   a. Ensure that all positions of responsibility under the Compliance and Ethics Program are assigned to individuals who are morally fit, honest, and capable of making the judgments called for under the duties of the position.
   b. Ensure that there are effective employee and vendor screening systems in place so that The Company does not hire or utilize individuals or entities with propensities to violate laws, regulations, or engage in unethical conduct.
   c. Provide input to Human Resources on policy and procedures relative to the performance appraisal program, making the Compliance and Ethics Program part of the overall evaluation process.
7. Ensure that the Compliance and Ethics Program effectively prevents and/or detects violations of laws, regulations, company policies, and the Code of Conduct.
   a. Develop internal audits and monitoring instruments to measure effectiveness of the Compliance and Ethics Program.
   b. Conduct or assist in conducting appropriate internal compliance reviews and audits.
8. Conduct and oversee investigations of matters that merit investigation under the Compliance and Ethics Program.
   a. Oversee the remediation and disciplinary processes to ensure that the Compliance and Ethics Program requirements are being enacted.
   b. Follow up and, as applicable, ensure resolution to investigations and other issues generated by the Compliance and Ethics Committee or other internal or external sources.
   c. Bring to the Compliance and Ethics Committee and senior management's attention all compliance issues for appropriate response and disciplinary action, if necessary.
9. Maintain documentation and track all issues referred to the Compliance and Ethics Officer and/or Compliance and Ethics Committee.
10. Make routine, periodic compliance reports to the Administrator regarding compliance activities, even if no violations are detected.
11. On at least an annual basis, the Compliance and Ethics Officer will:
    - Develop an annual compliance work plan. It is a reasonable expectation that the CO should be the person coordinating the implementation of the work plan, and there may be other individuals involved in completing auditing and monitoring activities identified in such a work plan.
    - Issue a report to the Senior Administration and the Governing Body that describes the compliance efforts that have taken place during the prior year and that identifies any changes to the Compliance and Ethics Program that need to be made to improve compliance. The report shall include the following:
      a. Copy of Audit Plan
      b. All audit results
      c. All reports of noncompliance (whether made by hotline call, telephone call, email, face-to-face communication, etc.)

d. All investigations into alleged noncompliance and results of the investigations
e. Response and corrective action, addressing identified and substantiated noncompliance

12. Monitor developments and changes in relevant state and federal law, regulations, government agency guidance, and court rulings, which may affect the Compliance and Ethics Program.
13. Notify the Governing Body promptly of changes in the law that may affect the Compliance and Ethics Program's effectiveness.
    a. Prepare proposed changes in the Compliance and Ethics Program for review and approval where appropriate.
    b. As necessary, and as specific compliance issues arise that require immediate attention, the Compliance and Ethics Officer will make a report on a more frequent basis.
14. Periodically review and revise the written Compliance and Ethics Program and the Code of Conduct as appropriate to reflect any changes in expectations and/or requirements.

The Compliance and Ethics Officer's initial activities include:

1. Assist in the development of a written Compliance and Ethics Program that consists of the substantive policies and procedures that will guide The Company's daily operations, such as policies on inducements for referrals, vendor contract, etc.; and the mechanical operation of the Company's Compliance and Ethics Program, including methods for reporting suspected violations, privacy protections, information security, employee compliance training, etc.
2. Assist in the development of The Company Code of Conduct, which is a clearly written document that includes:
    a. The general legal principles to which employees must adhere, stated in simple language.
    b. A description of how the process works mechanically, including how employees report infractions against the Code of Conduct. Enforce participation in the Compliance and Ethics Program as mandatory.
    c. Establish a Compliance and Ethics Committee.
    d. Train and inform the Compliance and Ethics Committee and provide committee members with clear guidance regarding their rules.
    e. Distribute the Code of Conduct.
    f. Conduct initial Compliance and Ethics Program training of all employees. Obtain a signed affirmation statement from employees and supervisors.
    g. Under the guidance of Compliance and Ethics Attorney, conduct legal training for supervisors, stressing their roles in the Compliance and Ethics Program.
    h. Establish systems for monitoring (including the audit functions), and for ongoing training of employees.
    i. Ensure that the entire written Compliance and Ethics Program is kept at the employment site where all employees can access it and advise employees where and how to access the written Compliance and Ethics Program.
    j. Ensure that compliance-related files are established and maintained as described in the manual.

The Compliance and Ethics Officer's ongoing activities include:

1. Under the supervision and recommendations of the Compliance and Ethics Attorney, manage and monitor the employee reporting process. Ensure that employee reports are seriously and promptly investigated and addressed, including implementing systems or policy changes as needed, and working with human resources personnel to instigate disciplinary action when needed.

2. Ensure that systems for routine auditing of billing practices, quality of care, contracts, privacy practices, information security, and related areas are in place and are working. Modify these as needed.
3. Conduct employee and vendor background checks.
4. Consult with members of the Compliance and Ethics Committee to obtain interpretations of any requirements of the Compliance and Ethics Program, seek investigative and remedial expertise, and coordinate delegated compliance and risk management activities to include privacy, information security, violence prevention, and safety management systems.

Compliance and Ethics Officer Qualifications:
The Compliance and Ethics Officer must:
1. Be a senior level person with knowledge and experience in healthcare and organizational management prior to hire.
2. Be able to conduct research and write thorough reports covering findings.
3. Possess communication skills needed to point out potential areas of improvement to organization leaders and Governing Body.
4. Possess knowledge of finance, statistics, and quality improvement.
5. A bachelor's degree is preferred, such as in communications, human resources, healthcare management, or business.
6. It is preferred that the Compliance and Ethics Officer possess a Compliance and Ethics Officer qualifying credential or be working on achieving that credential timely upon hire.

A. Role of the Privacy Officer

Privacy concerns the protecting and control of individually identifiable health information. The Company recognizes the increased complexity of protecting patient privacy while managing access to, and release of, information about residents. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and rules promulgated under the Act require a Privacy Officer. In addition, there are other federal and state laws and applicable regulatory and accreditation standards that have an impact on privacy.

The Privacy Plan is a component of The Company Compliance and Ethics Program. The Privacy Officer is appointed by the Governing Body. The Privacy Officer role may be subsumed in a discipline/department specific title and job description and be accountable to a direct supervisor, but the Privacy Officer, in collaboration with the appointed Compliance and Ethics Officer, is accountable to the Governing Body for all compliance and ethics management activities.

The Privacy Officer establishes and maintains accountability for privacy in The Company by ensuring the planning, coordination, implementation, evaluation, analysis, and reporting of activities, policies, procedures, and standards pertaining to The Company Privacy Plan. Refer to Policy PP 1.1 *Privacy Officer Role Description*. And CP 1.1.1 Section A

B. Role of the Information Security Manager

The Information Security Manager ensures the planning, coordination, implementation, evaluation, analysis, and reporting of activities, policies, procedures, and standards pertaining to the Information

Security Plan. The Information Security Manager role may be subsumed in a discipline/department specific title and job description and report to a direct supervisor but is accountable to the Governing Body's appointed Compliance and Ethics Officer for all compliance and ethics management activities.

Refer to Policy DI 1 section B, *Appointment of an Information Security Manager*

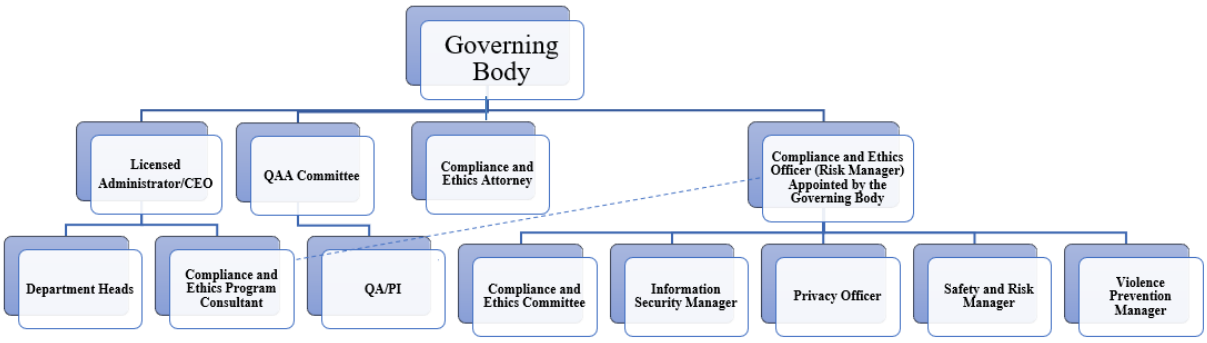
C. Role of the Violence Prevention Manager

The Violence Prevention Manager ensures the planning, coordination, implementation, evaluation, analysis, and reporting of activities, policies, procedures, and standards pertaining to the Violence Prevention Plan. The Violence Prevention Manager role may be subsumed in a discipline/department specific title and job description accountable to a supervisor but is accountable to the Governing Body's appointed Compliance and Ethics Officer for all compliance and ethics management activities. Refer to Policy WM 2.8 Section A.

D. Role of the Safety and Risk Manager

The Safety and Risk Manager ensures the planning, coordination, implementation, evaluation, analysis, and reporting of activities, policies, procedures, and standards pertaining to the Safety and Risk Management Plan. The Safety and Risk Manager role may be subsumed in a discipline/department specific title and job description accountable to a supervisor but is accountable to the Governing Body's appointed Compliance and Ethics Officer for all compliance and ethics management activities. Refer to Policy SM 1.0 *Safety Management Plan*

Relationship of Compliance and Ethics Officer to Compliance Management Roles*



* F837 States the Governing Body is responsible and accountable for the QAPI program.

Note: There is risk in establishing an effective compliance program if the compliance officer and/or the compliance department is subordinate to the provider's general counsel or financial officer (e.g., comptroller). By separating the compliance function from these key management positions, a system of checks and balances is established. If it is not feasible for the provider to separate the compliance function, then a procedure for addressing conflicts of interest or potential risks is recommended to achieve an appropriate system of checks and balances.

E. Appointment of a Compliance and Ethics Officer

Note, the Compliance and Ethics Officer Governing Body appointment encompasses oversight of all key compliance functions that fall under the appointment as noted in the organization chart (above).

WHEREAS, the Governing Body of CompanyName, having approved the adoption of a Compliance and Ethics Program and Code of Conduct; and

WHEREAS, the Compliance and Ethics Program requires the appointment of a Compliance and Ethics Officer; and

WHEREAS, the Governing Body having great confidence in the integrity, experience, and judgment of (*insert name*);

NOW THEREFORE, BE IT RESOLVED, that the Governing Body does hereby appoint (name) to be the Compliance and Ethics Officer of CompanyName beginning on _____; and

BE IT FURTHER RESOLVED, that the Governing Body authorizes the Administrator to name an interim Compliance and Ethics Officer should the Governing Body appointed Compliance and Ethics Officer resign, become disabled, or otherwise be unable to perform the duties. The Administrator will, if reasonably able to do so, consult with the Governing Body prior to the appointment of a replacement. Said interim appointment will be until the Governing Body appoints a replacement; and

BE IT FURTHER RESOLVED that the Compliance and Ethics Officer will vigorously carry out the duties as set forth in The CompanyName's Compliance and Ethics Program and that all employees of CompanyName will be informed of the importance of adherence to the Compliance and Ethics Program and the importance of their cooperation with the Compliance and Ethics Officer.

Signature _____

Date Adopted _____

Policy Number: CP 1.1.2

Policy Title: Compliance and Ethics Committee Charter

Policy Statement/Purpose: The Compliance and Ethics Committee has overall responsibility for oversight of compliance activities in coordination with Compliance Officer. This charter includes the duty and responsibilities for coordinating with the Compliance Officer.

Policy Interpretation and Implementation:

The Company Compliance and Ethics Committee meets no less than quarterly and has the following specific responsibilities:

1. Ensure sufficient resources and authority are delegated to the Compliance and Ethics Officer to reasonably ensure compliance with the Program. [42 CFR § 483.85(c)(3)];
2. Exercise due care and due diligence to ensure that the Compliance and Ethics Officer or anyone else in the operating organization with substantial discretionary authority has not had or does not have a propensity to engage in criminal, civil, and administrative violations under the Social Security Act. [42 CFR § 483.85(c)(4)];
3. Stays up to date on current issues and standards specific to The Company's business;
4. Ensures that The Company maintains and improves the Program to reflect the latest state, national, and industry standards;
5. Makes recommendations to management regarding recommended revisions to existing policies and new policies that may be necessary;
6. Reviews reports on Company compliance and ethics activities;
7. Assists the Compliance and Ethics Officer and senior management in putting into place appropriate response to compliance issues as well as appropriate disciplinary action;
8. Oversees the development and implementation of systems for communicating compliance questions and concerns and reports of wrongdoing;
9. Advises and assists the Compliance and Ethics Officer in his/her Compliance and Ethics Program responsibilities;
10. Reports regularly to the Governing Body on the operation of the Program and any significant developments; and
11. Ensures that The Company maintains and improves the *Code of Conduct* and Compliance and Ethics Program
12. Ensures The Company is meeting high standards of business, medical, legal, and personal compliance
13. Oversees:
    a. Matters relating to educational training, about The Company's standards of conduct and ensures they are properly disseminated, understood, and followed.
    b. The Compliance and Ethics Program.
    c. The investigation of reported violations.
    d. The development of monitoring and auditing procedures to ensure that the Compliance and Ethics Program is functioning effectively.
    e. The development and implementation of systems for communicating compliance questions and concerns and reports of wrongdoing.

    Review and update the compliance committee charter annually.

Committee Membership: The Compliance and Ethics Committee is a multidisciplinary team that consists of senior managers including:

Standing Members:
- Principal
- Administrator
- Compliance and Ethics Officer
- Privacy Manager/Officer if a standalone role
- Information (Security) Manager if a standalone role
- Safety Manager
- Violence Prevention Manager if a standalone role
- Director of Nursing

Ad Hoc Members may attend Compliance and Ethics Committee meetings on an *as needed basis* at the request of the Compliance and Ethics Officer or another standing member and includes the following positions:
- In-service Director
- MDS Coordinator
- Rehab Director
- Medical Director
- Admissions/Case Manager
- Medical Records Director (if applicable)
- Accounting Director
- Human Resource Director
- Pharmacy Consultant
- Compliance and Ethics attorney
- Ethicist
- Social Services
- Other Managers as designated

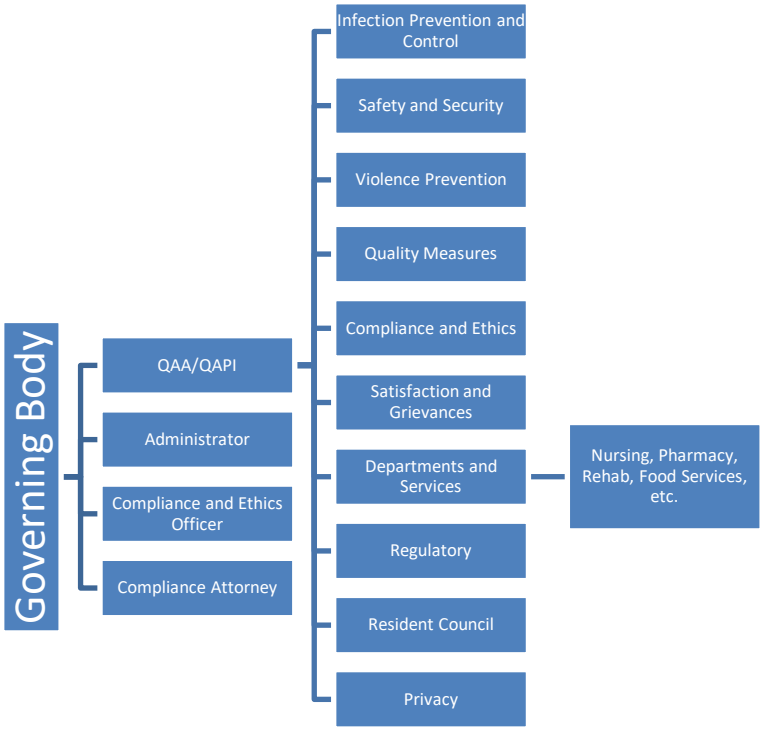
Committee Meetings:
- The Administrator assigns the chair of the Compliance and Ethics Committee, which may or may not be the Compliance and Ethics Officer.
- Duties for notetaking are assigned to any committee member.
- Attendance is tracked and trends will be reported to the Governing Body.
- Roll call of committee members will be documented, including who is in attendance and who is not at the committee meeting.
- It is the responsibility of each Compliance and Ethics Committee member to be present for each meeting.
    - Each member should be aware of this expectation.
- The Committee utilizes a Standard Meeting Agenda, the purpose of which is to guide the implementation and analyze the effectiveness of the Compliance and Ethics Program, help identify potential risks and exposures and document follow-up, and identify and document information to report to the Governing Body

- Leadership identifies staff designees to conduct risk assessment activities related to their department.
- Risks with the highest likelihood and impact potential to the facility are those the Governing Body should be monitoring.
- The Compliance and Ethics Committee will focus on the risks that truly impact the facility rather than a single individual or department's view of priorities.
- A Standard Meeting Agenda provides the Committee with a listing of rotational and elements-based topics that are required to be discussed to achieve an effective Compliance and Ethics Committee meeting**.**

- Monitoring and auditing are key activities of the Compliance Program and Compliance and Ethics Committee members.
  - *Monitoring* includes *regular* reviews performed as part of normal operations to confirm *ongoing* compliance in day-to-day activities, generating *trends* in performance.
    - Includes quantifiable comparison over time.
  - *Auditing* includes formal reviews of compliance with a set of standards as base (point in time) measures.
    - Audits set priorities for continuous monitoring activities as a component of strategic planning activities.
    - A previous month's audit should be completed prior to the Committee meeting. If not, corrective action for completion is noted.
    - Any "No" responses to audit questions will have corrective action noted with evaluation of follow-up at the subsequent Compliance and Ethics Committee meeting.
    - Missing or incomplete audits are part of the report given to the Governing Body on a regular basis.

(See ***CP 1.1.2 A - E*** in the Appendix of this chapter.)

Membership and Voting: Compliance and Ethics Committee members are expected to regularly attend the scheduled and called meetings. A simple majority of members present at a meeting constitutes a quorum for voting purposes. Note: The Compliance and Ethics Committee can be a component of the overarching QAA/QAPI Committee if allowed by state requirements, but meeting minutes and documentation must be distinct for the Compliance and Ethics Committee activities.



Committee Functions:

1. Analyze The Company's environment, the legal requirements with which it must comply, current governmental enforcement initiatives and specific risk areas.
2. Assess and modify existing policies and procedures that address these areas for possible incorporation into the Compliance and Ethics Program.
3. Work with Department Heads to develop, review and approve policies and procedures to promote compliance with the Compliance and Ethics Program.
4. Recommend and monitor, in conjunction with relevant departments, the development of internal systems and controls to carry out The Company's standards, policies, and procedures as part of its daily operations.
5. Determine the appropriate strategy/approach to promote compliance with the Program, and detection of any potential violation through hotlines and other fraud reporting mechanisms.
6. Develop a system to solicit, evaluate, and respond to complaints, problems, and ethical business dilemmas.
7. The Committee may also address other functions than the Compliance and Ethics Program as it becomes part of the overall operating structure and daily routine.
8. The Compliance and Ethics Officer will provide an internal activity report for the past quarter based on the plan of action agreed upon by the Committee. Compliance and Ethics Attorney will review the report and make recommendations as to the next areas to be addressed. A new plan of action will be collectively decided upon by the entire Committee.
9. Assist the Compliance and Ethics Officer in any other areas as delegated by Compliance and Ethics Officer.

10. Report to the Governing Body on all matters relating to the Compliance and Ethics Program on a periodic, but not less than quarterly basis.
11. Oversee the implementation and operation of the Compliance and Ethics Program.
12. Receive and act upon reports and recommendations from the Compliance and Ethics Officer.
13. Oversee the development and coordination of compliance educational and training sessions that focus on the essential elements of regulatory compliance.
14. Evaluate The Company's conformance to the Compliance and Ethics Program by periodic reviews of whether the Program's elements have been satisfied (e.g., whether there has been appropriate dissemination of the Program's standards, ongoing educational sessions, and internal investigations of alleged noncompliance).
15. The Compliance and Ethics Officer will provide an internal activity report for the past quarter based on the plan of action agreed upon by the Compliance and Ethics Committee. The Compliance and Ethics Committee will review the report and make recommendations as to the next areas to be addressed. A new plan of action will be collectively decided upon by the entire Compliance and Ethics Committee.
16. Investigations and Reviews of Compliance Matters: Notwithstanding the foregoing, upon the advice of, and where necessary at the direction of the Compliance and Ethics Attorney, the Compliance and Ethics Committee and through its delegate, the Compliance and Ethics Officer, shall have the ultimate authority to undertake and/or direct all investigations and reviews of any compliance related matter. When the Compliance and Ethics Committee or Compliance and Ethics Officer undertake to direct or investigate a matter, the Compliance and Ethics Officer shall be responsible for ensuring the appropriate completion of all documentation relating to such investigation.

All Compliance and Ethics Committee members shall sign a *Confidentiality Statement*. (Reference Appendix CP 1.1.2 A)

Policy Number: CP 2.0

Policy Title: Company Compliance and Ethics Plan: Standards, Policies, and Procedures

Policy Statement/Purpose: Establish Company expectations for the conduct of staff members and others with whom The Company is associated to reduce the possibility of fraud, waste, and financial abuse and maintain a proactive effort to incorporate contemporaneous changes to the standards of practice.

Policy Interpretation and Implementation:

Standards

1. Code of Conduct: Company policies include the adoption of a *Code of Conduct* (Appendix CP 2.1), which assists staff members in avoiding both the appearance and commission of improper activities. The Code of Conduct is distributed to all staff members and is made available to all associates. The Compliance and Ethics Officer is responsible for ensuring that all staff members and associates have acknowledged that they have received, read, and fully understand the Code of Conduct. (WM 2.4 Section E; WM Appendix 3, Section D; VC Appendix 1.0 D).
2. Compliance and Ethics Officer: The Compliance and Ethics Officer is responsible for developing and maintaining all compliance-related policies and procedures. The Compliance and Ethics Officer is available always to discuss compliance issues; reports compliance issues directly to senior management so that the issues can be properly addressed and investigated; and makes periodic reports on compliance issues and their resolution to the Compliance and Ethics Committee, the Governing Body, and the Compliance and Ethics attorney. All written compliance and ethics policies and procedures will be reviewed and revised periodically to reflect changes to business practices as well as changes to applicable laws, rules, and regulations. Revised policies and procedures shall become effective upon approval by the Compliance and Ethics Officer and Compliance and Ethics Committee. (See policy CP 1.1.1 *Position Description: Compliance and Ethics Officer*)

3. Lines of Communication: Company personnel must be able to communicate issues of concern openly and freely to their supervisors, the Compliance and Ethics Officer, and the Compliance and Ethics Committee. The Company is committed to maintaining an accessible and open communication system through which employees can (1) obtain answers to their questions on compliance policies and (2) report concerns about possible policy violations without fear of retribution. Company communication systems support communication of questions and concerns and communication of policies to associates.

4. Deficit Reduction Act (State specific): The Company must comply with state specific Deficit Reduction Act (DRA) requirements as noted in Policy FI Appendix 1.1

5. Policy Against Harassment: The Company has and enforces a policy against harassment.

Compliance Element 1: Policies and Procedures

A. Compliance Inquiry System

1). *Overview:* The Company's Compliance Inquiry System is maintained for resolving questions about the statutes, regulations, and rules covered by The Company's Compliance and Ethics Program. When anyone associated with The Company has questions about the appropriateness of a business activity or is unsure of the correct procedures to follow, the individual should first consult with a supervisor for clarification. If an individual is not comfortable discussing his or her concerns with a supervisor or believes that the supervisor may not have addressed his or her concerns appropriately or adequately, the individual may contact the Compliance and Ethics Officer or a Compliance and Ethics Committee member for further clarification. The Compliance Inquiry System is designed to provide a prompt answer to questions and to preserve the attorney-client privilege and work product doctrine.

2). *Inquiries:* Reimbursement inquiries may be related to:

a. documentation, billing procedures, coding, or other activities related to billing and claims for Medicare, Medicaid, or another third-party payor; or
b. coverage determinations, guidance, or other directives about items and services that may be reimbursable under Medicare, Medicaid, or another third-party payor.

3). *Standards:* Consistency and accuracy are critical standards of the Compliance and Ethics Program.

a. Oral inquiries and answers are discouraged except in an emergency. When oral advice is given, it must be documented promptly in writing.
b. Requests for advice, opinions, and clarification from counsel will be made exclusively through the Compliance and Ethics Officer.
c. When an employee obtains advice or clarification about the meaning of a law, regulation, Medicare manual provision, or other rule from anyone outside The Company, the advice must be documented.
d. If there is any question about the reliability or appropriateness of any advice or clarification, the Compliance and Ethics Officer should be contacted.

These requirements apply to advice, opinions, or clarification from any government agency, outside counsel, insurance carrier, intermediary, or consultant concerning interpretations of statutes, regulations, Medicare manual provisions, or any other directive affecting compliance with the Compliance and Ethics Program.

These requirements do not apply to communications between an internal billing office and an insurance carrier or payor as needed for the routine processing of claims, provided the procedures comply with the Compliance and Ethics Program.

B. Compliance Reporting System

1). *Overview:* The Company shall have accessible reporting procedures for all persons associated with The Company including employees, vendors, executives, Governing Body members, appointees, associates, students, residents, as well as members of the public. The Company is committed to developing and supporting all lines of communication to support its efforts to detect, address, and prevent compliance issues, including anonymous reporting. The Company's Compliance Reporting System includes a hotline to report suspicious conduct, violations of law, violations of Company policy, or significant information the reporter feels they cannot report to a supervisor.

2). *Duty to Report Concerns:* Any representative acting on behalf of The Company as noted above, must promptly report any suspected violation of the Compliance and Ethics Program and/or state or federal law, rule or regulation in person, by phone, or in writing to the Compliance and Ethics Officer, a supervisor or using the Compliance Reporting System noted below.

3). *Duty to Report Certain Activities:* Employees and agents who reasonably believe that any of the following activities have occurred, are occurring, or are likely to occur, must immediately report their suspicions to their supervisor or contact the Compliance Reporting System as noted below:

a. Excessive billing for evaluation testing under preadmission assessment and annual resident review (PASSR) regulations when not reasonable and necessary for diagnosis or treatment (e.g., annual screening required for Medicaid residents as part of the certification process and which is compensated by Medicaid as part of the daily rate).
b. Individual or group therapies that are not medically necessary.
c. Individual or group therapies performed by inappropriate types of providers.
d. Excessive volumes of medical supplies delivered to or solicited by Company staff or agents.
e. Unusually active presence of medical supply sales representatives who are given or request unlimited access to residents' medical receipts.

4). *Reporting system procedures:* Compliance Reporting System procedures, including the telephone number for the Compliance Hotline and designation of the Compliance and Ethics Officer as the contact person for compliance questions, concerns, and reporting are readily accessible to all persons associated with The Company. Reporting system information is posted conspicuously in break rooms, lounges, or other common areas. The Compliance and Ethics Officer maintains open lines of communication and may be reached by telephone, by inter-office mail, or by face-to-face communication.

It is the duty of the Administrator or any supervisor who receives a report of a possible compliance issue to report such issue to the Compliance and Ethics Officer or appropriate compliance personnel immediately.

In order of priority the Compliance Reporting System includes:

a. The appropriate department head or any other senior manager
b. The Administrator
c. The Compliance and Ethics Officer
d. The Compliance Hotline at ***(800) 557-1066***

Whether reporting by phone or in writing, the individual should be prepared to provide as much detail as possible, including names, dates (times), places, and the specific conduct the individual feels may violate the law or Company policy. If calling, the individual should be prepared to securely FAX relevant documents; if writing, the individual should include copies of relevant documents and provide his or her name and a telephone number and address where he or she may be contacted (if not reporting anonymously).

The reporting system is designed to protect the attorney-client privilege to the maximum possible extent and to maintain a record of all reports and the results of any related investigations or inquiries.

5). *Non-retaliation:* Personnel must be able to communicate issues of concern openly and freely to their supervisors, the Compliance and Ethics Officer, and the Compliance and Ethics Committee.
   a. There will be no retaliation for actions of good faith participation in the Compliance and Ethics Program including, but not limited to, reporting potential issues; cooperating or participating in the investigation of issues; participating in self-evaluations, audits, and remedial action; and/or making reports of inappropriate conduct to appropriate officials. (Reference Section D of this policy: *Protection of Employees* and policy WM 2.9 C *Non-Retaliation and Non-Retribution*)
   b. Failure to report in good faith, engaging in non-compliant behavior and/or encouraging, directing, facilitating participating in or permitting, either actively or passively, non-compliant behavior may result in disciplinary action. (Policy WM 2.9 *Disciplinary Standards*)

6). *Compliance Call Log:* All calls received will routinely be logged. A report will be created for each call received including, but not limited to, the following information:
   a. A list of the individuals involved in the reported issue and their roles
   b. Information about the caller if the caller has chosen to reveal his or her identity
   c. A summary of the nature of the call
   d. A detailed narrative of the caller's concerns
   e. Additional comments as needed

7). *Role of Compliance and Ethics Officer:* All reports will be communicated directly to the Compliance and Ethics Officer for review. The Compliance and Ethics Officer will:
   a. Confer with the Administrator to investigate the complaint and develop an action plan for resolution of the stated problem.
   b. Ensure that all Compliance Hotline calls are scrutinized, pursued, and investigated as they are received, and that all reports of compliance issues and violations are taken seriously and investigated accordingly.
   c. Document the investigation process, including the completion of the investigation.
   d. Follow up with the individual making the call or report and provide a direct response from the investigation and its resolution, if it was requested.
   e. Conduct monthly random interviews with staff to encourage communication. Staff is encouraged to express any concerns regarding compliance issues during these interviews, or at any time staff has a concern.
   f. Keep all communication confidential to the extent possible.

(Reference policy CP 1.1.1 *Position Description: Compliance and Ethics Officer*)

C. Screening and Evaluation of Associates

1. *Overview:* The Office of Inspector General (OIG) has established a list of individuals and/or entities who have been excluded from federally funded healthcare programs. The exclusions can be for various reasons and are often due to convictions for Medicare or Medicaid fraud. The OIG calls this list the List of Excluded Individuals/Entities (LEIE), and it is often referred to as the "exclusion list." The intention of the list is to ensure that those individuals and/or entities on the list do not receive payments from federal healthcare programs.

   The Company implements monthly screening procedures to avoid contracting with excluded parties. No federal healthcare program payment may be made for items or services given by an excluded individual or entity. Civil monetary penalties may be imposed against an individual who contracts with an excluded party, when they know or should have known the party was excluded. All entities that receive payments from The Company (including employees, contracted workers, and vendors), must be included in the monthly check. Results should be documented as proof of compliance.

2. *Screening procedures*:
   Screen all prospective owners, administrators, and agents against the OIG's List of Excluded Individuals. Download the list of excluded individuals from the OIG website at no charge. Monthly updates are available and should be downloaded regularly.
   a. Periodic screening of current contracted entities
   b. Require potential vendors to disclose if they are excluded
   c. Train human resource personnel of the effects of exclusion

3. *Screening requirements:*
   a. Investigate the background of employees by checking with all applicable licensing and certification authorities to verify that requisite licenses and certifications are in order
   b. Require all potential employees to certify that they have not been convicted of an offense that would preclude employment in a nursing company and that they are not excluded from participation in the Federal healthcare programs
   c. Require temporary employment agencies to ensure that temporary staff assigned to The Company have undergone background checks that verify that they have not been convicted of an offense that would preclude employment in The Company
   d. Check the OIG's List of Excluded Individuals/Entities and the U.S. General Services Administration's (GSA) list of debarred contractors to verify that employees are not excluded from participating in the federal healthcare programs
   e. Require current employees to report to the nursing company if, subsequent to their employment, they are convicted of an offense that would preclude employment in a nursing company or are excluded from participation in any Federal healthcare program
   f. Periodically check the OIG and GSA websites to verify the participation/exclusion status of independent contractors and retain on file the results of that query. (Reference WM 2.0 and VC Appendix 2.0 A)

4. *Downloading the database*
   a. The exclusion list can be found at https://exclusions.oig.hhs.gov . Along the right side of the page is a blue box with the title "Related Content." Select the first option, which is the "LEIE Downloadable Database."
   b. On the page that opens, (https://oig.hhs.gov/exclusions/exclusions_list.asp), select the first option, which is the most recent month's LEIE Database. Once you select this option, the entire database will download into an Excel spreadsheet.

5. *Checking the database*
   a. Manually check each Company name on the employee/vendor list to see if it is on the list.
   b. Alternatively, use a formula to check for duplicates or matches between your list and the database you downloaded.

6. *Monthly updates*
   a. The OIG publishes monthly updates to the database. These monthly supplements can be found on the same page where The Company downloaded the full database.
   b. Monthly supplements should be downloaded and added to the previously downloaded file. Be sure to update your list of employees/vendors to include any new entities that were hired/contracted with since the last time the database was checked.

7. *Investigations and Documentation*
   Any matches or "hits" identified when checking the list should be investigated. More often than not, "hits" are the result of someone with a similar name. It is important to keep documentation of the fact that the list was checked on a monthly basis and that any "hits" were looked into in order to make sure that The Company is not giving federal healthcare dollars to someone on the exclusion list.

8. *Additional lists*
   a. Additional federal exclusions may be included in the SAM/EPLS database, which must be checked monthly. The list can be found at https://sam.gov/content/exclusions. Select the "Advanced Search – Exclusion" option to check Company vendors and other companies, as necessary.
   b. In addition, check the state exclusion database monthly.

D. PROTECTION OF EMPLOYEES

1. *Confidentiality:* The Company strives to maintain the confidentiality of anyone reporting a suspected violation. However, under certain circumstances, the individual's identity may become apparent as The Company's investigation of the allegation progresses or may have to be revealed in the event governmental authorities become involved. Reference Section F of this policy)

2. *Non-retaliation:* No individual will be disciplined or suffer other repercussions solely on the basis that he or she reported what he or she reasonably believed to be misconduct or a violation of the Compliance and Ethics Program or The Company's Code of Conduct. The Company is committed to following the protections set forth in 31 U.S.C. § 3730(h). (See Policy WM 2.9 C *Non-Retaliation and Non-Retribution*)

   If The Company learns that an individual knowingly fabricated, distorted, exaggerated, or minimized a report of misconduct, either to injure someone else or to protect himself or herself, the individual will be subject to disciplinary action (Policy WM 2.9 *Disciplinary Standards*).

   If an individual who makes a report also admits to noncompliance on his or her part, the reporting itself does not guarantee protection from disciplinary action related to the underlying noncompliance. However, volunteering information about one's own errors, misconduct, or noncompliance will be considered, if the admission is complete and truthful, and was not already known to The Company (or about to be discovered). The weight to be given the report will depend on all the facts known to The Company at the time disciplinary decisions are made, according to the criteria discussed in Section I Compliance Investigation.

E. COMPLIANCE HOTLINE

Purpose of compliance hotline: The Company invites employees, agents, and affiliates to report potential unlawful practice so that it can be resolved expeditiously.

1). *Overview:*
   a. Provides an employee or agent an anonymous channel to report perceived problems without fear of retribution;
   b. Allows individuals to speak candidly. Any problem such as theft, sexual harassment, bribery, alcohol or drug abuse, fraud, discrimination, safety or health violations, wrongful discharge, or any other violation of law, regulation or company policy can be uncovered and resolved expeditiously;
   c. Helps demonstrate the effectiveness of the Compliance and Ethics Program.

2). *Hotline number communication*: The Company's toll-free Compliance Hotline telephone number ***(800) 557-1066*:**
   a. Is made available to all employees, agents, and affiliates of The Company to report suspected violations of the law, federal healthcare regulations, policies or procedures, or The Company's Code of Conduct.
   b. Is publicized and displayed in employee and public areas through a Compliance Awareness Poster (see Appendix CP 2.0 E) and Company newsletter.
   c. Is available 24 hours per day, 7 days per week through voice mail. All voice mail calls will be returned the next business day.
   d. Is managed by an external source for ensuring anonymity if requested by the individual making the report.

3). *Hotline number operations*: The Company hotline is operationally maintained by the Compliance and Ethics Officer who maintains its integrity including:

a. Ensuring proper functioning of the Hotline
b. Conducting investigations of all credible allegations
c. Following-up in response to all Hotline calls to:
    1. Provide feedback to callers; and
    2. Report Compliance Hotline activity to The Company's Governing Body on a consistent/regular basis.
d. Maintaining a secure area for all documentation
e. Providing Compliance Hotline information/instructions to all employees during orientation and annual compliance training

4). *Hotline call tracking:* All calls will be received by Med-Net Compliance, LLC, which will routinely check for and log messages.
a. Med-Net Compliance, LLC will prepare a Hotline Incident Report for each call received (Reference CP Appendix 2.0 B *Compliance Incident Report Log)*
b. The Hotline Incident Report will be securely emailed directly to the Compliance and Ethics Officer for review
c. The Compliance and Ethics Officer will track all Compliance Hotline calls through logging Hotline Incident Reports sequentially numbered according to date
d. All Compliance Hotline calls will be scrutinized, pursued and investigated as they are received
e. The Compliance and Ethics Officer will confer with the Administrator of The Company to investigate the complaint and develop an action plan for resolution of the stated problem
f. The Compliance and Ethics Officer will complete a Compliance Investigation Form to document the investigation process (Reference Appendix CP 2.0 C *Compliance Investigation Form)*
g. If requested, the individual making the call will receive a direct response from the investigation and its resolution
h. The resolution will be documented on the Corrective Action Plan (Reference Appendix CP 2.0 D *Compliance Corrective Action)*
i. The date of resolution will be documented on the original Incident Report to indicate completion of the report
j. Providing the control number to the caller as a tracking number so that the caller may call back anonymously and inquire about the status of his/her prior call
k. Creating case files for each complaint and keep files in a secure area

5). *Retaliation*: No retaliatory actions will be taken against any individual who reports compliance violations in good faith through the Compliance Hotline. (See policy item D above, *Protection of Employees*)

F. COMPLIANCE CONFIDENTIALITY

1). *Definition of confidential information:* Confidential information is all information learned during participation on the Compliance and Ethics Committee or employment with The Company and that is unknown to the public and/or the general employee population. This includes, but is not limited to, financial information, technical information, information relating to the contents of contracts, or any other proprietary or valuable information of The Company. This also includes sensitive information concerning residents, employees, and vendors. Reference Privacy section.

2). *Access to confidential information:* Members of the Compliance and Ethics Committee have access to confidential information and must not disclose such information to unauthorized individuals. He/she must agree to take appropriate steps to protect sensitive information from accidental disclosure. Reference Privacy section.

3). *Confidentiality Statement:* Every member of the Compliance and Ethics Committee must sign the *Compliance and Ethics Committee Confidentiality Statement* and agree in writing not to disclose any confidential information regarding The Company or its residents to any person, firm, corporation, association, or other entity for any reason or purpose whatsoever, or make use of such confidential information for personal advantage. Reference Appendix CP1.1.2 A *Compliance and Ethics Committee Confidentiality Statement.*

4). *Termination of Employment:* Upon termination of employment by The Company, employees working on the Compliance and Ethics Committee or having access to confidential compliance information must agree not to retain any original or copies of any file, document, record, or memorandum relating in any manner whatsoever to their employment with The Company. All such files, documents, records, and memoranda in their possession will be immediately returned to The Company upon termination of employment. Reference WM 2.11.

5). *The Compliance and Ethics Officer:* The Compliance and Ethics Officer will keep all reported information confidential by:

a. Refraining from requiring the caller to disclose his/her identity
b. Assuring anonymity
    1. If/when an employee chooses to disclose his/her identity; holding it in confidence as much as fully practical or permitted by law
    2. Refraining from recording the Compliance Hotline call and refraining from identifying the number/location of the call
    3. Keeping the Compliance Hotline Report as the only record of Compliance Hotline calls
    4. Maintaining the Compliance Hotline Report in a secure area.

Reference CP 1.1.1 *Position Description: Compliance and Ethics Officer*

G. Compliance Auditing and Monitoring

1). *Overview:* The Company is committed to remain consistent with applicable legal requirements and standards of practice. The Company has an established system for routine identification and self-evaluation of risk areas, including internal auditing and monitoring designed to detect criminal, civil, and administrative violations. Data is collected and analyzed on a regular basis to assess Company compliance with established standards of practice, quality, documentation, billing, and reimbursement guidelines. To the extent that The Company's monitoring activities reveal conduct which could potentially constitute violations of the Compliance and Ethics Program, failure to comply with applicable state or federal law, and other types of misconduct, The Company has an obligation to immediately investigate the conduct in question to determine whether a violation has occurred,

to take action, to discipline the person or persons involved, and to correct the problem. (Reference policy FI Section B *Reimbursement Auditing*)

2). *Compliance auditing and monitoring techniques:* The Company employs a variety of auditing and monitoring techniques and random checks to verify compliance with the Program including:

a. Periodic interviews with management personnel regarding their perceived levels of compliance within their departments or areas of responsibility
b. Questionnaires developed to poll personnel regarding compliance matters as well as the effectiveness of individual training techniques
c. Periodic written reports of department managers, utilizing assessment tools developed to track specific areas of compliance
d. Audits designed and performed by internal and/or external auditors using auditing guidelines
e. Investigations of alleged noncompliance reported through the Reporting Policy or other means
f. Exit interviews of departing employees

Auditing and monitoring are conducted regularly, and written reports are presented to the Compliance and Ethics Officer and Compliance and Ethics Committee at least quarterly. Areas of potential noncompliance are kept confidential.

The Compliance and Ethics Committee will review, revise, and issue modifications and/or updates to the Compliance and Ethics Program to employees based upon the results of such evaluation.

3). *Role of the Compliance and Ethics Officer:*

a. Is responsible for overseeing the monitoring of the various activities and operations of The Company, providing an assessment of the effectiveness of the Compliance and Ethics Program, and indicating the areas where the Compliance and Ethics Program may need to be revised or improved.
    1. Develop a schedule for periodic auditing and monitoring.
    2. Employ a variety of monitoring and auditing techniques including, but not limited to:
        - Audits designed and performed by internal and/or external auditors
        - Investigations of alleged noncompliance reported through the Compliance and Ethics Program Procedure or other means
        - Reevaluation of past audit results
        - Trend analysis
        - On-site visits
    3. The schedule will be reviewed at least annually in conjunction with the Compliance and Ethics Committee and revised, as necessary.
b. Is responsible for developing, approving, and coordinating monitoring plans and formal audits in consultation with the Compliance and Ethics Committee. The audits may be performed by internal or external auditors or another designee. (Reference CP Appendix 1.0 *Compliance Risk Assessment*
    1. Financial audit activities will assess baseline regulatory compliance performance by testing specific high-risk areas, as identified by the Office of the Inspector General (OIG) within associated Company policies and procedures
    2. Considerations in designing/conducting Audits
        - The Company's policies and procedures

- High-risk areas as identified by the OIG
- The Company's specific business operations

c. Audit findings are reported to the Compliance and Ethics Committee
d. Shall analyze the results of the auditing and monitoring to determine the root cause. Based on these reports, the Compliance and Ethics Officer and Compliance and Ethics Committee shall determine an appropriate response.
    1. Associates will be individually notified of their noncompliance by the Compliance and Ethics Officer. Depending upon the nature of the noncompliance, the Compliance and Ethics Officer may require the employee to undergo additional training, increase the number of records reviewed, or the frequency of the reviews. Instances of chronic noncompliance will be reported to the Compliance and Ethics Committee and the Administrator for further corrective action. (Reference policy CP 2.0 Section K *Compliance Corrective Action*).
e. Revise and issue modifications and/or updates to the Compliance and Ethics Program based upon results of the evaluations and/or changes in applicable laws, rules, and regulations.
f. Evaluates, no less than annually, the effectiveness of the *Code of Conduct* and other compliance policies and provide the results of such evaluation to the Compliance and Ethics Committee and the Governing Body.
g. Confers with Legal Counsel to discuss the operation and implementation of the Compliance and Ethics Program as often as necessary, but at least twice a year.

Reference Policy CP 1.1.1 *Position Description: Compliance and Ethics Officer*

4). *Qualifications of Auditors:* The reviewers should:
a. Possess the qualifications and experience necessary to adequately identify potential compliance issues about the matters under review
b. Be objective and independent of line management
c. Have access to relevant personnel, records, and areas of operation
d. Present a written evaluation concerning compliance activities to the Compliance and Ethics Officer
e. Specifically identify areas where corrective actions are needed

5). *Audit Process:* The auditor:
a. Selects a sample audit population that appropriately reflects the matter/area in question. The sample size should be no fewer than five (5) records.
b. Determines if the sample audit reveals a potential problem and whether a larger sample should be reviewed.
c. Determines if the larger sample confirms the problem and the nature, scope, and frequency of the problem.
d. Qualifies the impact of the problem (e.g.; legal, internal policy, etc.).
e. Determines the cause of the problem (e.g.; human error, computer error, lack of education, fraud, malice, etc.).

H. Compliance Response and Prevention

1). *Overview:* The Company has established a system for responding to compliance issues as they arise and to prevent future similar events from occurring, including investigating, retaining legal

consultation, updating policies and procedures, implementing corrective action plans, and, when appropriate, remitting payment and/or reporting misconduct to appropriate authorities.

2). *Responsibility:* It is the responsibility of all associated with The Company to assist in resolving compliance issues by participating in good faith in The Company's response to potential compliance violations, including cooperating when The Company is conducting investigations and abiding by identified corrective action.

3). *Compliance Response and Prevention Processes:* Reports received through either a reporting mechanism or through some other mechanism (e.g., auditing) are documented and assessed initially by the Compliance and Ethics Officer. If the initial assessment indicates that there is a basis for believing that the conduct reported constitutes noncompliance, the matter shall be reported to the Compliance and Ethics Committee for review.

All instances of potential noncompliance shall be investigated carefully to determine whether the allegation appears to be well-founded. The Compliance and Ethics Officer shall promptly begin an investigation in accordance with the established procedure noted in Section I, below.

I. COMPLIANCE INVESTIGATION

1). *Overview:* An Effective Compliance and Ethics Program requires the prompt investigation of complaints presented by anyone working for or doing business with The Company entity. Compliance issues must be properly identified and resolved. The Compliance and Ethics Officer will promptly investigate compliance-related complaints. All employees are expected to assist in investigation and resolution efforts. No promises will be made to the party making the disclosure regarding his or her liability or the steps The Company will take in response to the allegation.

2). *Role of the Compliance and Ethics Officer:* Reports received through either a reporting policy mechanism or through some other monitoring mechanism, shall be initially assessed by the Compliance and Ethics Officer. The Compliance and Ethics Officer's designee will conduct the investigation if the Compliance and Ethics Officer is not available.

a. The Compliance and Ethics Officer will complete a *Compliance Investigation Form*. (Reference CP Appendix 2.0 C, *Compliance Investigation Form*)
b. If the initial assessment indicates that there is a basis for believing that the conduct reported constitutes noncompliance with the Compliance and Ethics Program, applicable state or federal law, or other corporate policy, the matter shall be reported to the Compliance and Ethics Committee for review.
c. The Administrator will be notified of the nature of the complaint.
d. The Compliance and Ethics Officer, in conjunction with Compliance and Ethics Attorney, will be responsible for directing the investigation, including determining the most appropriate investigator to lead the investigation. Appropriate candidates to lead the investigation, in addition to the Compliance and Ethics Officer include, but are not limited to, Human Resources, Legal Counsel, Auditors, or Special Consultants. The chosen investigator, if other than the Compliance and Ethics Officer, shall report to and coordinate all aspects of the investigation with the Compliance and Ethics Officer.

e. The investigator should develop a written plan for the investigation. The plan should be revised as the investigation proceeds.

3). *Investigation Potential Noncompliance Process:* The following steps should be taken when any report or activity giving rise to an investigation occurs:

a. Commence an investigation as soon as reasonably possible, but in no event more than seven (7) days (or sooner as required by laws, rules, or regulations) following reasonable suspicion of a compliance violation. The investigation may include, but is not limited to:
   1. Interviews of the person(s) involved in or having knowledge of the potential noncompliance. Make sure the area where interviews will be conducted ensures privacy
   2. Interviewees with relevant information may be required to submit a signed, dated written statement
   3. If the Compliance and Ethics Officer does not request a written statement from Interviewee, the Compliance and Ethics Officer shall document the interview and he/she should sign and date the record
   4. If the Compliance and Ethics Officer determines that the presence of an individual under investigation could jeopardize the integrity of the investigation, he or she will seek to relieve that individual of his or her responsibilities until the investigation is completed. Further, the Compliance and Ethics Officer also will take any necessary steps to secure, or prevent the destruction of, relevant documents
   5. All employees are expected to assist in investigation and resolution efforts
   6. The specific allegation, issues, and identity of the complainant shall be kept confidential unless otherwise required by law
b. Create a timeline of events
   1. Review of related documents, if appropriate
   2. Review of applicable federal and state laws, rules, and regulations as well as Company policies and procedures
   3. Collaboration with the Compliance and Ethics Committee
   4. Consultation with Compliance and Ethics Attorney, auditors, healthcare consultants, etc.
c. Document every effort to substantiate potential noncompliance and retain the documentation with the original report. All allegations are evaluated to determine:
   1. If the allegation appears to be well-founded.
   2. Whether the alleged activity violates state or federal law or The Company Compliance and Ethics Program.
   3. Whether the alleged activity puts The Company at risk of economic injury or injury to reputation.
   4. The remedial/corrective action to be taken.
      - Not all actions that are not in strict compliance with statutory and regulatory requirements will require corrective action. The Compliance and Ethics Officer, in coordination with the appropriate Company personnel, including the Compliance and Ethics Attorney, will determine whether potential violations are indeed actual wrongdoing or error that requires corrective action. If an error is found, the Compliance and Ethics Officer will ensure that any necessary corrective action is documented. Remedial/corrective action:
        - Is imposed as a means of facilitating the overall goal of full compliance.

- Should assist Company employees, vendors, or business associates to understand specific issues and reduce the likelihood of future noncompliance.
- Should be sufficient to effectively address the instance of noncompliance.
- Should reflect the severity of the noncompliance and the past adherence to compliance standards.
- Applies to all associated with The Company. All are responsible for actively participating in the corrective action.

5. Whether the allegation warrants reporting to enforcement authorities and reporting timelines.

d. Identify the nature of the noncompliance, the immediate correction of any harm resulting from the violation, and the resolution of specific problems identified. Upon completion of the investigation, the Compliance and Ethics Officer, in conjunction with Compliance and Ethics Attorney, will be responsible for preparing a Corrective Action Plan with recommendations on corrective actions, including recommended disciplinary measures to be taken against the person or persons whose activities or conduct is the subject of the investigation. The plan may include:

1. A recommendation to revise applicable policies and procedures to clarify proper protocols and/or development of new systems to safeguard against future noncompliance of a similar nature (Reference policy CP 2.0 Section M *Compliance Reassessment/Annual Review*)

If an investigation reveals that changes to the Compliance and Ethics Program are warranted before the next scheduled Governing Body meeting, the Compliance and Ethics Officer, in consultation with Compliance and Ethics Attorney, is authorized to make such changes and to expend such funds as are necessary to ensure proper adjustments to the Compliance and Ethics Program without prior consent of the Governing Body. However, the Compliance and Ethics Officer will report any such proposed changes to the Administrator prior to implementation to secure his or her advice and to permit the calling of an emergency meeting of the Governing Body, if needed. Otherwise, any changes made to the Compliance and Ethics Program will be reported to the Governing Body at its next regularly scheduled meeting.

2. Additional mandatory training for affected individuals including, but not limited to, employees, contractors, vendors, and/or business associates (Reference policy WM 2.4 D *Compliance Training and Education*)
3. Increased auditing and/or monitoring (Reference policy CP 2.0 Section G *Compliance Auditing and Monitoring* and FI 1.0 B. *Reimbursement Auditing*)
4. For instances of financial fraud and abuse:
   - Focused review of records made by employees, contractors, vendors, or business associates for a defined period following discovery of noncompliance
   - A recommendation to not bill inappropriate claims (Reference policy FI 2.0)
   - A recommendation to repay any overpayments uncovered during the investigation, with interest, if appropriate (Reference policy FI 2.1 F)
   - A recommendation to report to appropriate authorities within sixty (60) days of discovery and repay any overpayments uncovered during the investigation, with interest, if appropriate, after the Compliance and Ethics Officer has investigated and considered the following:
     - Identification of the exact issue

- The amount involved
- Any patterns or trends that the problem may demonstrate within The Company's billing system
- The extent of the period affected
- The circumstances that led to the overpayment
- Whether or not The Company has a corporate integrity agreement in place that requires self-disclosure

5. Enforcement of disciplinary standards (Reference Policy *WM 2.9 Disciplinary Standards)*
6. Other reasonable corrective measures calculated to ensure adherence to applicable federal and state laws, rules, regulations, and The Company's Compliance and Ethics Program
7. Under no circumstances is retaliation for discussing a concern acceptable. This includes questions and concerns an employee discusses with an immediate supervisor, oversight authority, Compliance and Ethics Officer, Compliance and Ethics Committee member, or Compliance and Ethics Attorney

e. Conduct follow up and audit the corrective action for a defined period to determine whether it is being followed as well as its effectiveness in preventing the recurrence of similar violations.
f. Maintain a clear record of the investigation's conclusion as well as what factors were considered in making that determination if an allegation is not substantiated.
   1. If the investigation does not substantiate the concern, documentation regarding the investigation is still filed. Once complete, the documentation filed is kept for a minimum of six (6) years.
      - When a compliance violation is found to exist, all documentation related to the investigation is kept in an "open" file until a remediation plan and any related monitoring are complete.
      - All records related to reports of suspected violations will be preserved in accordance with The Company's document management program. (Reference BP 2.1)

g. Provide feedback to the source regarding the investigation, provided the issue was not reported anonymously. Sources who report anonymously may call to receive feedback. Responses should be general in nature and not reveal information of a confidential nature such as the individual's name or corrective action taken because of the investigation.

J. External Communications and Litigation

1). *Overview:* The Compliance and Ethics Officer shall address requests for information about The Company from individuals who are not affiliated with The Company. The Company is likely to be subject to frequent and routine requests for information and government reviews and/or litigation and may periodically receive legal documents from government auditors and investigators (e.g.; subpoenas, summonses, and legal complaints). The Company has systems in place to identify the appropriate response for dealing with requests for these documents to ensure full cooperation by The Company and its Associates. All contact with Government Agents/Investigators and all requests for information or interviews concerning The Company are immediately directed to the Compliance and Ethics Officer and Administrator.

The Administrator, with the Compliance and Ethics Officer, must not only receive legal documents immediately, but must forward them on to the Compliance and Ethics Attorney immediately to

ensure appropriate and consistent responses and to respond to deadlines that The Company is legally responsible to meet.

2). *General Guidelines for All Types of Inquiries:*

a. All Company Associates should be respectful and courteous to government investigators.
b. As soon as the investigators arrive, immediately notify the Administrator and Compliance and Ethics Officer. If those individuals are unavailable, then contact the most senior management person in your area. If a senior manager is not on the premises, the investigators should be asked to wait momentarily in an unused office or an area where no Company business is being conducted. Wait with the investigators, but do not discuss anything related to business with the investigators while waiting until a senior manager arrives.
c. The Administrator, Compliance and Ethics Officer, or senior manager should request identification from all investigators, including a business card for each investigator. Enforcement agents should be asked to show their badges.
d. The investigators should be asked the purpose of their visit and what information they are seeking.
e. Upon receiving this information, the Administrator, Compliance and Ethics Officer, or senior manager should immediately contact someone who can provide legal guidance.
f. Do nothing to interfere with the agents.

3). *Guidelines for Specific Types of Inquiries:*

a. Routine periodic surveys should be handled in the normal course of business. However, the Administrator and/or Compliance and Ethics Attorney should be contacted in the event there is an unscheduled visit by the state survey team, or agents other than usual state surveyors in attendance (e.g., OIG, FBI, or State Medicaid Fraud Unit).
b. If the inspectors are conducting an *OIG Audit:*
    1. Notify the Administrator and/or Compliance and Ethics Attorney
    2. The Administrator and/or Compliance and Ethics Attorney should be designated to receive all requests for information or documentation
    3. The investigators should be requested to make all requests for information through this designated individual
    4. A list should be made of all information and documents requested
    5. Original documents should not be given to the investigators
    6. Two copies of all documents taken by the investigators should be made: one copy for the investigators, and one for the Administrator and/or Compliance and Ethics Attorney
        - Do not be surprised if the original documents are taken
        - There will be an opportunity later, at the government's office, to photocopy any of the documents that were taken
        - If the government agents attempt to take actual computers, attempt to detach the computers for the agents to minimize damage to the wiring, etc.

c. If the investigators arrive with a *search warrant:*

1. The senior manager on-site should request a copy of the warrant and any accompanying exhibits or attachments and the business card (or name) of the agent in charge
2. The affidavit in support of the warrant should be specifically requested and the Compliance and Ethics Officer should be contacted immediately. Any instructions given by the Compliance and Ethics Officer shall be carefully followed.

3. Contact the Administrator and/or Compliance and Ethics Attorney and forward a copy of the warrant
4. The investigators will have the authority to seize original documents—the senior manager should politely request permission to make copies of important documents before they are seized
    - If permission is not granted, a careful list of documents seized, by category and location, should be made to the extent possible
5. All Associates should be directed to not interfere with investigators conducting a seizure pursuant to a search warrant. Associates perceived by the investigators to be interfering with the investigation may risk criminal sanctions, including but not limited to obstruction of justice

d. *Subpoenas, Summonses, and Legal Complaints:* Other than routine subpoenas for medical or personnel records, subpoenas, summonses, or other legal complaints involving The Company shall be given to the Compliance and Ethics Officer immediately. It is important that the Compliance and Ethics Officer and other appropriate individuals respond to subpoenas, summonses, and other legal documents. It is Company policy that staff not turn over documents or discuss the case with any individuals unless directed to do so. The Compliance and Ethics Attorney will be contacted, if appropriate.
    1. Company documents shall not be photocopied by the government agents on the premises.
    2. A correct and complete inventory of all items taken shall be requested from the government agents before they leave the premises.

4). A*ssociate Rights and Obligations:*

a. Associates should be advised that they may be contacted individually at home or at work by investigators. Individuals should be made aware of the following rights in the event they are contacted by government agents.
    1. Associates have the right to refuse to talk to investigators, or to refuse to be interviewed unless they have an attorney to represent them. It is not an indication of guilt to request an attorney, but rather a common-sense decision to have the assistance of someone who understands the context of government investigations and how to protect individual rights. The Company will provide counsel to represent the Associate in appropriate circumstances.
    2. Associates have the right to refuse to speak to the investigators. Associates must be advised that making a false statement to a government investigator may subject the Associate to criminal sanctions. Once Associates become aware of an ongoing government investigation, no documents in any way related to the investigation should be destroyed or discarded; this may subject the Associate to criminal sanctions.
        - After an investigation has begun, Associates should be instructed (1) not to speculate about the nature of the investigation; and (2) not to create memoranda, letters, emails, or other electronic or paper documents related to the investigation.
    3. If contacted by government investigators, Associates should notify the Administrator and/or Compliance and Ethics Attorney. Associates may not offer to provide access to Company documents. All requests for information and documents by government investigators should be processed through the Administrator and/or Compliance and Ethics Attorney.

5). *Role of Staff and other affected individuals:* Anyone claiming to represent a local, state, or federal agency requesting information, or an interview concerning The Company, should be immediately directed to the Compliance and Ethics Officer and Administrator. It is Company policy to cooperate with the authorities. Considerations:

a. While the agents may have the right to be on the premises to execute a warrant, this does not mean Company employees, affected individuals, and/or contractors must submit to interviews. No one is required to submit to questioning by government investigators or employees.
b. For anyone claiming to represent the government who contacts the associate at work or at home regarding The Company or the employee's employment:
    1. Ask for identification and a business card
    2. Determine precisely why he or she wishes to speak with you
    3. Tell the investigator that you wish to make an appointment for a date and time in the future
    4. Immediately notify the Compliance and Ethics Officer and Administrator
c. Employees and contractors need not explain Company operations, bookkeeping, records, or what any document means; however, employees and contractors will cooperate in locating items called for in the search warrant.
d. If a government agent makes requests or demands of you inconsistent with these instructions, seek the advice of the Compliance and Ethics Officer.
e. Other than routine subpoenas for medical or personnel records, if the employee/affected individual is served with a subpoena, summons, or legal complaint involving The Company, notify the Compliance and Ethics Officer and Administrator immediately. Simultaneously, send a facsimile of the document to the Compliance and Ethics Attorney immediately, noting your name, the date you received the document, and when and where you can be reached. It is very important that you do not turn over documents called for in a subpoena, do not discuss the case with the individual who served you with the subpoena, and do not discuss the subpoena with anyone other than the Compliance and Ethics Officer/Administrator and Compliance and Ethics Attorney.
f. No Employee, affected individual, or contractor may remove, alter, create, or destroy documents or records including, but not limited to, paper, tape, and computer records.

6). *Procedures for Ensuring Compliance with Complaints, Subpoenas, Summonses, and Court Orders:* The Compliance and Ethics Officer will maintain a record of every complaint, subpoena, summons, and court order served on The Company. The Compliance and Ethics Officer will be responsible for coordinating with the Compliance and Ethics Attorney as needed. The Compliance and Ethics Officer and Administrator, with assistance from the Compliance and Ethics Attorney, will be primarily responsible for a timely and appropriate response to the served documents.

7). *Contact with the Media:* All contacts concerning The Company with anyone from the media MUST be referred to the Compliance and Ethics Officer and Administrator.

8). *Contact with Attorneys:* All contacts concerning The Company with anyone claiming to be an attorney should be referred immediately to the Compliance and Ethics Officer and Administrator.

9). *Contact with Competitors:* All contacts with anyone representing a competitor of The Company or employed by a competitor should be reported to the immediate supervisor.

K. COMPLIANCE CORRECTIVE ACTION

1). *Overview:* Corrective action shall be imposed as a means of facilitating the overall Compliance and Ethics Program goal of full compliance. Corrective action plans should assist Company employees, vendors, or business associates to understand specific issues and reduce the likelihood of future noncompliance. Corrective action shall be sufficient to effectively address the instance of noncompliance and should reflect the severity of the noncompliance and the past adherence to compliance standards.

2). *Developing a Corrective Action Plan:* A Corrective Action Plan will be developed if any noncompliance is found in an internal review report, consultant's report, reports of questionable practices, investigations of complaints, internal monitoring, or audit results.

The Corrective Action Plan should identify the nature of noncompliance and immediate correction of any harm resulting from the violation and resolution of specific problems identified. The plan may include, but is not limited to:

a. A recommendation to repay any overpayments uncovered during an investigation (with interest, if appropriate).
    1. The overpayment must be reported to the appropriate governmental healthcare program within sixty (60) days after it is identified.
    2. Once a billing error has been reported and any overpayments returned (including any applicable deductibles and copayments), no further reporting to enforcement authorities is required unless there is evidence of a pattern of, or an attempt to conceal, intentional wrongdoing. The Compliance and Ethics Officer will consult with the Compliance and Ethics Attorney (and any other outside experts deemed necessary) in order to comply with this policy.
    3. The Compliance and Ethics Officer, whenever practical, will consult in advance with the Administrator and the Governing Body before reporting suspected violations of the law to third parties.
b. A recommendation to not bill inappropriate claims.
c. A recommendation to report to appropriate government authorities about the noncompliance and any variable fraud.
    1. The report should be filed within sixty (60) days of the discovery of the credible evidence of fraud and only upon the consultation of the Compliance and Ethics Attorney.
    2. In some situations, if violations of the False Claims Act are reported to the Office of the Inspector General (OIG) within thirty (30) days of learning of credible evidence, fines may be limited to double rather than triple the amount of damages.
    3. Refer to the Office of Inspector General (OIG) Provider Self-Disclosure Protocol.
    4. The Compliance and Ethics Committee and Compliance and Ethics Attorney will monitor settlement of issues reported to outside authorities.
d. Recommended revisions to existing policies and procedures and/or development of new systems to safeguard against future noncompliance of a similar nature. (Reference CP 2.0 Section M *Compliance Reassessment/Annual Review*)

e. Additional mandatory education and training for employees, vendors, and/or business associates who are the subject of the corrective action. (Reference Policy WM 2.4 D *Compliance Training and Education*)
f. Monitoring systems and auditing tools to ensure The Company's adoption of and compliance with the recommendations.
g. Focused reviews of an employee's, vendor's, or business associate's records for a defined period.
h. Other reasonable corrective measures calculated to ensure adherence to the Compliance and Ethics Program.
i. Any recommended disciplinary measures. (Reference WM 2.9 *Disciplinary Standards*)

3). *Considerations for Developing Corrective Action Plans:*
a. The Compliance and Ethics Officer shall follow up and audit corrective action plans to determine whether the corrective action plan is being followed promptly and thoroughly and is effective. The failure of an individual subject to a corrective action plan to adhere to the plan shall be grounds for further corrective action.
b. The Compliance and Ethics Committee must be involved in the development of all Corrective Action Plans that:
    1. result from a significant compliance violation;
    2. affect multiple departments or service lines; or
    3. involve revisions or additions to the Compliance and Ethics Program or system-wide policies and procedures.
c. It is against corporate policy for employees to be retaliated against for their participation in this process. This includes questions and concerns an employee discusses with an immediate supervisor, oversight authority, Compliance and Ethics Officer, or the Compliance and Ethics Committee.
d. The Compliance and Ethics Officer will keep all Corrective Action Plans and documentation in an "open" file until the monitoring period is successfully completed. Once complete, all documentation related to the investigation and corrective action filed is kept for a minimum of six (6) years.
e. The Compliance and Ethics Officer, in conjunction with the Compliance and Ethics Committee and Compliance and Ethics Attorney, shall implement procedures, policies, and systems necessary to reduce the potential for recurrence. (Reference WM 2.9 *Disciplinary Standards*)

L. Compliance and Ethics Training and Education

1). *Overview:* The Company takes steps to effectively communicate the standards and procedures it has set by requiring all employees and other agents to participate in compliance training programs, or by disseminating information that explains the requirements of compliance policies in a practical manner. As such, compliance training and education is provided for all employees, executives, Governing Body members, and all other affected persons associated with The Company, including vendors, consultants, students, and interns. Training includes Company specific regulatory compliance issues, and compliance responsibilities.

The Company attempts to communicate changes to, or modification of, the Compliance and Ethics Program concurrent with, or prior to, the implementation of such changes or modifications.

2). *Associate Responsibilities:* Should Associates have questions or uncertainties regarding compliance with applicable state or federal law, or any aspect of the Compliance and Ethics Program, including related policies or procedures, they should seek immediate clarification from the Compliance and Ethics Officer, management, Compliance and Ethics Attorney, or through the Compliance Hotline. (Reference policy WM 2.4 Section D *Compliance and Ethics Training and Education* and VC Appendix 1.0 E)

M. Compliance Reassessment and Annual Review

1). *Overview:* The Company performs a periodic reassessment and annual review of the Compliance and Ethics Program to evaluate its effectiveness and to make any necessary adjustments. The Company must change its policies and procedures, including forms, logs, and agreements as necessary and appropriate to comply with changes in the law or as needed by The Company.

2). *Evaluation:* The Company will employ a variety of evaluation techniques, including but not limited to:

a. Periodic interviews with management personnel regarding their perceived levels of compliance within their departments or areas of responsibility
b. Questionnaires developed to poll personnel regarding compliance matters, including the effectiveness of individual training/educational techniques
c. Periodic written reports of department managers utilizing assessment tools developed to track specific areas of compliance
d. Exit interviews for departing employees
e. Overall Systems Review and Recommendations – The compliance and ethics systems (Systems to Promote Care at the Center, Corporate, Divisional, and Regional levels) are to be assessed as to their effectiveness, reliability, scope, and thoroughness
    1. Effectiveness - Does the system produce desired outcomes/purposes?
    2. Reliability - Is the system dependable/predictable?
    3. Scope - What is the extent of the system throughout the monitored organization?
    4. Thoroughness - Is the system accurate, or are there omissions in its content and implementation?

3). *Aspects for Review:* Aspects of the Compliance and Ethics Program to include in the ongoing review include, but are not limited to:

a. The systematic review of Company policies and procedures as necessary and appropriate
    1. The Compliance and Ethics Officer is responsible for developing and maintaining all appropriate policies and procedures.
    2. All policies and procedures must be in written form.
    3. The Compliance and Ethics Officer, Compliance and Ethics Attorney, and Compliance and Ethics Committee must approve all policies and procedures for all compliance issues.
    4. If there are material changes in policies and procedures, the affected workforce must be trained. (Reference Policy WM 2.4 D *Compliance and Ethics Training and Education*)
b. Senior management reports on audit results and/or significant visit findings
c. Quality of Care Dashboard metrics:

1. Selected Clinical Indicator results (pressure injuries, returns to hospital, infection control metrics, etc.);
2. Proactive Steps taken to Ensure Resident Care including:
    - Professional Standards of Care
    - Rules and Regulations in 42 C.F.R. Part 483
    - State and Local Statutes and Regulations
    - Company policies and procedures

d. Analysis of Outcome Measures. Corrective interventions including response to Quality-of-Care Issues
    1. Ability to Identify Issue
    2. Ability to Determine Scope of Issue
    3. Ability to Conduct Root Cause Analysis
    4. Ability to Create Action Plan
    5. Ability to Execute Action Plan
    6. Ability to Monitor and Evaluate Plan
e. Internal quality control systems
f. Annual state survey outcomes and complaint survey findings
g. Reports on significant reportable events, disclosure program trends/issues, and OIG updates
h. Overpayments or other critical billing and MDS issues that have been identified as well as any IRO audit updates/outcomes
i. Staffing, overtime, turnover, and agency use
j. Compliance audit results, incidents/occurrences/adverse events, grievances
k. Rehabilitation services
    1. Skilled Rehabilitation Therapy
    2. Complies with Medicare Program Requirements -Therapy Minutes
    3. Complies with Medicare Guidance on Documentation of Medical Records
l. Significant operational issues
m. Communication system
n. Training programs - training compliance/completion rates, review of scheduled training activities, and recommendations from the Compliance and Ethics Committee for any additional training needs that have been identified

4). *Program Updates:* If an investigation reveals that changes to the Compliance and Ethics Program are warranted before the next scheduled Governing Body meeting, the Compliance and Ethics Officer, in consultation with the Compliance and Ethics Attorney, is authorized to make such changes and to expend such funds as are necessary to ensure proper adjustments to the Compliance and Ethics Program without prior consent of the Governing Body. However, the Compliance and Ethics Officer will report any such proposed changes to the Administrator prior to implementation to secure his or her advice and to permit the calling of an emergency meeting of the Governing Body if needed. Otherwise, any changes made to the Compliance and Ethics Program will be reported to the Governing Body at its next regularly scheduled meeting.

The Company shall make necessary adjustments to the Compliance and Ethics Program found to be warranted through the reassessment process. It may be necessary from time to time to amend the overall structure of the Program, as well as to amend various procedural and technical compo-

nents. To ensure that this Program remains a viable Program geared at maintaining defined standards of practice, the Compliance and Ethics Officer and Compliance and Ethics Attorney will periodically make amendments or modifications to the Program. All such amendments or modifications will be brought to the attention of the Compliance and Ethics Committee at its next regularly scheduled meeting.

The Compliance and Ethics Program is designed to accommodate future changes in the law which may arise. The Company anticipates that the scope of the Program may be updated to include issues not currently covered.

5). *Program Interpretation:* Questions concerning interpretation of any portion of The Company Compliance and Ethics Program, including policies and procedures, are directed to a supervisor, Compliance and Ethics Officer, or Administrator using the Compliance Inquiry System and Compliance Hotline described in Policy CP 2.0 Section A *Compliance Inquiry System*.

Policy Number: CP 2.1

Policy Title: Code of Conduct

Policy Statement/Purpose: Identify the Code of Conduct for all Company employees and Associates.

Policy Interpretation and Implementation: The Company and its employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors/contractors and subcontractors, agents, Chief Executive and other senior administrators, managers, executives, Governing Body Members, corporate officers, 1099 employees, and service contractors, hereinafter referred to collectively as "affected individuals," constantly strive to ensure that all activity by, on behalf of, or with the organization is in compliance with all applicable federal, state, and local laws, regulations, ordinances, administrative directives, and any other binding governmental directives ("Laws and Regulations").

The general principles articulated in this Code of Conduct are intended to provide guidance to individuals in their obligation to comply with applicable laws and regulations that also reflect The Company's mission, vision, values and ethical principles found in manuals, policies, and procedures. However, the general principles contained herein are neither exclusive nor complete. All affected individuals are expected to refer to The Company Compliance and Ethics Program, manuals, policies, and procedures as well as other relevant laws and regulations for further guidance. It is important for all affected individuals to recognize that they are required to comply with all applicable laws and regulations, as well as The Company's Compliance and Ethics Program, manuals, policies, and procedures, whether specifically addressed in this Code of Conduct. If questions regarding the existence of, interpretation, or application of any law, regulation, rule, standard, policy, and/or procedure arise, they should be directed to The Company's Compliance and Ethics Officer.

The Company expects everyone to whom this Code of Conduct applies to abide by its principles and to conduct the business and affairs of The Company in a manner consistent with the general policies set forth herein.

Nothing in this Code of Conduct is intended to, nor shall be construed as, providing any additional employment or contractual rights to employees and contractors or other persons.

ETHICAL BUSINESS PRACTICES

1. Achieving business results by illegal acts or unethical conduct is not acceptable. It is expected that all affected individuals shall act in compliance with the requirements of applicable law and this Code and in a sound ethical manner when rendering services to our residents and when conducting business and operational functions.

2. Affected Individuals shall perform their duties in good faith and to the best of their ability and shall not obtain any improper personal benefit by their relationship with The Company.

3. Other than compensation from The Company, and as consistent with the conflict of interest policies, affected individuals shall not have a financial or other personal interest in a transaction between The Company and a vendor, supplier, provider, or customer.

4. Each supervisor and manager is responsible for ensuring that the affected individuals within their supervision are acting ethically and in compliance with applicable law and the Code. All personnel are responsible for acquiring sufficient knowledge to recognize potential compliance issues applicable to their duties, and for appropriately seeking advice regarding such issues.

5. Honest Communication. The Company requires honesty from individuals in the performance of their responsibilities and in communication with The Company's attorneys and auditors. No employee, affected individual, or contractor shall make false or misleading statements to any state or federal officials, investigator, or person/entity doing business with The Company. Employees, affected individuals, and contractors shall not destroy or alter Company information or documents in anticipation of, or in response to, a request for documents by any applicable government agency or from any court.

6. Duty to Report. It is the ongoing and continuous obligation of all affected individuals of The Company to alert the Human Resources Department of any conviction, exclusion from participating in a state or federal healthcare program or finding that would disqualify them from providing services.

7. Financial Reporting. All Company business transactions shall be carried out in accordance with management's general or specific directives. All the books and records shall be kept in accordance with generally accepted accounting standards or other applicable standards. All transactions, payments, receipts, accounts, and assets shall be completely and accurately recorded on The Company's books and records on a consistent basis. All information, including financial reports, cost reports, accounting records, expense accounts, time sheets, and other documents recorded and submitted to other persons must accurately and clearly represent the relevant facts or the true nature of the transaction, and must not be used to mislead those who receive the information or to conceal anything that is improper.

8. Proprietary Information. The Company's affected individuals shall not steal information belonging to another person or entity, including from The Company, or use any publication, document, computer program, information, or product in violation of a third party's interest in such product. All affected individuals are responsible for ensuring that they do not improperly copy documents or computer programs in violation of applicable copyright laws or licensing agreements for their own use. Affected individuals shall not use confidential business information obtained from competitors or pre-employment agreements in violation of a covenant not to compete, or in any other manner likely to provide an unfair competitive advantage to The Company.

9. Business Relationships. Affected individuals shall not engage in any business practice intended to unlawfully obtain favorable treatment or business from any government entity or any other party in a position to provide such treatment or business. Affected individuals shall not use confidential or proprietary information about The Company for their own personal benefit or for the benefit of any other person or entity, except The Company.

    A. *Disclosure of Financial Interest*. Affected individuals shall disclose to the Compliance and Ethics Officer any financial interest, ownership interest, or any other relationship they (or a member of their immediate family) have with The Company's vendors or competitors.

B. *No Use of Insider Information*. Affected individuals may not use "insider" information for any business activity conducted by or on behalf of The Company. All business relations with contractors providing any services to The Company must be conducted at arm's length both in fact and in appearance, and in compliance with The Company's policies and procedures. Affected individuals must disclose personal relationships and business activities with such contractor personnel that may be construed by an impartial observer as influencing the affected individual's performance or duties. Employees and contractors have a responsibility to obtain clarification from management on questionable issues that may arise.

10. Affected individuals shall not engage in any financial, business, or other activity which competes with The Company's business which may interfere or appear to interfere with the performance of their duties, or that involve the use of The Company property, facilities, or resources, except to the extent consistent with the conflict of interest policies.

11. Affected individuals shall comply with applicable antitrust laws. There shall be no discussions or agreements with competitors regarding price or other terms for product sales, prices paid to suppliers or providers, dividing up customers or geographic markets, or joint action to boycott or coerce certain customers, suppliers, or providers.

12. The Company and its affected individuals shall not engage in unfair competition or deceptive trade practices, including misrepresentation of The Company's products or operations. Affected individuals shall not make false or disparaging statements about competitors or their products or attempt to coerce suppliers or providers into purchasing products or services.

13. Confidentiality. All affected individuals shall maintain the confidentiality of The Company's business information and of information relating to The Company's personnel, vendors, suppliers, providers, and residents. Affected individuals shall not use any such confidential or proprietary information except as is appropriate for business. Affected individuals shall not seek to improperly obtain or misuse confidential information of The Company's competitors.

14. Personal Use of Corporate Assets. All affected individuals are expected to refrain from converting assets of The Company to personal use. All business of The Company shall be conducted, and The Company's property utilized, in a manner designed to further The Company's interest rather than the personal interest of an individual employee or contractor. Affected individuals are prohibited from the unauthorized use or taking of The Company's equipment, supplies, materials, or services.

LEGAL COMPLIANCE

1. Gifts from Customers or Others. Affected individuals are prohibited from soliciting or accepting tips, personal gratuities, gifts, or other things of value from The Company's customers or others that seek to do business with The Company. If a customer or another individual wishes to present a monetary gift, he/she should be referred to the Compliance and Ethics Officer.

2. Gifts Influencing Decision-Making. Affected individuals shall not accept gifts, favors, services, entertainment, or other things of value to the extent that decision-making or actions affecting The

Company might be influenced. Similarly, the offer or giving of money, services, or other things of value with the expectation of influencing the judgment or decision-making process of any purchaser, supplier, government official, or other person by The Company is absolutely prohibited.

3. Gifts from Existing Vendors or Customers. Affected individuals may retain gifts from vendors or customers that have a nominal value, generally less than $50 in aggregate over each year. To the extent possible, these gifts should be shared with the affected individual's coworkers. Gifts of cash and cash equivalents (e.g., gift certificates) are never acceptable.

4. Vendor or Customer Sponsored Entertainment. Occasionally, at a vendor's or customer's invitation, an affected individual may accept meals or refreshments, attend a local theater or sporting event, or similar entertainment, at the vendor's or customer's expense, so long as the cost is of nominal value under the circumstances, generally less than $50 in aggregate over each year. In most circumstances, a regular business representative of the vendor or customer should be in attendance with the affected individual. Affected individuals should advise the Compliance and Ethics Officer of vendors or customers that offer such invitations on a frequent basis, even if the affected individual does not accept such invitations.

5. Conflicts of Interest. Affected individuals may not use their positions at The Company to profit personally or to assist others in profiting in any way at the expense of The Company.

6. Anti-Discrimination/Anti-Harassment. All affected individuals are responsible for ensuring that the work environment is free of discrimination or harassment due to sex, age, race, gender, color, religion, national origin, disability, or any other status protected under state or federal law.

7. Fraud and Financial Abuse. The Company expects all affected individuals to refrain from conduct which may violate any federal and state laws relating to healthcare fraud and abuse. Each employee and contractor is expected to: a) maintain honest and accurate records of services provided; b) follow current and applicable laws, regulations and guidelines to facilitate proper documentation of services; and c) take necessary steps to prevent the submission of claims for payment and reimbursement of any kind that are fraudulent, abusive, inaccurate, or medically unnecessary.

8. Kickbacks, Inducement, and Self-Referrals. The Company and all affected individuals shall comply with all laws relating to kickbacks, inducements, and self-referrals.

   The Company and all affected individuals shall not knowingly offer, pay, solicit, or receive bribes, kickbacks, or other improper remuneration in order to induce business reimbursable by any federal or state governmental program including, but not limited to, Medicare and/or Medicaid.

   All affected individuals are required to report any gifts or other gratuities, other than those of nominal value, received from any outside source that is in the position to benefit from the referral of business to The Company.

9. Lobbying/Political Activity. All affected individuals shall not directly or indirectly authorize, pay, promise, deliver, or solicit any payment, gratuity, or favor for influencing any political official or

government employee in the discharge of that person's responsibilities. Personnel shall not entertain government personnel about The Company's business.

EDUCATION

1. The Company will develop and implement a regular education and training program for all employees and external agents.
2. All employees and affected individuals are expected to participate in educational programs and abide by policy requirements.
3. Adherence to The Company's Compliance and Ethics Program will be a factor in evaluating the performance of an employee.
4. The Company will maintain records of all educational programs presented to employees and relevant external agents.

REPORTING OF VIOLATIONS

1. Illegal acts or improper conduct may subject The Company to severe civil and criminal penalties, including large fines and being excluded from certain types of federally funded insurance programs. It is, therefore, very important that any illegal activity or violations of the Code be promptly brought to The Company's attention.
2. Any director, officer, or employee or affected individual who is uncertain of, or believes, or becomes aware of any violation of this Code or any illegal activity by a director, officer, employee, or another person acting on The Company's behalf shall promptly report the violation or illegal activity in person, by phone, or in writing, to:
   a. the appropriate supervisor;
   b. the Administrator;
   c. the Compliance and Ethics Officer; or
   d. the Compliance Hotline at (800) 557-1066.

3. It is the duty of the Administrator or any supervisor who receives a report of a possible compliance issue to report such issue to the Compliance and Ethics Officer or appropriate compliance personnel immediately.
4. It is a violation for affected individual not to report a violation of the Code or any illegal activity. If you have a question about whether acts or conduct may be illegal or violate the Code, you should contact one of the persons listed above. It is a violation of this Code for affected individuals to whom a potential illegal act or violation of the Code is reported to not ensure that the illegal act or violation of the Code comes to the attention of those responsible for investigating such reports. If the illegal acts or conduct in violation of the Code involve a person to whom such illegal acts or violations might otherwise be reported, the illegal acts or violation should be reported to another person to whom reporting is appropriate.
5. It is The Company's policy to promptly and thoroughly investigate reports of illegal activity or violations of this Code. Affected individuals must cooperate with these investigations. You must not take any actions to prevent, hinder, or delay discovery and full investigation of illegal acts or violations of this Code. It is a violation of this Code for personnel to prevent, hinder, or delay discovery and full investigation of illegal acts or violations of this Code.

6. Affected individuals may report illegal acts or a violation of this Code anonymously. To the extent permitted by law, The Company will take reasonable precautions to maintain the confidentiality of those individuals who report illegal activity or violations of this Code and of those individuals involved in the alleged improper activity, whether it turns out that improper acts occurred. Failure to abide by this confidentiality obligation is a violation of this Code.
7. No reprisals or disciplinary action will be taken or permitted against individuals for good faith reporting of, or cooperating in the investigation of, illegal acts or violations of this Code. It is a violation of this Code for personnel to punish or conduct reprisals regarding individuals who have made a good faith report of, or cooperated in the investigation of, illegal acts or violations of this Code.

DISCIPLINARY ACTION

1. Individuals who violate the Code, or commit illegal acts are subject to discipline up to and including dismissal. Personnel who report their own illegal acts or improper conduct, however, will have such self-reporting considered when determining the appropriate disciplinary action. (Policy WM 2.9 *Disciplinary Standards*)

Policy Number: CP 2.2

Policy Title: Conflict of Interest

Policy Statement/Purpose:
To minimize the risk of potential conflicts of interest consistent with applicable legal requirements and standards of practice.

- Each Associate able to influence must annually disclose his or her affiliations and to execute an acknowledgement confirming that he or she has complied with The Company Code of Conduct (CP 2.1).
- Disclosure of an Associate's affiliations is intended to assist The Company in resolving conflicts of interest. An affiliation with another organization does not necessarily mean that an unacceptable conflict of interest exists or that the affiliation would unduly influence the Associate.

Policy Interpretation and Implementation: Each associate in a position to influence will submit a conflict of interest disclosure statement annually. See CP 2.2; WM Appendix 3, Section B; VC Appendix 1.0 Section B.

The Company provides guidance and establishes a procedure for the disclosure of potential conflicts of interest. Each employee is encouraged to act objectively when carrying out their duties as an employee of The Company to include avoiding conflicts of interest.

The Company relies on its employees to exercise their responsibilities in the best interests of The Company, The Company where they work, and the residents they serve. Employees should avoid all situations that are, or appear to be, conflicts of interest. Although it is impractical to attempt to define every situation that might create a conflict of interest, generally speaking, a conflict exists when an employee's personal interests or activities may influence his or her judgment in the performance of his or her duty to The Company and its customers. This policy offers guidance in identifying and addressing potential conflicts of interest.

SITUATIONS CREATING A POSSIBLE CONFLICT OF INTEREST

Financial Interests

A conflict may exist when an employee or an employee's immediate family member is in a position to influence the business decision of The Company or an outside concern and directly or indirectly (a) owns or otherwise engages in the same or similar kind of business as The Company, or (b) owns a significant interest in a competitor or concern with a current or prospective business relationship with The Company.

Outside Activities

A conflict may exist when an employee, or an employee's immediate family member, serves as director, officer, employee, or representative of a competing organization, or an organization which has a current or prospective business relationship with The Company. A conflict also may exist when an

employee engages in a personal business venture, charitable activity, or service in public office that prevents him or her from devoting the time and effort that his or her position at The Company requires.

1. Employees of The Company may not work for, consult with, or have an independent business relationship with any of The Company's service providers, vendors, competitors, or third-party payers. Employees may not invest in any payer, provider, supplier, or competitor, except through mutual funds or minority holdings of publicly traded securities.

2. Employees should not have other employment or business interest if
   a. The employee appears to represent The Company
   b. The employee provides goods or services similar to those The Company provides or is considering
   c. The other job interferes with the everyday duties as an employee of The Company

3. The employee should not use company assets for personal benefit or personal business purposes. Employee should not have business dealings in products or real estate if the value may be affected by Company business. Employees may not disclose or use any confidential information, such as financial data, payer information, computer programs, or customer information, for their own personal and business purposes.

4. Employees considering a second job, a consulting engagement, or healthcare-related investment, should review their plans with their immediate supervisor or the Compliance and Ethics Officer. Approval in advance is required before beginning such a task.

Confidential Information

Use of confidential information obtained through the employee's relationship with The Company for personal gain or for the benefit of others generally creates a conflict.

Transactions Involving The Company

A conflict may exist when an employee, or an employee's immediate family member (a) buys, rents, or sells any real estate or other property from The Company, except for a routine sale of The Company services; (b) benefits personally from any purchase or sale of property by The Company; or (c) derives personal gain from any transaction to which The Company is a party.

The Company's Governing Body or a designated Governing Body committee must approve any such transaction.

Business Opportunities

An employee may not take advantage of the opportunity that comes from knowledge gained in the course of employment for his or her own benefit or that of any other person or organization.

DISCLOSURE PROCEDURE FOR POSSIBLE CONFLICTS

Because it is not possible to list all situations or relationships which might create conflict of interest problems, and because each situation must be evaluated on the facts, employees should disclose promptly any circumstances which might constitute a violation of these guidelines. Employees should consult with the Compliance and Ethics Officer to determine if a conflict exists and, if so, how it should be resolved.

CONFLICT OF INTEREST FOR DIRECTORS, OFFICERS, AND SENIOR MANAGEMENT

Whenever a director, officer, or member of senior management has a personal interest in another party that has or may have business dealings with The Company**,** he or she should disclose that interest to the corporate secretary and refrain from participation in Company business decisions regarding that party.

Whenever a director, officer, or member of senior management has a personal interest in another party that has received, or may receive, a charitable contribution from The Company**,** he or she should disclose that interest to the corporate secretary and should seek permission from the corporate secretary before engaging in any discussions with The Company concerning charitable contributions to that party.

If a director, officer, or associate is in a position where access to Company proprietary information may materially influence his or her decisions in another party engaged in business or competition with The Company, he or she shall decline that information. Proprietary information includes financial, marketing, customer, pricing, medical management, or operations information and strategic plans and initiatives which are important to The Company or any of its affiliated organizations.

If a director, officer, or employee is in a position where access to Company proprietary information may materially influence his or her personal financial or investment decisions, he or she should decline that information.

Directors, officers, and members of senior management should complete an annual statement, in a form prescribed by The Company, disclosing financial, personal, and other interests and relationships that may present a conflict of interest. Any change to the information set forth in the annual statement should be disclosed to the corporate secretary as soon as reasonably practical.

Policy Number: CP 2.3

Policy Title: General Legal Duties and Antitrust Laws

Policy Statement/Purpose: The Company is committed to complying with all applicable legal requirements, standards of practice, and federal and state antitrust laws. It is critical that The Company avoids the appearance of wrongdoing. This policy summarizes The Company's general compliance-related legal duties and reinforces the importance of compliance for all Company associates.

Policy Interpretation and Implementation:

The Company must comply with state, as well as federal antitrust laws. In many states, these laws are known as unfair practices acts, and are generally modeled on the federal antitrust laws. Antitrust concerns arise under three principal federal antitrust statutes:

1. The Sherman Act, which prohibits concerted actions that constitute unreasonable restraints of trade, monopolization, and attempted monopolization
2. The Clayton Act, which prohibits tie-ins, exclusive contracts, and mergers and acquisitions that unreasonably restrain trade
3. The Federal Trade Commission Act, which prohibits unfair or deceptive trade practices

Process:

Antitrust issues to be avoided include:

1. Unfair trade practices, including bribery, deception, and other unfair business practices
2. Agreements to fix prices, collude with competitors, and price share
3. Boycotts and other forms of exclusive dealing agreements

If an employee is involved in a discussion with a competitor that begins to involve an improper antitrust topic, the employee should leave the meeting and immediately report the incident to the Compliance and Ethics Officer.

Federal Compliance-Related Laws

1. The Federal Civil False Claims Act 31 U.S.C. § 3729: The Federal Civil False Claims Act prohibits knowingly filing a false or fraudulent claim for payment or knowingly using a false record or statement to obtain payment for a false or fraudulent claim.
2. The Federal Criminal False Claims Act 18 U.S.C § 286: The Criminal False Claims Act prohibits any person from knowingly submitting a false, fictitious, or fraudulent claim for payment by the United States government and any such person may be found guilty of a felony and is subject to significant fines and imprisonment for up to five (5) years. Additionally, anyone conspiring with another person to defraud the government by obtaining or helping to obtain payment or allowance of any false, fictitious, or fraudulent claim is subject to significant fines and/or imprisonment for up to ten (10) years.
3. The Federal Civil Monetary Penalties Statute 42 U.S.C. § 1320a-7a: The Federal Civil Monetary Penalties Statute prohibits any person, with the exception of beneficiaries of federal healthcare programs, from knowingly engaging in a broad range of conduct resulting in false or improper claims payable in United States government funds, and any such person is liable for significant penalties and fines.

4. The Federal Health Care Fraud Statute 18 U.S.C. § 1347: The Federal Health Care Fraud Statute prohibits any person or entity from knowingly and willfully defrauding or attempting to defraud any healthcare benefit program, or obtaining through fraud or false pretenses, representations, or promises, any money or property owned or controlled by any healthcare benefit program in connection with the payment or delivery of healthcare benefits, items, or services, and any such person shall be subject to significant fines and/or imprisonment for up to ten (10) years.
    a. If a violation of this statute results in serious bodily injury, the person committing the violation is subject to significant fines and/or imprisonment for up to twenty (20) years.
    b. If a violation of this statute results in death, the person committing the violation is subject to significant fines and/or imprisonment for any term of years, or for life.
    c. Liability under this statute is not limited to federal healthcare benefit programs such as Medicare and Medicaid. Fraud as to private health insurance providers or any other healthcare benefit program falls within the scope of this statute as well.
5. The Federal False Statements Statute 42 U.S.C. § 1320a-7b(a): The Federal False Statements Statute prohibits any person from knowingly and willfully making false statements in connection with the delivery or payment of healthcare benefits, items, or services payable in United States government funds and any such person is subject to significant fines and imprisonment
6. The Federal Anti-Kickback Statute 42 U.S.C. § 1320a-7(b): The Federal Anti-Kickback Statute prohibits soliciting, receiving, or offering to pay any remuneration of any kind (including rebates, kickbacks, or bribes) in exchange for referring or recommending the referral of any individual to The Company that are paid for by federal healthcare programs; or offering or granting any benefit to a referring physician or other referral source on the condition that such physician or referral source refer or agree to refer any federal healthcare program business to The Company or an Associate.
7. The Federal Physician Self-Referral Law (Stark) 42 U.S.C. § 1395nn: The Federal Stark Law prohibits a physician from referring residents to an entity for certain designated health services if the physician, or an immediate family member of the physician, has a financial relationship with the entity, unless the financial relationship falls within certain exceptions.

Criminal and Civil Penalties

Federal law provides criminal penalties for knowingly or willfully making false statements in connection with the delivery or payment of healthcare benefits, items, or services payable in United States government funds. In addition to the criminal penalties, (significant fines and imprisonment), for false statements and illegal remuneration, there are also civil penalties for false or improper claims when the person submitting the claim knew or should have known the service was not provided as claimed or the claim is false and for payments to induce physicians to reduce or limit services to residents eligible for benefits. Such penalties include, but are not limited to, exclusion from participation in federal and state healthcare programs, loss of professional license, etc.

Medical Records Retention

1. Medicare

    a. Records for Reimbursement

Medicare requires providers to maintain and make available to the intermediary "records and documents [including medical records] necessary to ascertain information pertinent to the determination of the proper amount of [Medicare] payments due" (Provider Reimbursement Manual, PRM-1, § 2304.1). In addition to this general requirement, Medicare designates several specific periods of retention. For instance, hospitals must retain clinical and other medical records relating to Medicare claims for at least five (5) years after the month the Medicare cost report is filed with the Intermediary (Hospital Manual, HIM-10, §§ 413,413.1). However, if the provider has a reimbursement appeal for which the medical records might be relevant, the records for the relevant cost year should be retained until the appeal is finally resolved.

b. Conditions of Participation

As a condition of Medicare participation or coverage, providers and suppliers of health services are required to retain medical records for prescribed periods of time. The requirements for specific providers and suppliers are described below.

i. Hospitals

Hospitals are required to retain medical records in their original or legally reproduced form for a period of at least five (5) years as a condition of Medicare participation (42 C.F.R. § 482.24(b)(1)).

The Medicare Conditions of Participation also place varied requirements on hospitals regarding the length of time records for specific services must be maintained. For instance, a hospital must maintain records of radiologic services including copies of printouts and reports and films, scans, and other image records for at least five (5) years (42 C.F.R. § 482.26(d)(2)). As for laboratory services, the conditions of participation require that a hospital must first ensure that all laboratory services provided to its residents are performed in a company certified in accordance with 42 C.F.R. Part 493 (42 C.F.R. § 482.27(a)). Part 493 requires that laboratory test requisitions or authorizations and records of patient testing, including an original report or an exact duplicate of each test report (preliminary and final), must be retained for a minimum of two (2) years after the date of reporting (42 C.F.R. §§ 493.1105, 1107, 1109). Immunohematology records, including reports, must be retained for no less than five (5) years (42 C.F.R. § § 493.1107, 1109; 21 C.F.R. Part 606, Subpart 1). Pathology test reports must be retained for a period of at least ten (10) years after the date of reporting (42 C.F.R. § 493.1109).

ii. Long-Term Care Facilities

Medicare requires long-term care facilities to retain clinical records on each resident for the period required by state law, or, if there is no state requirement, for five (5) years from the date of discharge for adults; and three (3) years after the resident reaches legal age under state law for a minor (42 C.F.R. § 483.75(1)).

iii. Home Health Agencies

The Medicare Conditions of Participation require home health agencies to retain their clinical records for five (5) years after the month the relevant cost report is filed, unless state law requires the records to be retained for a longer period of time. The HHA's policies must provide for retention of clinical records even after the HHA discontinues operations (42 C.F.R. § 484.48).

iv. Comprehensive Outpatient Rehabilitation Facilities

A comprehensive outpatient rehabilitation company participating in Medicare must retain its clinical records for five (5) years after patient discharge. Further, a company which is

no longer able to provide services must provide for the continued maintenance of its clinical records (42 C.F.R. § 485.60(c)).

v. Clinics and Rehabilitation Agencies Providing Outpatient Physical Therapy and/or Speech Pathology Services
Medicare requires clinics and rehabilitation agencies that provide outpatient physical therapy and/or speech pathology services to retain clinical records for at least as long as the state's respective statute or statute of limitations requires, or, if there is no state requirement, for five (5) years after the date of discharge for adults and, for minors, three (3) years after the patient becomes of age under state law or five (5) years after discharge, whichever is longer (42 C.F.R. § 485.721(d)).

vi. End-Stage Renal Disease Services
Medicare Conditions for Coverage require End-Stage Renal Disease facilities to retain their clinical records for at least as long as required by state law or, if there is no state requirement, for five (5) years from the date of discharge or, in the case of a minor, for three (3) years after the patient becomes of age (42 C.F.R. § 405.2139 (e)).

vii. Other Services
Methadone treatment programs must maintain records traceable to specific residents, showing dates, quantity, and batch or code marks of the drug dispensed, for a period of three (3) years from the date of dispensing (21 C.F.R. § 291.505(d)(13)(ii)). Likewise, when narcotic drugs are administered for treatment of narcotic dependence for hospitalized residents, the hospital must maintain accurate records showing dates, quantity, and batch or code marks for the drug used for at least three (3) years (21 C.F.R. § 291.505(t)(2)(u)).

The federal regulations protecting confidentiality of Alcohol and Drug Abuse Treatment Records do not have specific general retention periods. However, the regulations require that the records be maintained in a secure room, locked file cabinet, safe, or other similar container when not in use (42 C.F.R.- § 2.16). In addition, if a program discontinues operations or is acquired by another program, it must purge patient-identifying records or destroy the records unless the patient gives written consent to transfer the records, or there is a legal requirement that the records be kept for a specific period. In such cases, the records are to be sealed and labeled with the name of the program and citation to the court order or law requiring retention and must be destroyed as soon as practical after the end of the required retention period (42 C.F.R. § 2. 19(a).

2. State Medical Records Laws (Reference *State Specific Requirements* at Section 13)

Policy Number: CP 2.4

Policy Title: Risk Management

Policy Statement/Purpose: The Company ensures compliance with applicable laws and regulations regarding the management of risk to support the achievement of company objectives; protect residents, staff, associates, and business assets; and ensure financial sustainability.

Policy Interpretation and Implementation: Risk management is a component of The Company Compliance and Ethics Program.

The Company has a risk management program to proactively address compliance concerns and to mitigate their impact.

1. Electronic Protected Health Information

It is the policy of The Company to implement data security measures sufficient to reduce risks and vulnerabilities to a reasonable and acceptable level to comply with HIPAA. The Company will implement a formal documented plan for managing data security risks and vulnerabilities to electronic protected health information. Such plan shall ensure the confidentiality, integrity, and availability of all electronic protected health information (ePHI) that The Company creates, receives, maintains, or transmits; protect against reasonably anticipated threats or hazards to the security or integrity of such electronic protected health information; and protect against reasonably anticipated uses or disclosures of such electronic protected health information. The plan will include the assignment of responsibilities, the evaluation of recommendations from the Information Security Manager, and the implementation of a continuous monitoring, feedback, and assessment process.

a. The Information Security Manager will be responsible for all tasks related to data risk management in accordance with the policies of The Company. The Information Security Manager will develop and implement at least the following policies and procedures and keep them up to date:
   - Administrative
   - Formal mechanism for processing records
   - Establish access controls
   - Security configuration management
   - Workforce termination
   - Security awareness training
   - Media controls
   - Workstation use
   - Destruction of paper records
   - Creating personal identities
   - Verifying personal identities
   - Confidentiality agreements
   - Trading partner agreements
   - Vendor agreements
   - Disaster recovery and contingency planning

b. Physical Safeguards, including physical access controls
c. Technical Services

d. Technical Mechanisms
e. The Information Security Manager will monitor breaches and quality of the data security system
   - Certification
   - Vulnerability Assessment
   - Audit Trails
   - Security incidents
f. A risk assessment will be conducted at least yearly. Specific implementations will be technology specific

A. MEDICAL RECORD REQUEST REVIEW

Submitting a Medical Record Request

Med-Net will conduct a review of any request for medical records received from any party. In the event that a request for medical records is received, an email containing the request should be sent to the 'Risk Management' Outlook Distribution Email Group provided by Med-Net. Each distribution group contains Risk Management Committee Members.

The review will include the following:

- Review of the content. Essential information may include complete and clear:
  - Identification of the resident, including contact information
  - Identification of the entity to which the information is to be provided, including contact information
  - List of information to be released
- Verification of the legal authority of the requestor. The person or entity requesting information must have legal standing to receive the information requested If required under federal or state law, evidence of legal authority may require a witness signature or notary public seal on the request form, evidence of the relationship between the requestor and the resident, documentation from a court of competent jurisdiction, or other means.
- Verification of appropriateness of information requested for release. Medical Records personnel should review the content of the information being released to ensure that:
  - An authorization is not required. For resident care, an authorization is not required by HIPAA, but it may be required by state law
  - For all requests requiring valid authorization or other legally required pre-condition for release of records and where the request is not compliant with Provider/Company's required authorization or other pre-condition for release, the Provider/Company must make a reasonable effort to provide requestor with a compliant form and/or reasonably assist requestor to satisfy the authorization or other pre-condition for release requirement(s).
  - It conforms to the information that is requested
  - It complies with the HIPAA Privacy Rule minimum necessary standard which requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. The minimum necessary standard DOES NOT APPLY TO:
    - Disclosures to or requests by a health care provider for treatment purposes
    - Disclosures to the individual who is the subject of the information

- Uses or disclosures made pursuant to an individual's authorization
- Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules
- Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes

- Uses or disclosures that are required by other law

Prior to presenting the request to Med-Net, The Company's staff should verify the resident's identification, as provided in the request for release, against The Company's master resident index to ensure the correct records are retrieved. The resident's legal name, date of birth, gender, Social Security number, address, telephone number, guarantor, subscriber, or next-of-kin are key identifying elements that assist in establishing the proper individual. When there are multiple individuals whose demographics are similar, staff should complete additional investigation, such as comparing a resident's signature on the consent with consents contained in the medical record.

Information that pertains to behavioral health or substance abuse care falls under more stringent state and federal regulations and requires particular care in the review of the request, authorization for release, and provision of the specified information to the entity designated to receive it.

Once Med-Net has completed the review of the request, a notification will be sent either approving or denying the request.

2. FINANCIAL INTEGRITY (FI)

2. FINANCIAL INTEGRITY (FI)

Policy Number	Policy
FI 1.0	FINANCIAL INTEGRITY MANAGEMENT PLAN A. FINANCIAL AUDITING AND MONITORING B. FINANCIAL REIMBURSEMENT AUDITING C. MEDICAL RECORD MONITORING D. FINANCIAL COMPLIANCE INVESTIGATION E. EXTERNAL COMMUNICATIONS AND LITIGATION F. FINANCIAL COMPLIANCE CORRECTIVE ACTION
FI 2.0	FINANCIAL BUSINESS PRACTICES A. GENERAL ACQUISITION B. COST REPORTING C. PURCHASING SYSTEM
FI 2.0.1	MEDICARE ENROLLMENT/DISENROLLMENT
FI 2.1	BILLING MANAGEMENT A. CONTRACTS FOR BILLING SERVICES B. MEDICARE BILLING C. MEDICARE CREDIT BALANCE REPORTING REQUIREMENTS AND CERTIFICATION D. MONTHLY BILLING STATEMENTS E. DEMAND BILLING F. REFUND OF OVERPAYMENTS G. ACCOUNTS RECEIVABLE/COLLECTIONS/BAD DEBT
FI 2.2	RESIDENT FUND MANAGEMENT A. DEPOSIT OF RESIDENT FUNDS (ADVANCED PAYMENTS) B. COMMINGLING OF RESIDENT FUNDS C. RESIDENT PERSONAL SPENDING ACCOUNT MANAGEMENT AND AUTHORIZATION D. QUARTERLY ACCOUNTING OF RESIDENT FUNDS E. CONVEYANCE OF FUNDS UPON A RESIDENT'S DEATH F. PRIVATE RESIDENTS PAYMENTS G. DISCRIMINATION AGAINST RESIDENTS AND PAYMENT PROVISIONS
FI. 2.3	AUDIT BY CERTIFIED PUBLIC ACCOUNTANT

Policy Number: FI 1.0

Policy Title: Financial Integrity Management Plan

Policy Statement/Purpose: To ensure the integrity of the various Financial Management components of the Compliance and Ethics Program, as well as to ensure that The Company is complying with all financial compliance policies and applicable laws, rules, and regulations.

Policy Interpretation and Implementation: The Financial Integrity Management Plan is a component of the overarching Company Compliance and Ethics Program.

1). *Overview:* It is the policy of The Company that the Compliance and Ethics Officer will oversee the auditing and monitoring of various activities and operations including, assessment of the effectiveness of the Compliance and Ethics Program that includes financial integrity management and related corrective actions and program improvements. To the extent that The Company's monitoring activities reveal conduct which could potentially constitute violations of the Compliance and Ethics Program, failure to comply with applicable federal or state law, or any other type of misconduct, the Compliance Officer has an obligation to immediately investigate the conduct in question to determine whether any such violation occurred, take action to facilitate any necessary discipline with respect to the person or persons involved, and correct the problem. (Reference policy CP 2.0 Section G *Compliance Auditing and Monitoring)*

B. Reimbursement Auditing

1). *Overview:* Internal auditing standards are integral to the Compliance and Ethics Program. Data will be collected and analyzed on a regular basis to assess the facility compliance with the established standards of practice. Access to the staff members' resident medical and billing records is essential. (Reference CP 2.0 Section G *Compliance Auditing and Monitoring)*

2). *Compliance Review:* Routine chart review will be conducted for each Department to assess compliance with the established standards of practice and billing guidelines. (Reference CP Appendix 1 A-G *Compliance Risk Assessment)*

3). *Scope of Review:* Concurrent and prospective reviews of both billing and medical records will be conducted. (Retrospective review will be conducted when no current charts are available.) Payor reviews will be phased in as follows.

a. Initially, the reviewers will focus on Medicare records.
b. When determined by the Compliance and Ethics Officer, Compliance and Ethics Committee, and the Administrator, or if required by law, the Scope of Review will be expanded to Medicaid records.
c. When determined by the Compliance and Ethics Officer, Compliance and Ethics Committee, and Administrator, or as required by law, the Scope of Review will be expanded to other third-party payors.

Review Procedures: Reviewers skilled and trained in the clinical and reimbursement processes shall conduct routine and random reviews from a representative sample of each staff member's medical and billing records for a designated period ("Audit Period"). Review may be both prospective and retrospective.

The billing and medical records will be drawn at random by the Reviewer from residents' records occurring within a specified Audit Period as follows.

a. A minimum of 10% of monthly claims submitted, representing a cross-selection of all professional staff billing. If there is greater than 5% error rate in any given month per professional biller, then the sample should be expanded based upon Compliance and Ethics Committee review. Additional records may be reviewed at the discretion of the Compliance and Ethics Officer.

The Reviewers will examine the records for compliance with the applicable standards of practice, specifically, compliance with billing-related statutes, regulations, and guidelines.

The Reviewers will review a representative sample of each Practice Group or Staff Service billing records for the Audit Period and compare the charges found in those records with the documentation entered into the medical record through utilization of a Triple Check process. The Reviewer will assess the following:

a. Whether the recognized documentation guidelines are met
b. Whether key elements of the service were provided by the staff member
c. Where the services were provided
d. Whether the billing codes are supported by the documentation
e. Other aspects of billing as determined by the Compliance and Ethics Officer in collaboration with the Compliance and Ethics Committee.

Review codes for noncompliance shall be used and can be amended as necessary to ensure continued compliance with current law and interpretation.

Reviews will be conducted of billings and medical records of all staff members, regardless of the character of their practices or payor mixes. Reviewers are expected to maintain medical records and other resident information confidentially. Resident information can be disclosed to the Compliance and Ethics Committee, Compliance and Ethics Officer, and others charged with administering the Compliance and Ethics Program, but all such persons shall maintain the confidentiality of resident information. All Reviewers, the Compliance and Ethics Officer, and Compliance and Ethics Committee staff shall be required to sign a confidentiality statement upon their employment. (Reference CP Appendix 1.1.2 A)

Review Reports: Each Reviewer will prepare a report detailing the total number of billable encounters reviewed, the number of random charges reviewed as selected from the billing records, the number of compliant and noncompliant records, and the reasons for noncompliance.

The Reviewer's findings will be presented to the Compliance and Ethics Officer and Compliance and Ethics Committee who may direct additional reviews and refer issues to the QAPI Committee for ongoing auditing and monitoring and tracking and trending.

Compliance and Ethics Officer Reports: From the review data developed by the Reviewers, the Compliance and Ethics Officer will analyze the data to determine compliance trends. The results of this analysis will be reported at each Compliance and Ethics Committee meeting.

Objections to Review Report: The staff member may object to any final review report by submitting objections to the Compliance and Ethics Officer.

a. Any objections must be made in writing and must be stated with particularity.
b. The objection must be made by the staff member within fifteen (15) business days of the date the Compliance and Ethics Officer transmits the report to the Compliance and Ethics Committee.
c. Objections to the law or billing guidelines will not be considered.

The Compliance and Ethics Officer will consider and rule on all objections in a timely manner. The Compliance and Ethics Officer may request additional information supporting the objection from the aggrieved staff member.

If the Compliance and Ethics Officer agrees with the objection, then the matter is concluded, and the Reviewer's report shall reflect the change. The record of his or her decision shall state the reasons, with citations to appropriate billing regulations, Intermediary or Carrier letters or bulletins, or other supporting documentation.

If the Compliance and Ethics Officer disagrees with the aggrieved staff member, he or she shall advise the staff member of that decision and his or her appeal rights. The record of the Compliance and Ethics Officer's decision shall state the reasons, with citations to appropriate billing regulations, or other authorized documentation. Written notice of disagreement shall be provided to the staff member. The method of transmission will be determined by the Compliance and Ethics Officer. If the staff member fails to make a timely appeal in the manner, the review report results shall stand, and the Compliance and Ethics Officer may implement a corrective action plan as required. (Reference policy CP 2.0 Section K *Compliance Corrective Action*)

ACTION ON NONCOMPLIANT CLAIMS

Internal Reports- These reports will be used as the basis for action on noncompliant claims.

Action on Noncompliant Claims - The Company, the Compliance and Ethics Committee, and the Compliance and Ethics Officer expect the staff members to follow the actions below when advised about noncompliant bills. Failure to follow these standards as determined from reviews and investigation, shall result in disciplinary measures against the faculty member, which can include termination of employment. Furthermore, when a claim is identified as noncompliant, the correction active plan shall incorporate the appropriate claim refund or withdrawal process as described below:

a. Payment will be refunded for encounters erroneously billed or misbilled.
b. If a claim has been billed but is unpaid, the Payor will be notified, and the billing withdrawn.
c. If the claim has not been billed, then no billing will be made unless and until the Compliance and Ethics Officer determines that a correct billing can occur.
d. Claims may not be rebilled without approval of the Compliance and Ethics Officer.

Notice: The staff members will be individually notified of their noncompliance by the Compliance and Ethics Officer. Depending upon the nature of the noncompliance, the Compliance and Ethics Officer may require the staff member to undergo additional training, increase the number of records reviewed, or increase the frequency of the reviews. Instances of chronic noncompliance will be reported to the Compliance and Ethics Committee and the Administrator for further corrective action. (Reference CP 2.0 Section K *Compliance Corrective Action)*

GENERAL REQUIREMENTS

Communications: All communications between the Compliance and Ethics Officer or staff with the Centers for Medicare & Medicaid Services (CMS), the fiscal Intermediary, or Carrier shall be documented at the time of the communication. This documentation shall include the following:

a. The date, time, and method of the communication
b. The names and titles (if known) of the individuals engaged in the communication, and the employee preparing this documentation
c. A detailed description of the billing advice received, including citations to regulations, provider letters, or other bulletins
d. Any other information conveyed by CMS, the fiscal Intermediary, or Carrier
e. A confirmation letter shall be sent to CMS, the fiscal Intermediary, or Carrier documenting or confirming the billing advice received
f. The documentation and copies of the confirmation letters must be given to the Compliance and Ethics Officer promptly, who shall retain them permanently in his or her files

Confidentiality: Reviewers are expected to confidentially maintain the information contained in the medical records; however, medical record information that is relevant to an analysis of the staff member's billing practices may be disclosed to the Compliance and Ethics Committee and Compliance and Ethics Officer, provided it has been redacted to eliminate resident-specific information or information which identifies or tends to identify the resident. To ensure compliance with this standard, Reviewers will be required to sign confidentiality statements upon their engagement or employment and sign re-acknowledgements at intervals determined by the Compliance and Ethics Officer. (Reference CP 2.0 Section F *Compliance Confidentiality* and Policy PP Appendix 2.0.1 Section D *Confidential Information Agreement*)

C. MEDICAL RECORD MONITORING

1). *Overview:* The Company has a process in place to monitor medical records standards of practice monthly.

2). *Medical Record Monitoring Process:*

a. Monthly, a nurse from one unit will monitor two (2) medical records from another unit so that each unit will have two (2) charts reviewed every month. The nurse will utilize the Medical Records Review form to capture the data from his/her evaluation.
b. The completed Medical Records Review form will be submitted to The Company Compliance and Ethics Officer. The Compliance and Ethics Officer will review this information and identify trends. Specified deficits in standards of practice are addressed internally immediately, and the Compliance and Ethics Attorney should be notified, accordingly.

c. The results of monthly audits will be discussed at The Company's quarterly Compliance and Ethics Committee meetings.

D. Financial Compliance Investigation

Reference Policy CP 2.0 Section I *Compliance Investigation*

E. External Communications and Litigation

Reference Policy CP 2.0 Section J *External Communications and Litigation*

F. Financial Compliance Corrective Action

Reference Policy CP 2.0 Section K *Compliance Corrective Action*

Policy Number: FI 2.0

Policy Title: Financial Business Practices

Policy Statement/Purpose: To ensure the integrity of financial business practices, as well as to ensure that The Company is complying with all business practice Policies, applicable Laws, Rules, and Regulations.

Policy Interpretation and Implementation: Financial business practices are components of the overarching Company Compliance and Ethics Program.

A. General Acquisitions

1). *Overview:* Companies often grow by acquisition, buying smaller companies or facilities outright, purchasing some or all of their assets, by mergers, or through joint ventures. Each of these methods of growth carry varying degrees of risk to The Company. It is possible to acquire more than new business – The Company could be acquiring civil and criminal liability. Depending on the nature of the acquisition, The Company could be taking on criminal liability for actions that occurred before the acquisition, not just liability for actions that occur after the acquisition.

Even transactions structured as asset purchases only (rather than stock purchases) can be vulnerable to successor liability. Some courts have found "de facto" mergers where the successor company has assumed responsibility for completing a project begun by the acquired company, where it takes credit for selling the acquired company's work, collects money, or makes repairs on prior projects.

Acquisitions in which key management personnel from the target company are retained pose special problems. In certain regulated businesses, employment contracts are susceptible to government claims that they are unlawful installment sales contracts disguised as employment contracts.

The Company has established procedures and protocols to be used in the "due diligence" process of scrutinizing the backgrounds and operations of businesses targeted for acquisition. In addition to the usual review of target companies' "profit and loss statements," the review process will include the following procedures.

2). *General Acquisition Procedures:*

a. Past Violations: The Company will acquire only those ongoing businesses that operate within the law and are free of evidence of current violations of the law. The target company will be required to make written disclosure about the existence of, and details about:
    1. Any past violations of local, state, or federal criminal laws during the life of The Company, or during the past fifteen (15) years, whichever is less
    2. Whether it is currently under investigation by any governmental agency
    3. Whether it is the subject of any threatened or pending civil litigation
    4. Whether any current or former "high level" or "substantial authority" personnel have ever been the subject of investigations or charged with offenses relevant to the acquisition

A target company's denial of relevant past violations must be certified in writing. Further, The Company will offer employment only to those employees of acquired businesses who are without past violations of relevant criminal laws and who do not have a propensity to engage in illegal activities.

b. Certifications: As part of any final purchase, key officials of the target company will be required to execute certifications attesting to their awareness (or lack thereof) of violations, investigations, unlawful practices, and the like, unless approval to forego such certifications is given by The Company's Governing Body.
c. Escrow of Purchase Price: The Company will escrow a portion of the purchase price to be held in escrow for a period of time (with a partial payout over a period of time) for payment of any threatened or pending judgments and as a general reserve in the event of a criminal indictment where the due diligence suggests that the target company may be vulnerable to criminal charges.
d. Target Company's Compliance and Ethics Program: Counsel for The Company will be asked to conduct a careful review of the target company's Compliance and Ethics Program, if any, to determine whether the Program is sufficient to satisfy a sentencing court that the plan is "effective" within the meaning of the Federal Sentencing Guidelines. Review of the plan will include a determination of how long the Program has been in existence, its effectiveness, and the results of its audit and training components.

   The Company's Compliance and Ethics Program will be used to analyze the target company's operations to determine whether they can be reasonably assimilated into The Company's operations.
e. Indemnification: Unless provided otherwise by The Company's Governing Body, indemnification agreements with the target company will be required if it is the subject of a pending investigation.
f. Acquisition Contracts: The Company will establish a written policy identifying those employees of The Company who are authorized to negotiate for the purchase of businesses (whether by asset or stock) and related contracts (such as employment contracts with sellers or noncompete contracts).

   All contracts for the purchase of any business will be reviewed by Counsel and will contain the following restrictive language:

   "This contract will not take effect and will not be binding on The Company unless and until signed by the Compliance and Ethics Officer after documented consultation with the Compliance and Ethics Attorney in the space designated below." [A signature line and title with date should be provided.]

   "No amendment to this contract will be binding on The Company unless and until signed by the Compliance and Ethics Officer after consultation with Compliance and Ethics Attorney in a fashion expressly acknowledging approval of the amendment."

3). *Adherence to Acquisition Procedures:* The Company's acquisition personnel will follow the written audit standards and procedures established by the Compliance and Ethics Officer, which implement the policies set forth in this section.

B. COST REPORTING

1). *Overview:* The Company has systems in place to ensure various cost reports, prepared in connection with its operation and to receive payment, are prepared as accurately as possible and in conformity with applicable law and regulations. If errors are discovered, billing personnel shall contact an immediate supervisor promptly for advice concerning how to correct the error(s) and notify the appropriate payor.

2). *Cost Reporting Elements that are Incorporated into the Compliance and Ethics Program*:

a. Cost Reporting Guidelines: In the preparation of cost reports or the compilation of information to be sent to outside parties to prepare cost reports on The Company's behalf, all employees involved in the preparation of cost reports shall abide by Company guidelines including:
   1. Costs are consistent with prudent buyer principle rules, and reasonably related to patient care
   2. Information provided for or used in the cost report is adequately supported by documentation
   3. Non-allowable costs are properly identified and removed
   4. Costs are reported in the appropriate cost categories
   5. Statistics are based on reliable information
   6. Related parties are identified, and their services treated in accordance with program rules
   7. Costs claimed in non-conformity with program rules, as interpreted by the Medicare or Medicaid program or the fiscal intermediary (FI), either are disclosed in a letter accompanying the cost report or are included in protested amounts

b. Reporting False Cost Reporting Practices: If an employee or agent who has any reason to believe that anyone (including the employee himself or herself) is engaging in questionable or false cost reporting or is engaged in questionable internal accounting practices shall immediately report the practice to his or her immediate supervisor, the [compliance hotline, anonymous drop box, post office box, etc.], or the Compliance and Ethics Officer or any of the officers designated to receive such report verbally or in writing. Employees or agents who report a suspected cost reporting or accounting irregularity in good faith shall not be retaliated against or subject to adverse action. (Reference policy CP 2.0 Section B *Compliance Reporting System*).

c. Failure to act when an employee has knowledge that someone is engaged in questionable cost reporting or accounting irregularities shall be considered a breach of that employee's or agent's responsibilities and shall subject the employee to disciplinary action by The Company, including possible termination of employment or of their contractual relationship with The Company. (Reference policy WM 2.9 *Disciplinary Standards*).

C. PURCHASING SYSTEM

1). *Overview:* The Company has a trackable purchase and approval process/system in place to ensure conformity with applicable policy, law, and regulations.

2). *Purchase Request Elements that are Incorporated into the Compliance and Ethics Program:*

a. All purchases for The Company will utilize a number purchase system.
b. Prior to making any purchase, a completed purchase request, listing items and their cost, must be submitted to the Administrator for approval.
c. The purchase request is tracked for completion and monitoring:
    1. The person placing the order retains the original approved purchase request and immediately sends a copy to the Business Office.
    2. The Business Office places the order and retains a copy of the approved purchase request on file.
    3. Upon receipt of the merchandise, the Business Office receives the packing slip/invoice and matches it to the approved purchase request and processes for payment.
    4. Food and Nutrition Services will not be required to use purchase requests for food or replacement supplies. All other purchases by Food and Nutrition Services will be done through the purchasing system.
    5. Department heads are provided access to the purchasing system, including a supply of paper purchase orders, as appropriate.

Policy Number: FI 2.0.1

Policy Title: Medicare Enrollment/Disenrollment

Policy Statement/Purpose: If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary's healthcare coverage, The Company is committed to complying with regulations regarding enrollment/disenrollment and resident rights.

Policy Interpretation and Implementation: A change in a beneficiary's healthcare coverage must be initiated by the beneficiary or his/her representative. Under no circumstances should the LTC facility *require, request, coach, or steer* any resident to select or change a plan for any reason. Medicare.gov is the official government site for information about enrolling or disenrolling in Original Medicare and Medicare Advantage Plans.

1) Facility's Responsibilities

STEP I: Explain orally and in writing the impact to the beneficiaries if they change to a stand-alone drug plan and Original Medicare. Information at a minimum should include:

A clear explanation that the beneficiary would no longer be a member of the Medicare Advantage Prescription Drug Plan (MAPD's) or Medicare-Medicaid Plan (MMP).

An explanation that medical services will be billed to original Medicare and/or Medicaid and what this means regarding deductibles and copays and loss or lack of supplemental coverage for the beneficiary.

The name of the drug plan that will cover the beneficiary's medications, including the deductible and co-pays/coinsurances, especially related to their current drug therapy.

Specific information regarding the beneficiary's opportunities to change Medicare plans and Medicare prescription drug coverage while in the facility (i.e., every month) and when discharged (i.e., for 2 months following the month of discharge) or by virtue of being eligible for Medicare and Medicaid (i.e., every month).

An explanation that enrollment in a stand-alone prescription drug plan (PDP) will be effective the first day of the month following the month of enrollment/disenrollment.

An explanation that in some cases the beneficiary may not be able to reenroll into the MA or MAPD plan the beneficiary previously had (or for that matter into any MA or MAPD plan), even if the beneficiary has a valid election period.

Beneficiaries with ESRD that disenroll from an MA plan and return to original Medicare can **never** re-enroll in an MA plan; such beneficiaries must stay with original Medicare until the beneficiary no longer meets the definition of having ESRD.

Employer sponsored MAPDs may not and do not have to accept a beneficiary back into the plan.

STEP II: Policies and procedures regarding the process for assisting beneficiaries with changing their healthcare coverage should include at a minimum:

Under what circumstances the facility can assist a beneficiary with a plan change.

A document must be signed by the beneficiary or representative acknowledging that specific information regarding the impact of a change in coverage was provided to the beneficiary/ representative orally and in writing, and that they understand the information.

An attestation signed by the facility staff member that assisted with the change in enrollment must indicate that the beneficiary or representative requested the change, and that the beneficiary or representative (as applicable) received and understood the minimum required information.

Assisting Residents with Enrolling/Disenrolling in Medicare and Medicare Advantage Plans

Facility staff can assist residents or their legal representatives to compare Original Medicare and Medicare Advantage Plans by reviewing information available at: https://www.medicare.gov/sign-up-change-plans/different-types-of-medicare-health-plans. This link offers a search option to locate a Medicare approved agent in their individual state with whom they can speak for guidance and explanations on numerous coverage related topics.

Medicare.gov provides information that staff can use to educate residents on how to disenroll in Medicare and Medicare Advantage Plans at the following link: https://www.medicare.gov/medicare-search?global_search=disenrollment

Assisting Residents with Changing Medicare and Medicare Advantage Plans during a Stay and at Discharge

Residents can use the free plan finder tool on Medicare.gov. The plan finder tool can be accessed at: https://www.medicare.gov/find-a-plan/questions/home.aspx.

Residents can contact their local State Health Insurance Assistance Program (SHIPS). SHIPs can provide Medicare counseling through a trained staff member or volunteer. This service can be accessed at: https://www.shiptacenter.org/

Provide these resources to residents discharging to the community so they can find the best Medicare Advantage Plan for them in the community. A resident discharging from a skilled nursing facility or an intermediate care center has up to two months to change their Medicare Advantage plans outside of the general enrollment period.

Those Who May Complete an Enrollment/Disenrollment Request

In general, the Medicare beneficiary is the only individual who may execute a valid request for enrollment/disenrollment from a Medicare Advantage plan, or another individual who is the legal representative as the law of the State in which the beneficiary resides may allow. CMS does recognize State laws that authorize persons to make such requests for Medicare beneficiaries.

Persons authorized under State law may be court-appointed legal guardians, persons having durable power of attorney for healthcare decisions, or individuals authorized to make healthcare decisions under State surrogate consent laws, provided they have authority to act for the beneficiary in this capacity.

Medicare and Nursing Home Resident Open Enrollment

A Medicare beneficiary that is living in a nursing home can:

Switch Medicare and Medicare drug plans when discharged to the community for up to two months following the month of discharge.

Switch Medicare and Medicare Drug Plans every month while a resident in a nursing home. (The switch will not be effective until the first day of the following month).

A Medicare Advantage plan can choose to be "open" or "closed" for these types of enrollments. It is the decision of the Medicare Advantage plan.

Consequences of Beneficiary Disenrollment by the LTC Facility

If documentation of a beneficiary's request to change enrollment cannot be provided by the LTC facility, CMS will consider the enrollment not to be legally valid, cancel the enrollment action, and, if necessary and appropriate, reinstate the beneficiary's MA, MAPD, or MMP coverage as if never disenrolled (Medicare Managed Care Manual, Chapter 2, Sec. 40.6).

CMS will report these incidents to the Medicare Drug Integrity Contractor (MEDIC) that investigates fraud and abuse incidents.

2) Division of Medicare Health Plans Operation (DMHPO) Responsibilities

If CMS becomes aware that a beneficiary's MAPD enrollment has been terminated and the beneficiary alleges that they did not request/know/understand that this was done, CMS will request documentation to support that the facility appropriately assisted the beneficiary with their choice to change coverage.

If the facility has the beneficiary sign documentation regarding their understanding of the change, CMS will expect to find that the beneficiary's assessed cognitive level also supports an ability to understand this type of information. NOTE: It is imperative that the resident's cognitive status is assessed accurately on the MDS since it is likely that the MDS may be the source document to determine whether the resident has appropriate decision-making abilities.

3) Survey and Certification Responsibilities:

Resident Rights

The freedom of choice provisions at sections §1802 and §1902(a)(23) of the Social Security Act provide that any individual entitled to insurance benefits under Medicare or Medicaid may obtain health services from any institution, agency, or person qualified to participate under this title.

Nursing home residents, like all other Medicare beneficiaries, have a right to choose their Part D plans. The statute, at section 1860D-1, and implementing regulations at 42 C.F.R. 423.32, ensure that right, and do not lessen that right simply by virtue of the beneficiary's admission to a nursing facility.

42 CFR §483.10(c) The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. A change in health insurance coverage may affect a resident's medical care and treatment. The LTC facility may not play a role in changes to a resident's health insurance coverage without the resident's or designated representative's full knowledge and consent.

F552 in Appendix PP of the State Operations Manual provides guidance on the resident's right to be informed of health status, care, and treatment.

42 CFR §483.15(a)(2) The facility must not require residents or potential residents to waive their rights to Medicare or Medicaid. Surveyor guidance at F620 in Appendix PP of the SOM clarifies that facilities must not seek a direct or indirect waiver of rights to Medicare or Medicaid benefits.

42 CFR §483.10(b)(3) In the case of a resident adjudged incompetent …, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf and In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. The facility should verify that a surrogate or representative has the necessary authority to make both financial and healthcare decisions.

The facility must respect the resident's wishes to delegate decision-making authority. The surveyor may consider citing F551 if someone other than the appointed or designated representative is making decisions for the resident.

Long-Term Care Pharmacy

Although residents have rights to choose their Medicare plans, the rights do not, however, give unbridled freedom of choice for nursing home residents to choose a *pharmacy,* except for those states with a "right-to-choose" state law.

NOTE: Please check with your state regulations to determine if you are in a "right-to-choose" state.

Common Concerns in Nursing Facilities:

There may be cases where a nursing home acts in a way that frustrates a beneficiary's ability to receive cost effective coverage under Part D for needed prescription drugs under his or her preferred plan.

When a facility exclusively engages a pharmacy that does not have an arrangement with the Part D plan selected by the beneficiary, the beneficiary may be unable to obtain coverage of needed drugs through his or her Part D plan, and may incur higher Part D premiums and/or cost sharing if he or she must switch to an alternative plan in order to receive Part D coverage of his or her drugs.

A facility may not overreach its authority and try to steer a resident to one or more Part D plans preferred by the facility or its pharmacy. Residents in such cases might feel compelled to choose another Part D plan that may not best satisfy their needs in order to conform to the wishes of the facility and its pharmacy.

Failure by a facility to permit residents to receive coverage of needed drugs that would be available from the Part D plan of their choosing could constitute a violation of the facility's pharmacy obligations that require facilities to acquire all drugs that meet the needs of each resident.

It is expected that nursing homes work with their current pharmacies to ensure that they recognize the Part D plans chosen by that facility's Medicare beneficiaries, or, in the alternative, to add additional pharmacies to achieve that objective. Or, at its option, the facility could contract exclusively with another pharmacy that contracts more broadly with Part D plans.

Regulators Perspective

Regulators may perceive undue influence and potential self-interest by the facility (convenience of the facility over needs of the resident) if a facility representative encourages a resident to switch Medicare plans.

Regulators may perceive facility self-interest being placed ahead of resident self-interest if a facility admits a resident knowing that the facility does not have a third-party payor agreement in place, and thereby puts the resident at risk of a higher payment with an out of network provider.

PHI and the Transmission of Benefit Enrollment Information

American National Standards Institute Accredited Standards Committee X12N 834 (ANSI ASCX12N 834) is used to transmit benefit enrollment maintenance files, new enrollment information, changes to the current range of benefits, and the termination of benefits for a subscriber.

All ePHI for Medicare beneficiaries must use this transmission service when sending electronic files to Medicare Advantage plans.

Open Enrollment Period for Medicare Advantage and Medicare prescription drug coverage (Community-Based)

October 15-December 7 each year:

Change from Original Medicare to a Medicare Advantage Plan.

Change from a Medicare Advantage Plan back to Original Medicare.

Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.

Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.

Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.

Join a Medicare Prescription Drug Plan.

Switch from one Medicare drug plan to another Medicare drug plan.

Drop your Medicare prescription drug coverage completely.

5-star special enrollment period (Community-Based)

Medicare uses information from member satisfaction surveys, plans, and healthcare providers to give overall performance star ratings to plans. A plan can get a rating between 1 and 5 stars. A 5-star rating is considered excellent. These ratings help one compare plans based on quality and performance. Medicare updates these ratings each fall for the following year. These ratings can change each year.

A Medicare beneficiary can only switch to a 5-star Medicare Prescription Drug Plan if one is available in their area.

A Medicare beneficiary can only use this Special Enrollment Period once during the timeframe below.

Note: Medicare beneficiaries can switch to these plans once from December 8-November 30 each year:

- **A 5-Star Medicare Advantage Plan**
- **A 5-Star Medicare Cost Plan**
- **A 5-Star Medicare Prescription Drug Plan**

5-star special enrollment period

If a Medicare beneficiary moves from a Medicare Advantage Plan that includes prescription drug coverage to a stand-alone Medicare Prescription Drug Plan, they will be disenrolled from their Medicare Advantage Plan, including the health benefit. They will be returned to Original Medicare for coverage of their health services.

If the Medicare beneficiary moves from a Medicare Advantage Plan that has drug coverage to a 5-star Medicare Advantage Plan that doesn't, they may lose their prescription drug coverage. They will have to wait until the next enrollment opportunity to get drug coverage and may have to pay a Part D late enrollment penalty.

Medicare Advantage Open Enrollment Period (Community-Based)

January 1-March 31 each year:

What *can* be done during this enrollment period:

- A Medicare Advantage Plan (with or without drug coverage), may be switched to another Medicare Advantage Plan (with or without drug coverage).
- A beneficiary can disenroll from their Medicare Advantage Plan and return to Original Medicare. If they choose to do so, they will be able to join a Medicare Prescription Drug Plan.
- If a beneficiary is enrolled in a Medicare Advantage Plan during their Initial Enrollment Period, they can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months that they have Medicare.

What *can't* be done during this enrollment period:

- Switch from Original Medicare to a Medicare Advantage Plan.
- Join a Medicare Prescription Drug Plan if they are in Original Medicare.
- Switch from one Medicare Prescription Drug Plan to another if they are in Original Medicare.

Centers for Medicare & Medicaid Services (CMS).

(Memo to Long term Care Facilities on Disenrollment Issues. 26, May 2015. Centers for Medicare & Medicaid Services (CMS).)

(Nursing Homes and Medicare Part D. 11, May 2006. Medicare Advantage Plans. Retrieved from Medicare.gov accessed 29, July 2019.)

Policy Number: FI 2.1

Policy Title: Billing Management

Policy Statement/Purpose: To ensure the integrity of Company billing management practices as well as to ensure that The Company is complying with all billing Policies, applicable laws, rules, and regulations.

Policy Interpretation and Implementation: Billing management is a component of the overarching Company Compliance and Ethics Program.

A. Contracts for Billing Services

Cross reference VC 1.0 Section D *Contract for Billing Services*

B. Medicare Billing

1). *Overview*: The Company is committed to prompt, complete, and accurate billing of all services provided to residents for payment by residents, government agencies, Medicare, or other third-party payors and ensure that billing is consistent with applicable legal requirements and standards of practice. Billing shall be made only for services provided, directly or under contract, pursuant to all terms and conditions specified by the government or third-party payor and consistent with industry practice.

2). *Billing Practices:*

a. The Company and its employees shall not make or submit any false or misleading entries on any bills or claim forms, and no employee shall engage in any arrangement, or participate in such an arrangement at the direction of another employee (including any officer of The Company or a supervisor), that results in such prohibited acts. Any false statement on any bill or claim form shall subject the employee to disciplinary action by The Company, including possible termination of employment. (Reference Policy WM 2.9 *Disciplinary Standards*)

b. Prohibited Billing Practices: False claims and billing fraud may take a variety of different forms including, but not limited to, false statements supporting claims for payment, misrepresentation of material facts, concealment of material facts, or theft of benefits of payments from the party entitled to receive them. The Company and employees shall specifically refrain from engaging in the following billing practices:

1. Make claims for items or services not rendered or not provided as claimed (such as billing for three hours of therapy when only a few minutes were provided).
2. Submit claims to Medicare Part A for residents who are not eligible for Part A coverage, in other words, who do not require services that are so complex that they can only be effectively and efficiently provided by, or under the supervision of, professional or technical personnel.
3. Submit claims to any payor, including Medicare, for services or supplies that are not medically necessary or that were not ordered by the resident's physician or other authorized caregiver.
4. Submit claims for items or services that are not provided as claimed, such as billing Medicare for expensive prosthetic devices when only non-covered adult diapers were provided.

5. Submit claims to any payor, including Medicare and Medicaid, for individual items or services when such items or services either are included in the provider's per diem rate for a resident or are of the type that may be billed only as a unit and not unbundled.
6. Double bill (billing for the same time or service more than once).
7. Provide inaccurate or misleading information for use in determining the Patient Driven Payment Model (PDPM) or other resident, payment, or acuity classification scale score or ranking assigned to the resident, including but not limited to misrepresenting a resident's medical condition on the minimum data set (MDS).
8. Pay or receive anything of financial benefit in exchange for Medicare or Medicaid referrals (such as receiving non-covered medical products at no charge in exchange for ordering Medicare-reimbursed products).
9. Bill residents for services or supplies that are included in the per-diem payment from Medicare, Medicaid, a managed care plan, or other payor.

c. Reporting False Billing Practices: If an employee has any reason to believe that anyone (including the employee himself or herself) is engaging in false billing practices, that employee shall immediately report the practice to his or her immediate supervisor, the Compliance Hotline, or the Compliance and Ethics Officer or any of the officers designated to receive such report verbally or in writing. (Reference Policy CP 2.0 Section B *Compliance Reporting System* and Section E *Compliance Hotline*)

Failure to act when an employee has knowledge that someone is engaged in false billing practices shall be considered a breach of that employee's responsibilities and shall subject the employee to disciplinary action by The Company, including possible termination of employment. (Reference Policy *WM 2.9 Disciplinary Standards)*

3). *Billing Procedures:*

a. Daily
   1. Census is updated with new admissions or readmissions, discharges, and status changes per data completed by the Admissions Office.
   2. Census, along with face sheets are securely provided to all ancillary vendors per contractual agreements.
   3. Weekly as part of the transmission process, the MDS coordinator will submit the MDS software "Batch File" submitted to the QIES database to billing that will identify the PDPM classification. The MDS coordinator ensures prior to sending to billing there is a clean Validation Report for the submitted MDSs in the Batch File. The Business Office billing system is updated with the PDPM scores, modifiers, and assessment dates provided. If clinical data is unable to be provided via network computer, the MDS coordinator will provide the PDPM/RUGS scores and assessment dates to the Business Office through written format.
   4. An MDS schedule listing PDPM scores provided and PDPM scores required is printed and given to the MDS Coordinator and Director of Nursing.

b. Last business day of the month
   1. A preliminary Medicare census printed from the Business Office billing system is faxed to all ancillary vendors as a double check for billing proper source.

c. First business day of month

1. Medicare census accessed from the Business Office billing system is securely provided to all ancillary vendors for their billing to The Company for PPS residents per contractual agreements.
2. When PPS charges are received from ancillary vendors, they are checked against the Business Office billing system Medicare census for final verifications. Corrections are done immediately with ancillary vendors, and credits are received the following month.
3. Once ancillary invoices are entered into the Business Office billing system, along with the Medicare PDPM classifications, the UB04s are produced. The Business Office Manager, the Director of Therapy, MDS Coordinator, the Director of Nursing, the Administrator and other Disciplines as appropriate must review the UB04s prior to electronic transmission of claims. (Triple Check)
4. After billing is transmitted, the following items are filed in a secure, retrievable system for each Medicare resident (if applicable):
   - UB04
   - Copy of pharmacy bill
   - Copy of x-ray/EKG bill
   - Copy of ambulance charges
   - Copy of therapy logs: PT, OT, ST and Respiratory
   - Copy of DME charges
   - Copy of lab charges
   - Copy of any other miscellaneous billing
   - If any resident charges/bills are in a monthly billing roster, they should be filed in a monthly Medicare file folder. (The original roster billing is posted and filed with Accounts Payable)

d. When a Medicare claim is paid, a copy of the remittance advice is filed with the resident's Medicare information.

C. Medicare Credit Balance Reporting Requirements and Certification

1). *Overview:* The Company has systems in place to comply with information that has been prepared by the Centers for Medicare & Medicaid Services (CMS).

2). *Instructions for Completion for a Medicare Credit Balance Report:*

a. Do not report credit balance data relative to any payor other than Medicare, such as Medicaid, resident paid, etc.
b. If the appropriate adjustment requests (such as a corrected claim or documentation of other payment) have not been previously submitted, it should be attached to the credit balance report.
c. Complete column 15 on Medicare Secondary Payor cases. If it involves Auto or Liability, also indicate an "M" for Med-Pay and "C" for Liability in column 15 along with the primary payor name and address. (Reference FI 2.1 B)
d. The report should list only credit balances owed to Medicare which occurred/were discovered during the quarter and are still outstanding on the last day of the quarter. If the credit has been corrected on a remittance advice prior to the end of the quarter, it should not be reported. Balances which were reported on a previous quarterly report and are still outstanding should not be reported again.

e. Please direct any questions to _____ at _____ (phone). Or fax them to _____ (fax).
f. Complete the *Medicare Credit Balance Report Certification* found at FI Appendix 2.1 A.
g. The credit balance report and certification should be mailed to the following address in time to arrive within Thirty (30) days after the end of the reporting calendar quarters:

_____

_____

_____

D. MONTHLY BILLING STATEMENTS

1). *Overview:* The Company provides each resident with an itemized statement for services rendered during the billing cycle.

2). *Monthly Billing Procedures:*
a. Residents are billed monthly. The billing statement includes an itemized listing of services and charges for:
1. Private room rates (as applicable)
b. Charges for non-covered items provided by outside services are billed directly to the resident or representative (sponsor), government agencies, etc. (Note: If billings made by the outside suppliers are considered excessive, the resident should contact the Administrator or designated representative).
c. The resident will be notified in writing at least thirty (30) days prior to a change in his/her billing.

E. DEMAND BILLING

1). *Overview:* The Company submits a demand bill to the Medicare intermediary when requested to do so by the resident.

2). *Demand Bill Procedures:*
a. Prior to, or upon admission, the Admissions Office informs the resident of his or her right to submit demand bills to the Medicare intermediary.
b. If a resident disputes a company's conclusion that the billed services are not covered in the Medicare program, the resident has a right to insist that the provider submit a demand bill to the intermediary to confirm that such services are or are not covered. (Note: During the time this decision is pending, The Company will not require, request, or accept an advance deposit or other payment for the disputed item(s)).
c. If the provider company determines that the disputed services are not covered by Medicare for "technical" reasons (e.g., the resident has not satisfied the 3-day hospitalization requirement, the resident's Medicare days are exhausted, the resident is not admitted to the SNF within the required time after discharge from the hospital, etc.), the prohibition on advance payment for the non-covered service/item does not apply. (Note: The resident has the right to insist that The

Company submit a demand bill; however, during the time the intermediary is making its determination on coverage, The Company may charge an advance deposit for such services/items).

d. Should the demand bill be rejected by the Medicare intermediary, the provider company will provide such information, in writing, to the resident.
e. Should the intermediary determine that such service/item is covered under the Medicare program, The Company will refund any advance deposit made by the resident upon receipt of payment of such service from the intermediary. (Note: Policies governing refunds are in Policy FI 2.1 Section F *Refund of Overpayments*.

F. Refund of Overpayments

1). *Overview:* The Company has procedures in place to ensure refunds of overpayments are made consistent with applicable legal requirements and standards of practice.

2). *Refund of Overpayment Policy:*

a. Standards of Conduct state that submission of any claim or request for reimbursement or payment that is false or inaccurate will not be tolerated. If inaccuracies are discovered in claims already submitted for payment or reimbursement, the payor shall be immediately notified, and appropriate action taken to remedy the matter.
b. Personnel will promptly refund to any federal government, state agency, or private payor any overpayment received in error due to incorrect billing or for services found on audit not to meet coverage requirements. The refund process will be completed within sixty (60) days from the discovery of the overpayment.
c. Any monies on deposit with The Company shall be refunded upon the appropriate request or the death of the resident.

3). *Refund of Overpayment Procedures:*

a. Anyone who determines an overpayment was made must notify his/her supervisor immediately with the following information:
    1. Resident name
    2. Type and amount of overpayment
    3. Date
    4. Payor
b. The issue should be researched promptly and discussed with all department managers involved in the service rendered to substantiate the overpayment.
c. As soon as it is determined that the overpayment exists, a refund to the appropriate payor should be completed as soon as possible but not later than sixty (60) days.
d. If an electronic adjustment can be completed, it should be completed as soon as possible but not later than sixty (60) days.
e. Routine processing errors should be reported to the immediate supervisor and corrected as soon as they are identified using the above procedures.
f. Follow all standard business office procedures.
g. If unable to resolve an issue, consult with the Regional Account Manager or Company designee as soon as possible.

4). *Refunds Due Residents:* Upon receiving a written request from the resident, the following schedule will be implemented:
   a. Monies on deposit in The Company's resident petty cash fund will be refunded promptly.
   b. Within thirty (30) days of the death of a resident, the resident's personal funds and a final accounting of those funds will be made available to the resident's representative, or to the probate administering the resident's care.
   c. Should a resident pay for services for which retroactive Medicare/Medicaid eligibility is determined, a prompt refund will be made to the resident upon The Company's receipt of payment from the intermediary.
   d. Information concerning refunds and Medicare/Medicaid eligibility are posted publicly on the resident bulletin board.
   e. Inquiries concerning refunds should be referred to the Business Office.
   f. Anyone who determines there may be an overpayment must notify his/her supervisor immediately with the following information:
      1. Resident name
      2. Type and amount of overpayment
      3. Date
      4. Payor
   g. The issue should be researched promptly and discussed with all department managers involved in the service rendered to substantiate the overpayment.
   h. As soon as it is determined that the overpayment exists, a refund to the appropriate payor should be completed as soon as possible but not later than thirty (30) days.
   i. If an electronic adjustment can be completed, it should be completed as soon as possible but not later than thirty (30) days.

5). *Processing Errors:*
   a. Routine processing errors should be reported to the immediate supervisor and corrected as soon as they are identified using the above procedures.
   b. Follow all standard business office procedures.
   c. If unable to resolve an issue, consult with the Regional Account Manager or Company designee as soon as possible.

G. Accounts Receivable, Collections, and Bad Debt

1). *Overview:* The Company has procedures in place for collecting past due accounts and bad debt write-offs.

2). *Collecting Past Due Accounts:*
   a. Payment source private: The Business Office will utilize all reasonable means to collect outstanding balances due from the resident and/or private payor. Reasonable means include, but are not limited to, sending the responsible party a minimum of three (3) consecutive monthly statements indicating the balance due. If The Company has exhausted all reasonable efforts and is still unable to collect the outstanding balance due to The Company, then the outstanding balance will be written off at that time as a bad debt.

3). *Medicaid:* The Business Office will bill the state Medicaid program for up to twelve (12) months. If payment is denied or unpaid after twelve (12) months, the account will be written off as a bad debt.

4). *Medicare:* The Business Office will bill Medicare intermediary for up to twelve (12) months. If payment is denied or unpaid after twelve (12) months, this account will be written off as a bad debt.

5). *Medicare Co-Insurance Private:* The Business Office will utilize all reasonable means to collect outstanding balances due from the private payor. Reasonable means include, but are not limited to, sending the responsible party a minimum of three (3) consecutive monthly statements indicating the balance due. If The Company has exhausted all reasonable efforts and is still unable to collect the outstanding balance due to The Company, then the outstanding balance will be written off at that time as a bad debt and identified on the appropriate Medicare cost report listing for Part A or Part B bad debts.

6). *Medicare Co-Insurance Medicaid:* The Business Office will bill the state Medicaid program. When payment is received, the balance, which represents a bad debt, will be written off and put on the appropriate Medicare cost report listing for Part A or Part B bad debts.

Policy Number: FI 2.2

Policy Title: Resident Fund Management

Policy Statement/Purpose: To ensure the integrity of resident fund management as well as to ensure that The Company is complying with all resident fund management compliance policies and applicable laws, rules, and regulations.

Policy Interpretation and Implementation: Resident Fund Management is a component of the overarching Company Compliance and Ethics Program.

A. Deposit of Resident Funds (Advance Payments)

1). *Overview:* Residents are required to make payments in advance for requested items and services not included in The Company's Medicare/Medicaid payment. Residents will *not be required* to make advance payments for services or items which are reimbursed to The Company through Medicare/Medicaid payment.

2). *Deposit of Resident Funds Policy:* Residents are permitted to deposit their personal funds with The Company.

a. Should the resident permit The Company to hold, safeguard, and manage his or her personal funds, The Company will:
    1. Deposit funds more than $50.00 ($100.00 for Medicare residents) into an interest-bearing account
    2. Deposit the resident's funds into the residents' trust fund account maintained at a bank
    3. File in the resident's financial record a copy of his or her account authorization
    4. Provide the resident with a quarterly accounting of his or her funds on deposit with The Company
b. The Company will not charge the resident a fee for managing his or her personal funds.
c. Funds not on deposit in the residents' trust fund account are deposited into the resident petty cash fund managed by The Company on behalf of the resident.
d. Inquiries concerning the resident trust fund account and resident petty cash fund should be referred to the Business Office.
e. Administrative policies governing refunds are outlined in Policy FI 2.1 Section F - *Refund of Overpayments*.

3). *§ 483.10 Resident Rights*: (e) 10 B (vi) Assurance of financial security.
The Company must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with The Company. States may have a specific formula for the surety bond.

4). *Deposit of Resident Funds Procedures:*

a. Residents will *not be required* to make advance payments for services or items which are reimbursed to The Company through Medicare/Medicaid payment.

b. Should there be doubts about the eligibility of the resident to receive Medicare/Medicaid benefits, The Company reserves the right to require one (1) month's room and board deposit in advance. (Reference Policy FI 2.1 Section E *Demand Billing*.
c. Residents will be required to make advance payments for items or services requested and received that are not included in The Company's Medicare/Medicaid payment. Resident will be provided with a list of items and services that are not included in Medicare/Medicaid reimbursement to The Company.
d. Administrative policies governing refunds are outlined in Policy FI 2.1 Section F *Refund of Overpayments*.

B. Commingling of Resident Funds

1). *Overview:* Commingling of resident funds with other funds of The Company shall be prohibited.

2). *Comingling of Resident Funds Policy:*
a. The Company does not permit commingling of resident funds with funds of The Company.
b. Resident funds are deposited in a resident trust fund account which is separate from The Company's banking account.
c. The resident is provided with a quarterly accounting report of his or her funds on deposit with The Company.
d. Inquiries concerning the resident trust fund account and petty cash fund are referred to the Business Office.

C. Resident Personal Spending Account Management and Authorization

1). *Overview:* The Company has policies to manage and protect resident personal spending accounts.

2). *Personal Spending Account Policies:*
a. Residents are discouraged from keeping large sums of money in their room. The Resident Personal Spending Account provides easy access to funds for personal needs and is especially beneficial for residents for beauty shop services, trips out of The Company, and to make purchases or give monetary gifts to family or friends.
b. The resident or representative must implement authorization to both manage and access the account. (Reference FI Appendix 2.2 A; FI Appendix 2.2.B)
c. The moneys will be available to the resident seven (7) days per week at his or her request, or the representative upon request for the resident.
d. Proof of disbursement is required for each transaction, and a record of it will be retained in The Company accessible for review upon request.
e. Interest from the Personal Needs Account will be distributed quarterly based upon the resident's account balance at the end of the quarter.
f. Statements of all transactions shall be submitted to the resident/representative quarterly.
g. Upon discharge from The Company, a final accounting will be made, and the balance will be returned to the resident or mailed to The Company to which the resident has been transferred.

3). *§ 483.10 Resident Rights:* (e) 10 B (vi) Assurance of financial security. The Company must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the

security of all personal funds of residents deposited with The Company. States may have a specific formula for the surety bond.

4). *Private Pay Residents:* Private paying residents may elect to deposit monies into the Resident Personal Spending Account with The Company. There is no minimum or maximum for the account.

5). *Medicaid Residents:* Each Medicaid recipient living in a long-term care company can retain $35 from his or her income. Where there is no income, $40 is provided by the SSI program for the resident's personal needs. If the resident or representative chooses, this amount will be retained monthly by The Company in the Resident Personal Spending Account.

a. The maximum accumulation allowed in the Personal Needs Allowance Account is $2,000. If the balance reaches $1,800, the Business Office notifies Social Services, who will inform the resident or representative that the resource limit is approaching.
b. Upon the death of a Medicaid recipient, the balance remaining in the account will be released upon receipt of (1) a letter from County Welfare Agency stating there was no assistance provided for burial expenses, and (2) a letter of administration from the County Surrogate's Office designating the person handling the estate.
c. Personal Needs Account funds unclaimed after ninety (90) days will be sent to the State Treasurer.

D. Quarterly Accounting of Resident Funds

1). *Overview*: The Company provides each resident who has funds managed by The Company on his/her behalf with a quarterly accounting of such funds.

2). *Quarterly Accounting of Resident Funds Procedures:*

a. The Company will provide an individual quarterly accounting of funds managed for each resident with personal funds entrusted to The Company.
b. Separate quarterly statements will be prepared by the Business Office and each record will include:
    1. The resident's balance at the beginning of the statement period
    2. The total of deposits and withdrawals by the resident for the quarter
    3. Any interest earned
    4. The ending balance for the quarter
    5. Any petty cash on hand
    6. The total amount of cash on deposit and petty cash on hand

c. Statements of residents who are eligible for SSI or medical assistance will reflect the difference between the ending balance and the applicable benefits eligibility level.
d. Inquiries concerning quarterly statements are referred to the Business Office.

E. Conveyance of Funds Upon a Resident's Death

1). *Overview:* The Company has policies to ensure conveyance of funds upon a resident's death are consistent with applicable legal requirements and standards of practice.

2). *Conveyance of Funds upon a Resident's Death Procedures:* Upon the death of a resident, a representative of the Business Office determines if the resident has any monies on deposit with The Company.

a. Upon notification of a resident's death, a representative of the Business Office will review the resident's records and determine if any of the resident's monies are on deposit with The Company or with the financial institution in which resident funds are on deposit.
b. Should the resident have funds on deposit, a final accounting and transfer of funds will be made to the resident's representative or probate jurisdiction administering the resident's estate.
c. Within thirty (30) days of the death of the resident, The Company will convey the deceased resident's personal funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.
d. Inquiries concerning the release of resident funds should be referred to the Administrator or to the Business Office designee.

F. Private Pay Residents Payments

1). *Overview:* The Company has policies to ensure residents make timely payments for services rendered that are not covered in the Medicare/Medicaid payment.

2). *Private Pay Resident Policies:*

a. The resident or legal representative is responsible for payment of his or her monthly charges on a timely basis. Statements not paid by the designated date of each month will be considered delinquent.
b. Resident accounts delinquent for more than the designated number of days will be considered grounds for discharge.
c. Payment may be made by:
    1. the resident; or
    2. the individual who has control of, or access to, the resident's funds.
d. Individuals who may have control of the resident's funds will be held responsible for payment of the resident's account. Failure to do so may result in legal action and/or the discharge of the resident.
e. Inquiries concerning payment should be referred to the Business Office designee.
f. Administrative policies governing financial agreements are outlined in The Company's *Admission Agreement*.

G. Discrimination Against Residents and Payment Provisions

1). *Overview:* The Company protects and promotes the rights of each of The Company's residents from discrimination with respect to payment provisions consistent with applicable legal requirements and standards of practice. The Company maintains identical policies and practices for all individuals regarding transfer and discharge, regardless of payment source, and complies with applicable law with respect to admissions decisions, as well as the provision of services under the state Medicaid plan.

2). *Elements of The Company Corporate Compliance and Ethics Program:*

a. The Company will not require residents or potential residents to waive their rights under Medicaid or Medicare, nor require oral or written assurances that residents or potential residents are not eligible, or will not apply, for Medicaid or Medicare benefits
b. The Company will not require a third-party guarantee of payment as a condition of admission, expedited admission, or continued stay at The Company. The Company may require a person who has legal access to and/or control over a resident's income or resources to pay for Company care or sign a contract to provide payment for the resident's services, without requiring the person to assume personal financial liability for such care
c. For Medicaid eligible residents, The Company will not charge, solicit, accept, nor receive for services covered by Medicaid any gift, money, donation, or other consideration, in addition to any amount required to be paid under the state Medicaid plan, as a precondition of admission, expedited admission, or continued stay at The Company
d. The Company may charge residents amounts above and beyond payment received by Medicaid for items and services requested by the resident and not included in the Medicaid package of "nursing company services" as long as The Company gives proper notice of the availability and cost of such services or items and does not condition the resident's admission and continued stay on the purchase of such items or services
e. The Company may solicit, accept, or receive charitable, religious, or philanthropic contributions from an organization or a person unrelated to a Medicaid resident as long as such contribution is not a condition of a resident's admission or continued stay. All offers for the donation of such contributions shall be reported to The Company Administrator, Corporate Compliance and Ethics Officer, or other person designated by the provider, for a determination that such contribution is allowed under applicable law.

Policy Number: FI 2.3

Policy Title: Audit by Certified Public Accountant

Policy Statement/Purpose: To ensure the integrity of the Financial Management System as well as to ensure that The Company is complying with all financial compliance policies, applicable laws, rules, and regulations, and The Company engages a certified public accountant to conduct quarterly/annual audits.

Policy Interpretation and Implementation:

1. The Accounting Office Manager will contact the accounting firm to set a date for the accountant to review the general ledger each quarter and annually.
2. Payroll taxes and payroll accruals will be done and posted to the general ledger.
3. The general ledger will be prepared for the accountant's review to assure all cost centers are correct and proper accounting procedures were followed.
4. The certified public accountant will prepare financial statements for ownership on a quarterly/annual basis.

3. VENDOR AND ASSOCIATE CONTRACTS AND SERVICES (VC)

3. VENDOR AND ASSOCIATE CONTRACTS AND SERVICES (VC)

Policy Number	Policy
VC 1.0	CONTRACTING PLAN AND PRINCIPLES A. VENDOR CONTRACTS B. PPS/MEDICARE PART A C. ENGAGEMENT OF OUTSIDE CONTRACTORS D. CONTRACT FOR BILLING SERVICES E. STAFFING AGENCY CONTRACTING F. THERAPY CONTRACTS AND SERVICES G. PHYSICIAN AND OTHER REFERRAL SOURCES CONTRACTS H. PHYSICIAN INDEPENDENT CONTRACTING I. FEDERAL GOVERNMENT CONTRACTING J. BUILDING AND EQUIPMENT LEASES POTENTIAL REFERRAL SOURCES CONTRACTS
VC 1.1	CONFLICT OF INTEREST
VC 1.2	CODE OF CONDUCT
VC 2.0	REFERRALS
	A. REFERRALS FOR SERVICES B. PHYSICIAN REFERRAL AND ASSOCIATE KICKBACK
VC 2.1	BUSINESS ASSOCIATES TYPICAL BUSINESS ASSOCIATES FOR A LONG-TERM CARE COMPANY

Policy Number: VC 1.0

Policy Title: General Contracting Principles

Policy Statement/Purpose: The Company ensures that contracts are entered in accordance with applicable laws and regulations and consistent with The Company Compliance and Ethics Program.

Policy Interpretation and Implementation: The Company is a party to numerous contracts that bind it to specific rights and obligations according to the terms of the contracts. The Company has adopted general contracting principles to ensure that contracts receive appropriate review, and that The Company is not committed to contracts that are against its own best interests.

1). *Overview:* General contracting principles ensure that contracts receive appropriate review, and that The Company is not committed to contracts that are against its own best interests.

2). *Contract Restrictions:* All service agreements and contracts for the purchase of goods that commit The Company to a total obligation in excess of $10,000 should contain the following or similar language:

This contract will not take effect and will not be binding on The Company unless and until signed by the Compliance and Ethics Officer after documented consultation with the Compliance and Ethics Attorney in the space designated below. [A signature line and title with date should be provided.]

No amendment to this contract will be binding on The Company unless and until signed by the Compliance and Ethics Officer, after consultation with the Compliance and Ethics Attorney in a fashion expressly acknowledging approval of the amendment.

3). *Uniform Contracts:* Where possible, The Company will use uniform contracts that have been reviewed and approved by the Compliance and Ethics Attorney for transactions with vendors and purchasers of services. Uniform contracts are not required for vendors and purchasers that regularly do business with The Company using standard preprinted contracts; however, The Company will seek to supplement such agreements with its own standard provisions as needed.

The uniform contracts will be circulated throughout The Company. The uniform contracts will be reviewed annually by the Compliance and Ethics Attorney if any changes are needed. A copy of each uniform contract will be maintained by the Compliance and Ethics Officer.

Changes or amendments to the pre-approved uniform contracts must be approved in advance by the Compliance and Ethics Officer, after consultation with the Compliance and Ethics Attorney where appropriate.

Contracts that already exist when uniform contracts are developed and circulated need not be modified; however, a uniform contract should be employed upon the renewal, modification, or restatement of the agreement where contractually practicable.

4). *Evergreen Contracts:* Self-renewing contracts (or contracts with so-called evergreen clauses) should be avoided. All contracts should be written to have a specific termination date of no more than two (2) years from the effective date.

5). *Execution of Contracts:* Contracts will be executed only by an authorized representative of The Company and of the other contracting party.

6). *Maintenance of Contracts:* Original, executed contracts will be maintained at the location where the contract was entered. Copies of all executed contracts will be provided immediately after execution to the Compliance and Ethics Officer for central filing.

A. VENDOR CONTRACTS

1). *Overview:* The Company has systems in place to ensure vendor contract meet requirements when the items or services supplied by the vendor are reimbursable by federal or state healthcare programs. The Company provides oversight for the services risk areas provided by contractors, subcontractors, agents, and independent contractors.

2). *Requirements for Vendor Contracts (contractors, subcontractors, agents, and independent contractors)*

a. All applicable vendor agreements must:
   1. Be in writing and specify the items or services to be provided
   2. Specify the payments that will be made to the vendor. Payments will either be made in accordance with applicable fee schedules or guidelines established by federal or state agencies or other third-party payers or will be based on fair market value. Payments may not reflect the volume or value of referrals provided to or by The Company
   3. Be signed by all parties
   4. Be negotiated only by the Compliance and Ethics Attorney and/or the Administrator, owner(s), or their designees
   5. Be approved by the Compliance and Ethics Attorney or his or her designee prior to execution
   6. Specify all obligations of the parties
   7. When taken, be reasonable in its entirety
   8. Not take into consideration the value or volume of referrals provided by or to The Company except as is specifically permitted by the "safe harbors" found at 42 C.F.R. Pat 1001.952
   9. Not involve free or discounted goods or services or goods or services below fair market value to induce a referral to or by The Company except as specifically permitted by the "safe harbors"
   10. Not involve the referral or transfer of any resident to or by The Company to induce the other party to refer or obtain referrals or residents from The Company
   11. Certify that the vendor is eligible for participation in Medicare and/or Medicaid. On a quarterly basis, The Company will check for vendor's status on federal and state government web sites including:
      - Office of the Inspector General List of Exclusions and Reinstatements – http://www.exclusions.oig.hhs.gov/search.html

- General Services Administration List of Contractors Barred from Dealing with the Federal Government – http://www.sam.gov
- State specific websites as noted on VC Appendix 2.0 A
  - If The Company does not have access to the Internet, The Company will request the Compliance Attorney to conduct the certification on a quarterly basis
  - Any vendor who has been convicted of a criminal offense related to healthcare, or who has been debarred, excluded, or held to be otherwise ineligible for participation in federal healthcare programs, will not be eligible to continue the contractual relationship with The Company

12. Contain a clause stating that the vendor will cooperate with The Company if Medicare, Medicaid, or another third-party payer conducts an audit or otherwise requests documentation regarding services or supplies provided by the vendor or its subcontractors
13. Contain a clause stating that the vendor will comply with The Company's Compliance and Ethics Program
14. If the value or cost of the services or supplies to be provided under the agreement equals or exceeds $10,000 over a 12-month period, the contract must:
    - Contain a clause requiring the vendor to retain records for a period of at least four (4) years after the furnishing of services and supplies.
    - Contain a clause requiring the vendor to retain records verifying the nature and extent of the costs of the services and supplies.
    - Ensure that those records be made available to The Company upon request.
    - Require the vendor to impose similar obligations on any subcontractor it uses to provide services or supplies under the contract.
15. The vendor and any subcontractor of the vendor shall cooperate with The Company if any third-party payer, including the Medicare or Medicaid program, conducts an audit or otherwise requests documentation regarding services or supplies provided by the vendor or its subcontractor
16. No vendor contracts shall be executed until The Company has reviewed the OIG's *List of Excluded Individuals and Entities*, or other applicable sources, and verified that the vendor currently is certified to participate in the Medicare and Medicaid programs, and is not abject to any sanction that would render The Company unable to legally contract with vendor
17. Contracts with entities in which the medical director has an ownership or investment interest: Contracts between The Company and any entity in which The Company's medical director and ownership or financial interest present special issues under federal and state law. No contract may be executed between The Company and any entity in which The Company's medical director has an ownership, investment, or other financial interest without approval by the Compliance and Ethics Attorney or his or her designee [or other people selected by The Company]
18. All building and/or equipment leases shall meet the requirements referred to in Policy VC 1.0 Section I *Building and Equipment Leases* and shall be reviewed and approved by the Compliance and Ethics Attorney or his or her designee prior to execution to avoid violation of federal anti-kickback or Stark laws. Similar state laws may also apply and should be reviewed so that all such leases comport with state law as well

b. Part B Services: For services which The Company must submit consolidated bills to the Medicare program for items and services provided to Medicare Part B residents receiving services in The Company or under The Company's plan of care, all vendor agreements shall:
    1. Provide that the vendor will bill The Company for those Part B services provided to Medicare residents and that are subject to consolidated billing requirements, and that the vendor will not submit bills directly to Medicare for such services
    2. Provide that the vendor or its subcontractors will ensure that The Company receives any orders or certifications necessary to provide the service, as well as supporting documentation required to receive payment from Medicare or Medicaid for such service
    3. Provide that the vendor or its subcontractors will participate fully, as reasonably requested by The Company, in any appeals by The Company, of payment decisions by any third-party payor in connection with items or services rendered by the vendor or its subcontractors
    4. Provide that the vendor and its subcontractors will participate, as reasonably requested by The Company, in The Company's Compliance and Ethics Program and Quality Assurance program, including any internal or external audits by The Company of The Company's billing, payment, and/or collection procedures and quality assurance
    5. Require that the vendor and its subcontractors notify The Company prior to execution of a contract and, on an ongoing basis, of the imposition of any penalties and/or sanctions, including termination of Medicare and/or Medicaid program participation imposed by CMS, the OIG, or any state Medicaid agency, and of the initiation of any audit or investigation of the vendor and/or its subcontractors by any such agency
    6. The Company may also conduct a background investigation on vendors whose job functions or responsibilities may impact The Company's compliance with federal or state law or the Compliance and Ethics Program
        - Vendors will be required to fill out a pre-engagement application and respond to all questions therein, when applicable, including whether they have been:
            - Convicted of a criminal offense related to healthcare; specifically:
                - Criminal offenses related to the delivery of an item or service under Medicare or Medicaid
                - Criminal offenses related to the neglect or abuse of residents in connection with the delivery of a healthcare item or service
                - Felonies related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a healthcare item or service, if the conviction or guilty plea occurred after August 21, 1996
                - Felonies related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, if the conviction or guilty plea occurred after August 21, 1996
                - Listed by the government as debarred, excluded, or otherwise ineligible for federal program (e.g., Medicare and Medicaid) participation

B. PPS/MEDICARE PART A

1). *Overview:* The Company has policies that applicable vendor contracts will contain provisions clarifying The Company's responsibility to bill for all services provided under PPS/Medicare Part A and that such vendors will not bill Medicare separately for those services.

2). *PPS/Medicare Part A Billing Provisions:* All applicable vendor agreements must contain the following provisions regarding billing under PPS/Medicare Part A:

a. Vendor will bill The Company, not Medicare, for services provided to Medicare Part A residents, except for services excluded under PPS
b. Vendor must ensure that The Company is provided with all necessary orders, certifications, etc., prior to providing services, in addition to all documentation necessary to receive payment
c. Vendor will cooperate fully in any appeal of third-party payer payment decisions relating to items or services provided by The Company
d. Vendor will participate in The Company's quality improvement program, including the quarterly quality assurance committee meetings, and The Company's Compliance and Ethics Program, including internal or external audits requested by The Company
e. Vendor will notify The Company immediately of the imposition of any remedies, fines, or other sanctions imposed by federal or state regulatory agencies
f. Vendor will bill The Company for services to Medicare Part A residents, and vendor will not submit bills directly to Medicare for such services, except for those services specifically excluded from PPS
g. Vendor, or its subcontractors, will ensure that The Company receives any orders or certifications necessary before providing the service, as well as supporting documentation required to receive payment from Medicare or Medicaid for such service
h. Vendor, or its subcontractors, will participate fully, as reasonable requested by The Company in any appeals
i. The Company must be notified of payment decisions by any third-party payor in connection with items or services rendered by the vendor or its subcontractors
j. The Company provides that the vendor and its subcontractors will participate as reasonably requested by The Company, in The Company's Compliance and Ethics Program and quality assurance program, including any internal or external audits by The Company or The Company's billing, payment, and/or collection procedures and quality assessments
k. Require that the vendor and its subcontractors, notify The Company prior to execution of a contract and, on an ongoing basis, of the imposition of any remedies or sanctions, including termination of Medicare and/or Medicaid program participation imposed by the OIG or a state Medicaid agency, and of the initiation of any audit or investigation of the vendor and/or its subcontractors by any such agency

C. ENGAGEMENT OF OUTSIDE CONTRACTORS

1). *Overview:* The Company may need the services offered by outside contractors who are not employees of The Company, including physicians and other potential referral sources. Several federal and state laws protecting against fraud and abuse in the healthcare industry apply to these contractual relationships. The following policy and procedure is designed to ensure that The Company's engagement of outside contractors complies with applicable fraud and abuse laws.

2). *Commission and Fee Arrangements:* Unless the arrangement is permitted by applicable law, The Company will not enter into commission or fee arrangements with firms or persons that are not serving as bona fide agents or consultants, or with any firm in which a government official or employee is known to have an interest.

Commissions or fees paid to an agent or consultant must be reasonable as to amount and consistent with the normal practice of the industry for the products involved and for the services rendered. All commission and fee arrangements will be covered by a written contract, which will be reviewed and approved in advance by Counsel and comply with *Contracts with Outside Contractors* below.

3). *Contracts with Physicians and Other Potential Referral Sources:* All of The Company's independent contractor arrangements with physicians and other potential referral sources will be reviewed by Counsel to ensure compliance with federal and state laws governing fraud and abuse and physician self-referrals.

4). *Contracts with Outside Contractors:* Under some circumstances, an outside contractor is considered an agent of The Company, thus, all relationships with outside contractors will be subject to the following requirements:

a. To the extent that written agreements with outside contractors are used, the agreements should contain normal terms and conditions as well as:
    1. a clear description of the services to be rendered;
    2. a representation that nothing will be done to improperly influence the actions of government officials;
    3. a requirement that the contractor comply with The Company's policies concerning ethical and legal business practices, this policy statement, applicable law, and the government contracting standards of conduct applicable to employees of The Company;
    4. a provision for revocation of the contract and repayment of all funds paid under the contract in the event the contractor violates either applicable law or the standards and policies set forth in this policy statement; and
    5. language prohibiting the contractor from subcontracting in the name of The Company and requiring that any subcontracts be reviewed and approved by Counsel for The Company.
b. No contractor who provides services that may affect payment for resident care may be engaged on a percentage or other incentive basis that ties the contractor's compensation to increases in resident revenues.
c. All contractors will be subject to background screenings.
d. All contractors will be given and required to acknowledge receipt and understanding of those portions of the Compliance and Ethics Program Manual that are relevant to their duties and agree to be bound thereby.
e. Each contractor will be required to execute the *Code of Conduct* for Healthcare Providers to ensure compliance with the Compliance and Ethics Program.

5). *Advice from Consultants:* Any action taken on advice received from outside consultants concerning coding, billing, and reimbursement issues should be consistent with the procedures described in Policy VC 1.0 Section C, *Engagement of Outside Contractors*.

D. CONTRACT FOR BILLING SERVICES

1). *Overview:* The Company's Medicare and Medicaid billing may be handled by outside billing service providers. Similarly, The Company may occasionally provide billing services for other healthcare providers. The Company is committed to submitting only those claims for reimbursement that are accurate, based upon medically necessary items and services rendered or costs incurred, and substantiated by verifiable documentation. This policy establishes guidelines for the billing arrangements to which The Company is a party, to ensure that billings submitted by or on behalf of The Company comply with applicable laws, regulations, and other publications relevant to Medicare and Medicaid billing.

2). *Contracts for Billing Services in General:* Billing work will be performed only under terms of a written contract. All billing contracts will be approved on an annual basis by the Compliance and Ethics Officer in consultation with Counsel, as needed. The purpose of the annual review is to ensure that those arrangements and contracts meet the criteria in this policy.

3). *Billing Services Provided on Behalf of The Company:* All contracts between The Company and any other entity for the handling of The Company's Medicare and Medicaid billing should address the following issues:

a. The billing entity's experience in billing for the specific services at issue in the contract
b. Allocation of responsibility for documentation and knowledge of standards which pertain to the services at issue in the contract and the manner of updating such information
c. Obligations regarding periodic monitoring of documentation and reports submitted during the term of the agreement
d. Responsibility for conveying to The Company any information received by the billing entity pertaining to Medicare and Medicaid billing, including general policy documents as well as specific correspondence, profile information, audit requests, overpayment notification, interviews, subpoenas, and summonses directed to the billing entity
e. Responsibilities regarding participation in cost payment audits, even to survive the termination of the agreement, as well as availability of and access to data from prior periods
f. Responsibilities regarding write-offs, appeals, and the respective parties' obligations to assist with appeals
g. Ability to terminate at will, in accordance with Medicare requirements, and, if possible, liquidated damages or indemnification for losses from billing errors
h. The Company's ownership of and access to the data on which the billings are based, documents created by the billing entity, the billings submitted, the collections, denials, and payor inquiries
i. Confidentiality of documents provided to the billing entity by The Company and documents created by the billing entity
j. Retention by the billing entity of relevant records in a manner consistent with law and The Company's document management system

All billing contracts will be reviewed to assure that payment of the billing entity is not based on improper incentives that may encourage the submission of claims regardless of whether the claims meet applicable coverage criteria for reimbursement or accurately represent the services rendered.

The Company will use its best efforts to amend any contract for its Medicare and Medicaid billing as necessary to ensure the foregoing issues are addressed at the first opportunity.

4). *Billing Services Provided by The Company:* All billing relationships between The Company and its healthcare provider clients, where appropriate, should:

a. be in writing and comply with Contract Restrictions in Policy VC 1.0 *Contracting Plan and Principles;*

b. be reviewed by Counsel to verify that all obligations of the parties to the contract meet existing statutory and legal requirements; and

c. set forth clear understandings as to:

- Time limits for bringing disputes arising out of the contractual relationship
- The controlling law and conflicts of laws
- Liquidation of damages and limitation of damages
- Indemnification and subrogation of rights and claims
- Clarification of the responsibilities of the parties, including documentation, coding decisions, and training
- Record creation and retention responsibilities

Any agreements that do not contain the necessary and appropriate contract provisions will be corrected as soon as contractually permissible or as business needs dictate.

E. CONTRACTING WITH A STAFFING AGENCY

1). *Overview:* The Company Compliance and Ethics Program vendor contract policies address potential liability with relationships with any temporary staffing agency. The contract is the most explicit way to articulate expectations that the agency takes the same precautions that the nursing home takes with its own personnel.

2). *Staffing Agency Contracting Expectations:*

- Criminal background checks
- Adherence to licensure requirements
- Monitoring nurses'/staff continued eligibility to participate in federal healthcare programs
- Ongoing compliance training
- Participation in the Compliance and Ethics Program
- Key terms must be identified and defined
- Responsibilities, duties, and objectives for both parties must be specifically identified
- The temporary staffing agency must be required to take responsibility for adhering to any state and federal laws and regulations, as well as Joint Commission standards, if applicable, that apply
- Agreement must be reached and articulated on the hiring policies and standards of the temporary staffing agency
- Termination rights must be clearly articulated

In addition to entering into a contract with the temporary staffing agency, the nursing home should assess the qualifications of the agency with respect to its hiring standards, ongoing requirements for training its staff, and other business practices.

F. THERAPY CONTRACTS AND SERVICES

1). *Overview:* The Company is committed to providing quality therapy services and to providing only those therapy services that are reasonable and necessary to a resident's appropriate care, and consistent with government and third-party payor coverage guidelines and the criteria set forth below.

2). *Therapy Contracts and Services Criteria:* The following requirements are incorporated into The Company Compliance and Ethics Program.

PHYSICAL THERAPY SERVICES

a. Medicare: Required Elements - Physical therapy services provided to Medicare residents by The Company must:
    1. Relate directly and specifically to an active written treatment regimen established by the resident's physician after any needed consultation with the qualified physical therapist
    2. Be reasonable and necessary to the treatment of the resident's illness or injury
    3. Be of such a level of complexity and sophistication, or the condition of the resident must be such, that the services required can be safely and effectively performed only by a qualified physical therapist or under his or her supervision. Services not requiring the performance or supervision of a physical therapist are not considered reasonable or necessary physical therapy services, even if they are performed or supervised by a physical therapist
    4. Be provided pursuant to an expectation that the condition will improve significantly in a reasonable (and generally predictable) period based on the assessment made by the physician, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state
    5. Be reasonable in terms of amount, frequency, and duration
b. Medicaid: Required Elements - Physical therapy services, including all necessary supplies and equipment, provided to Medicaid residents by The Company must:
    1. Be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law
    2. Be provided to a recipient by or under the direction of a qualified physical therapist.

SPEECH THERAPY SERVICES

a. Medicare: Required Elements - Speech therapy services provided to Medicare residents by The Company must:
    1. Be reasonable and necessary to the treatment of the resident's illness or injury
    2. Relate directly and specifically to a written treatment regimen established by the resident's physician after any needed consultation with the qualified speech pathologist
    3. Be considered under accepted standards of practice to be a specific and effective treatment for the resident's condition
    4. Be of such a level of complexity and sophistication, or the resident's condition must be such, that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist
    5. Be provided pursuant to an expectation that the resident's condition will improve significantly in a reasonable (and generally predictable) period based on the assessment by the physician,

or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state
6. Be reasonable in terms of amount, frequency, and duration under accepted standards of practice

b. Medicaid: Required Elements - Speech therapy services, including the necessary supplies and equipment, provided to Medicaid residents by The Company must:
   1. Be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law
   2. Be provided to a recipient by or under the direction of a speech pathologist or audiologist

OCCUPATIONAL THERAPY SERVICES

a. Medicare: Required Elements - Occupational therapy services provided to Medicare residents by The Company must:
   1. Be prescribed by a physician
   2. Be performed by a qualified occupational therapist or a qualified occupational therapy assistant under the general supervision of a qualified occupational therapist
   3. Be reasonable and necessary for the treatment of the resident's illness or injury
   4. Be provided pursuant to an expectation that the therapy will result in a significant practicable improvement in the resident's level of functioning within a reasonable period

b. Medicaid: Required Elements - Occupational therapy services, including all necessary supplies and equipment, provided to Medicaid residents by The Company must:
   1. Be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law
   2. Be provided to a recipient by or under the direction of a qualified occupational therapist

OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY SERVICES

a. Outpatient physical, occupational, and/or speech therapy services provided to Medicare residents by The Company must:
   1. Be provided only to residents who were or are under the care of a physician. The resident's clinical record must reflect that a physician has seen the resident at least every thirty (30) days
   2. Be provided pursuant to a written plan established by a physician, physical therapist, occupational therapist, or speech pathologist for furnishing such services, and which periodically is reviewed by the physician
   3. Be required by the resident
   4. Be recertified by the resident's physician at least once every thirty (30) days if the services continue over time

G. PHYSICIAN AND OTHER REFERRAL SOURCES CONTRACTS

1). *Overview:* Federal and state anti-kickback and physician self-referral laws prohibit the offer or payment of any compensation to any party for the referral of residents. All physician agreements shall be reviewed and approved by the Compliance and Ethics Attorney prior to execution to avoid violation of federal anti-kickback or self-referral laws. Similar state laws also may apply. (Reference VC Appendix 2.0 A)

2). *Referral Sources Contracting:* The Company's contracts with physicians and other potential referral sources will comply with applicable laws regarding resident referrals. The Company:

a. Shall comply with the policies governing gifts set forth in this *Company Corporate Compliance and Ethics Manual*
b. Shall not accept or solicit a referral from a physician to an entity in which the physician (or an immediate family member) has a financial relationship (broadly defined to encompass any ownership interest, investment interest, or compensation agreement) for a designated health service as defined in 42 USC Part 1395nn(h)(6), except as permitted by law. Designated health services include:
    1. Clinical laboratory services
    2. Rehabilitation services including physical therapy, occupational therapy, and speech language pathology services
    3. Radiology and other imaging services including magnetic resonance imaging (MRI), computerized axial tomography (CT) scans, PET scans, and ultrasound services
    4. Radiation therapy services and supplies
    5. Durable medical equipment and supplies
    6. Parenteral and enteral nutrients, equipment, and supplies
    7. Prosthetics, orthotics, and prosthetic devices and supplies
    8. Home health services
    9. Outpatient prescription drugs
    10. Inpatient and outpatient hospital services
    11. Nuclear medicine services
c. Shall have physician agreements that
    1. are in writing;
    2. are approved by the Compliance and Ethics Attorney or his or her designee prior to execution;
    3. are negotiated by the Compliance and Ethics Attorney, The Company Administrator, owner(s), or their designees;
    4. are signed by all parties;
    5. are reasonable in their entirety;
    6. specifically describe:
        - The services to be performed are full- or part-time, position description and scope of authority, reporting relationships, skills necessary, licensing or certification requirements, and performance requirements for bonus
        - The method of compensation (i.e., annual, per diem, or hourly; units of compensation tied to units of the structure of the relationship, and incentive compensation related to service performed). Supporting documentation should be reviewed and retained
        - The amount to be compensated which is supported by a fair market value (FMV) analysis. FMV determination can be made by assessing multiple sources of objective data such as professional organization salary surveys (i.e., Medical Group Management Association), proprietary physician surveys from consulting firms, telephone surveys, public records, and historical compensation information. Incorporate the specific needs of the arrangement and any other special circumstances affecting compensation. Supporting documentation should be reviewed and retained;
    7. shall not take into consideration the value or volume of referrals provided to The Company; and

8. shall be for a term or at least one (1) year.

H. Physician Independent Contracting

Overview: There is a written arrangement in place that is signed by both parties when payment is made by the facility to the physician/Licensed Independent Practitioner who serves as an independent contractor.

Procedure: Key Compliance Considerations for the Review of independent physician/LIP contractors include:

a. Physicians/LIPs who are not employed (i.e., independent contractors) must have an arrangement in writing and signed by both parties before compensation is paid or services are performed.
    1. The arrangement is current
    2. Compensation formula must be set in advance if physicians will refer services to the organization with which they are under contract
    3. The compensation formula for independent contractors must always be set in advance
    4. An independent contractor's compensation must not be adjusted retroactively
    5. For personal services agreements, the aggregate compensation—not just the compensation formula—must be set in advance
    6. The arrangement was negotiated at arm's length
b. The compensation must be fair market value and a result of arm's length negotiations between the two parties
    1. The term of the arrangement is at least one year
c. To meet Stark Law exceptions and Anti-Kickback Statute safe harbors, financial arrangements have to have a term of at least one year
d. There are no amendments to the arrangement that have changed the rate of payment within the first year
    1. There are no implications in the arrangement that indicate there is payment of any kind for referrals
e. Improper financial incentives for referrals to physicians and other referral sources could lead to an overutilization of healthcare services
    1. The service provided is defined in sufficient detail
f. Physician/LIP arrangements must specify all of the services and items covered by arrangements between the parties.
    1. The payment amounts match the terms of the arrangement
g. Remuneration to a physician/LIP that is not addressed appropriately in an arrangement may be considered a violation of fraud and abuse regulations
    1. Non-monetary compensation provided to the physician is tracked and reported appropriately
h. The Stark Law provides exceptions for physician non-monetary compensation on condition that it does not exceed the threshold ($423 for 2020)
    1. The compensation rate is within FMV
    2. Consistent with identified services
    3. Phase III rule of the Stark Law states that "a reference to multiple objective, independently published salary surveys remains a prudent practice for evaluating fair market value."

I. Federal Government Contracting

1). *Overview:* The Company is committed to complying with all applicable government-contracting laws and regulations when it acts as a prime contractor or subcontractor on federal projects or federally funded projects. The laws and regulations governing government contracting impose requirements traditionally not associated with purely commercial business transactions. This policy addresses key risk areas associated with The Company's legal obligations under government contracts.

2). *Cost Record, Price Estimates, and Time Charging*: The Company will maintain and provide the government with audit access to accounting and other records as a basis for payment on existing contracts and estimates on future contracts. Records must be accurate and preserved for the period required by applicable laws and contract provisions. All costs and labor must be charged accurately and to the appropriate account, regardless of the status of the budget for that account. The Company prohibits the charging of labor or material costs to the wrong contract, charging contract effort to an overhead or indirect account, falsification of time cards, and improper destruction or alteration of records.

3). *Cost or Pricing Data:* The Company will make full disclosure in negotiations for government contracts or subcontracts. The Company prohibits the submission of cost or pricing data that is not current, accurate, and complete as of the date of agreement on price.

4). *Unallowable Costs:* Any proposals for reimbursement of indirect costs that The Company submits to the government, either under cost reimbursement contracts or as part of overhead rates, will not contain "unallowable" costs, such as costs for advertising, public relations, donations, entertainment, fines and penalties, lobbying, defense of fraud proceedings, and goodwill. The Company will request reimbursement only for those indirect costs that are clearly allowable or as to which The Company has a good faith argument are allowable. Clearly unallowable costs must not be included in indirect cost proposals.

5). *Quality Control, Testing, and Compliance with Specifications:* The Company will deliver goods and services that meet all applicable contract requirements for quality control specifications and testing requirements.

6). *Certification and Representation:* The Company's employees and other representatives must exercise due diligence to ensure that any certifications or affirmative representations made on the part of The Company that pertain to federal projects, such as compliance with socioeconomic programs, contract specifications, environmental laws, and various procurement regulations, are accurate when made.

J. Building and Equipment Leases Potential Referral Sources Contracts

1). *Overview:* All building and equipment leases shall meet the requirements below and shall be reviewed and approved by the Compliance and Ethics Attorney or his or her designee, prior to execution to avoid violation of federal anti-kickback or Stark laws. Similar state laws may apply and should be reviewed to ensure that such leases comport with state law.

2). *Referral Source Contract Requirements:* The following requirements are incorporated into the Compliance and Ethics Program. In general, building and/or equipment leases shall:

a. Be in writing
b. Have a term of at least one (1) year
c. Specify the premises or equipment covered by the lease
d. Set the rental charge in advance
e. Specify the exact schedule of access or use, the precise length, and the exact rent if the lease is for part-time or periodic access
f. Charge a rental or lease charge consistent with fair market value, and which does not take into consideration the value of business or referrals between the parties
g. Be commercially reasonable and not exceed what is necessary for the legitimate business purpose of the lease
h. Specify that vendor will submit all bills in accordance with the payment method and amount set forth in the vendor agreement
i. Be signed by all parties
j. Certify that the vendor is currently eligible for participation in the Medicare and, where applicable, Medicaid programs
k. The agreement shall be negotiated only by the Compliance and Ethics Attorney and/or The Company Administrator or their designees or other people selected by The Company
l. The agreement shall be approved by the Compliance and Ethics Attorney or his or her designee or other people selected by The Company
m. If the value or cost of the services or supplies to be provided under the vendor agreement equals or exceeds $10,000 over a 12-month period, the vendor will, for a period of at least four (4) years after the furnishing of services and supplies and make such records available upon request by The Company, and the vendor shall impose similar obligations on any subcontractor it uses to provide the services and supplies under the vendor agreements
n. The vendor and any subcontractor of the vendor shall cooperate with The Company if any third-party payer, including the Medicare or Medicaid program, conducts an audit or otherwise requests documentation regarding services or supplies provided by the vendor or its subcontractor

Policy Number: VC 1.1

Policy Title: Conflict of Interest

Policy Statement/Purpose:
To minimize the risk of potential conflicts of interest consistent with applicable legal requirements and standards of practice.

- Each Associate able to influence must annually disclose his or her affiliations and to execute an acknowledgement confirming that he or she has complied with The Company Conflict of Interest Policy (CP 2.2).
- Disclosure of an Associate's affiliations is intended to assist The Company in resolving conflicts of interest. An affiliation with another organization does not necessarily mean that an unacceptable conflict of interest exists or that the affiliation would unduly influence the Associate.

Policy Number: VC 1.2

Policy Title: Code of Conduct

Policy Statement/Purpose: Identify the Code of Conduct for all Company employees and Associates.

Policy Interpretation and Implementation: The Company, its employees and contractors, and those with whom The Company associates and/or contracts, where appropriate, constantly strive to ensure that all activity by, on behalf of, or with The Company follows all applicable federal, state, and local laws, regulations, ordinances, administrative directives, and any other binding governmental directives ("Laws and Regulations").

Policy Number: VC 2.0

Policy Title: Referrals

Policy Statement/Purpose: The Company ensures that all resident referrals are consistent with applicable legal requirements and standards of practice.

Policy Interpretation and Implementation: The Company accepts referrals from all licensed, independent practitioners (LIPs) legally authorized to diagnose and refer clients for care, consistent with The Company Compliance and Ethics Program.

A. Referrals for Services

1). *Overview:* The Company has a process in place to accept referrals from licensed independent practitioners (physicians, dentists, podiatrists, etc.) who are legally qualified to diagnose and refer clients for care.

2). *Receiving Referrals:*
   a. Verbal referrals will be accepted
      1. Must be received from known providers
      2. Must be followed by written referral in five (5) working days
   b. Written referrals will be accepted that contain a verifiable practitioner signature
      1. Hand carried
      2. Mailed
      3. Faxed
   c. Emailed referrals will not be accepted as they do not provide a verifiable signature

3). *Referral Requirements:*
   a. Resident's name
   b. Date of referral
   c. Diagnosis and diagnosis code (preferred)
   d. General or specific treatment prescription
   e. Contraindications
   f. Practitioner's signature

4). *Referral Types:*
   a. Initial referrals
      1. All new referrals, received thirty (30) days past the "date of referral", will not be accepted
      2. All new referrals, received thirty (30) days past the "date of referral", will require a new/current referral to initiate the intake process
   b. Continuation Referrals
      1. Referrals for continuation of care must be received prior to the expiration of the previous referral
      2. Referrals for continuation of care can only be authorized from the practitioner, or his or her representative, who prescribed the initial care

3. Residents supported by Medicare and Medicaid require a continuation referral, obtained by the Business Office, every thirty (30) days

c. Other
   1. Referrals received by a licensed medical consultant (physician) who is not the resident's primary physician, but is providing consultation to the primary referring physician as a second opinion, will be accepted
   2. Referrals received after evaluation, by a clinic medical (physician) consultant during a company sponsored or hosted clinic will be accepted
      - The medical consultant does not assume responsibility for the primary care of the resident
      - All reports are sent to the consultant who may elect to confer with the resident's primary physician
   3. Referrals received from practitioners who are licensed by the state to refer, but are not licensed physicians, will only be accepted under the following conditions:
      - They are countersigned by a licensed physician before they are admitted to The Company
      - They are licensed clinical psychologists who receive payment for service from The Company
      - They are Physician Assistants who have been approved by Medicare/Medicaid and The Company can collect fees for service based on their signatures and licenses to practice
   4. Referrals received from a licensed medical physician, after evaluation by a Company therapist who is licensed by the state to perform evaluation without referral, will be accepted
   5. When residents are referred by a social worker or other service provider to another agency, the referral should contain at least the following:
      - The place or person where or to whom the resident is being referred
      - The reason for the referral
      - The name of the contact person
      - Summary of Company outcomes that have been achieved by the resident

B. Physician Referral and Associate Kickback

1). *Overview:* To provide quality healthcare to members of the community, The Company employs and conducts business with many different physicians. The Company's interactions with physicians can affect a variety of issues, including the anti-kickback law, the IRS rules on employee and independent contractor status, and the Stark II self-referral law. The Company is committed to complying with all applicable laws in its relationships with physicians, maintaining the highest ethical standards, and ensuring that the physicians practicing at The Company also adhere to the highest ethical standards.

2). *The Stark II Self-Referral Law:* The Stark II Self-Referral law prohibits physicians from referring residents to The Company for certain health services if the physician or a physician's family member has a financial relationship with The Company. A financial relationship can include an ownership or investment interest or a compensation arrangement. Any relationship involving the transfer of payments or benefits, including income guarantees, certain types of loans, free or discounted services, equipment, or office space, constitutes a compensation arrangement.

To ensure that all financial arrangements between The Company and physicians comply with federal law governing prohibitions on physician self-referrals, all arrangements involving physicians who may refer residents for any of the following services **must** be submitted to the Compliance and Ethics Officer prior to execution and approved by Counsel:

a. Clinical laboratory services
b. Physical therapy services
c. Occupational therapy services
d. Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services
e. Radiation therapy services and supplies
f. Durable medical equipment and supplies
g. Parenteral and enteral nutrients, equipment, and supplies
h. Prosthetics, orthotics, and prosthetic devices and supplies
i. Home health services
j. Outpatient prescription drugs
k. Inpatient and outpatient hospital services

3). *The Anti-Kickback Law:* Physicians and employees are strictly prohibited from accepting gifts, favors, payments, services, or anything else of value which might appear to influence the actions of the physician or of The Company. Physicians and employees may retain gifts of nominal value, such as pens, coffee mugs, and other similar novelties, but must refuse any gift of more than nominal value and should report any inappropriate offers to the Compliance and Ethics Officer. Physicians and employees are strictly prohibited from soliciting or accepting anything of value in exchange for patient referrals or in exchange for purchasing or leasing any item or service which may be reimbursed by Medicare, Medicaid, or any federal or state healthcare program.

Compliance with these policies is a required condition of employment or continued engagement with The Company. Violations of these policies should be reported in accordance with the Compliance and Ethics Program's Reporting Policy. (Reference policy CP 2.3 *General Legal Duties and Antitrust Laws* and policy CP 2.0 section B *Compliance Reporting System*)

No employee of The Company may enter into any agreement or arrangement calling for a commission, rebate, bribe, kickback, or otherwise, which such employee knows or should suspect is intended to or likely to result in an improper reward, either directly or indirectly.

Employees and other Company representatives may not offer or give inducements to anyone in exchange for a decision or action that is favorable to The Company. Employees and other Company representatives may not give anything of value to anyone under circumstances that could create even an appearance that The Company is seeking preferential treatment or is paying a reward for referrals. An improper reward includes anything of value, not just money. For example, free or special price services or trips at The Company expense, without a proper business purpose, would be considered an improper payment just as readily as a cash payment. Further, no action that would otherwise be suspect is permissible merely because it appears to be customary in a particular location or a particular area of business activity.

Company employees will not request or accept fees, commissions, compensation, gifts, or gratuities from contractors or suppliers, directly or indirectly. However, small gifts, gratuities, and promotional items of less than $50.00 in value that are given as tokens of appreciation or esteem are permissible.

Business relationships and practices that may be construed as improper kickback arrangements, and which therefore are restricted under the Compliance and Ethics Program, are described below. See "Illegal Remuneration" in Policy CP 2.3 *General Legal Duties* for a discussion of the statute prohibiting kickbacks.

a. Free or Below-Fair Market Value Goods or Services:
    1. Except for routine discounts to payors and certain marketing activity, The Company will not provide goods, services, or other items of value free of charge or at a price below fair market value to influence the flow of business to The Company. However, certain equipment or services (e.g., specimen collection materials) may be provided to customers, without additional cost, in connection with healthcare services that The Company furnishes to such customers, to permit The Company to perform such services properly
    2. All employees and independent contractors engaged in marketing for The Company will be provided with a copy of The Company's Code of Conduct. (Reference policy CP 2.1 *Code of Conduct*). The Company expects its employees, independent contractors, and other representatives to always adhere to these ethical standards. All employees engaged to market The Company's services and products will be required to attend educational programs concerning ethical and legal business practices. To ensure that its independent contractors comply with The Company's policies concerning ethical and legal business practices, the *Code of Conduct* and applicable policies will be incorporated by reference into all contracts with independent contractors (Reference VC Appendix 1.0 D)
    3. Each company must regularly inform the Compliance and Ethics Officer, in writing, of all existing arrangements involving commission-based payments to employees or independent contractors for business they generate for The Company and must supply a copy of any contracts for, or other documentation of, such arrangements. The Compliance and Ethics Officer, together with the Compliance and Ethics Attorney, will review all commission-based marketing arrangements for consistency with Compliance and Ethics Program requirements. Any arrangements contrary to Program requirements will be modified, amended, or corrected as soon as practicable under the terms of the agreement

b. Kickback Arrangements with Potential Referral Sources for Long-Term Care Services:
    Many arrangements with potential referral sources for long-term care services may be viewed as kickback arrangements. Referral sources can include physicians, residents, their family members, hospitals, other long-term care facilities, home health agencies, pharmacies, hospices, and rest homes. Some examples of kickback arrangements follow, although the list is not exhaustive:
    1. Fees to a physician for plans of care the physician certifies on behalf of a long-term care company affiliated with The Company
    2. Disguising referral fees as salaries by paying referring physicians for services they have not rendered, or by paying more than fair market value for services they have provided
    3. Offering free services to beneficiaries if they agree to switch providers
    4. Providing hospitals with free discharge planners to induce referrals
    5. Providing or accepting meals, entertainment, gifts, or benefits to induce referrals

6. Receiving excessive or inappropriate payments from a hospice to provide services to nursing company ("NF") residents who have elected the hospice benefit
7. Receiving free services, such as 24-hour nursing coverage, in return for referrals
8. Providing home health aide services, such as bathing, assistance with grooming, or meal preparation, to Medicare beneficiaries receiving skilled home healthcare who reside in assisted living facilities, when The Company is already required by state law to provide these services under its license
9. Contracting with suppliers and providers to induce referrals to a company affiliated with The Company
10. Solicit or receive any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for furnishing (or arranging for the furnishing) of any item or service for which payment may be made in whole or in part under a federal healthcare program
11. Solicit or receive any remuneration, directly or indirectly, overtly or covertly, in cash or any kind, in return for purchasing, leasing, ordering, or arranging for, or recommending purchasing, leasing, or ordering any goods, company service, or item for which payment may be made, in whole or in part under a federal healthcare program
12. Offering or providing any gift, hospitality, or entertainment of more than nominal value to any Medicare and Medicaid beneficiary. Examples of permissible items include pens, T-shirts, water bottles, etc., valued at less than fifty dollars ($50), if such items are not offered or provided to influence healthcare decisions by a beneficiary, family member, or responsible party
13. Offering waivers of coinsurance or deductible amounts as part of any advertisement or solicitation
14. Routinely waiving coinsurance or deductible amounts, only waiving such amounts after determining in good faith that the resident is in financial need, or after making reasonable efforts to collect the cost-sharing amounts from the resident
15. Participating in any arrangement with a healthcare plan that effectively requires The Company and its employees to forego certain Medicare cost-sharing amounts
16. Participating in any arrangement with a heath care plan that requires The Company and its employees to waive charges for copayments and deductibles when Medicare is the primary payer and the applicable Medicare reimbursement is higher than the plan fee schedule amount

These activities and any other kickback arrangements are prohibited and must be reported immediately to the Compliance and Ethics Officer.

c. Discharge Planning by a Skilled Nursing Company or Nursing Company: A Skilled Nursing Company ("SNF") or Nursing Company ("NF") is legally required to perform discharge planning services for its residents. The Company prohibits delegation of discharge planning activities to other personnel not connected with The Company except in very narrow circumstances that require prior approval from the Compliance and Ethics Officer.
d. Gifts/Benefits to or from Physicians, Suppliers, and Other Entities:
    1. Gifts or other benefits may not be given to, or solicited or received from, physicians, suppliers, or other persons or entities, except as permitted above
    2. Periodic inventory checks will be performed to detect whether any SNF has received unordered supplies, such as incontinence supplies or wound care products

e. Referrals to or by Hospice: Provide services pursuant to a written agreement with a hospice program that meets the conditions of participation for hospices (42 CFR Pat 418) upon evidence that the resident qualifies for and has properly elected the hospice benefit.
    1. Develop and implement, in conjunction with the hospice program, a coordinated plan of care
    2. Bill the Medicare and/or Medicaid programs only for the treatment of conditions unrelated to the terminal illness, as permitted by law
    3. For residents eligible for Medicare hospice benefits and Medicaid coverage of the resident's room and board, The Company shall not accept payment by a hospice for room and board provided to a hospice resident in excess of the amount that The Company would have received if the resident had not been enrolled in hospice. Any additional payments from the hospice for items and services purchased from The Company must represent the fair market value of such additional items and services provided to the resident that are not included in the Medicaid daily rate
    4. Provide only those services The Company is allowed to provide to hospice residents under applicable law
    5. Not engage in any arraignment in which The Company offers, accepts, provides, or receives free services to or from a hospice in exchange for a promise or agreement to refer nursing company residents to the hospice, or vice versa

4). *Independent Contractors/Employees:* All agreements with physicians should be reviewed by the Compliance and Ethics Officer with the assistance of the Compliance and Ethics Attorney, as necessary. The Compliance and Ethics Officer will review all agreements with physicians to determine whether there is an independent contractor relationship or an employee relationship in light of the relevant IRS guidelines.

To ensure that the public is informed about independent contractors and to avoid liability for the acts or omissions of independent contractors, all such arrangements with independent contractors must be reviewed by the Compliance and Ethics Officer. Notices should be posted conspicuously in an area where those dealing with the independent contractor will be properly informed of the independent contractor relationship. Resident forms should include a notice disclosing which goods or services, if any, are provided by independent contractors. The form of such notices should be reviewed by the Compliance and Ethics Attorney.

5). *Private Benefit/Private Inurement:* The Company may not engage in activities primarily serving private interests and may not enter into agreements in which the profits of The Company pass to "insiders" such as physicians. The Company may not pay physicians unreasonable or excessive compensation, whether the compensation is for goods or services. Employees who learn of activities or arrangements which may involve excessive or unreasonable compensation or other substantial private benefits, or private inurement must report their concerns to the Compliance and Ethics Officer in accordance with the Compliance and Ethics Program's Reporting Policy. (Reference Policy CP 2.0 Section B *Compliance Reporting System*)

Officers, directors, and other individuals having similar powers or duties within The Company should scrutinize all proposed transactions with physicians. Officers, directors, and others should ensure that physicians are paid based on the fair market value of the goods or services provided. All transactions involving physicians must be approved by Governing Body members or committee

members without an interest in the transaction in accordance with the guidelines suggested by Congress and discussed in detail above. The Governing Body or committee considering the transaction must obtain and rely upon comparison data as appropriate for the transaction. For example, if The Company is to enter into an employment agreement with a physician, the Governing Body or committee should obtain and review information on compensation paid to physicians with similar skills and experience in the region. This information may generally be obtained through compensation surveys and similar materials. The Governing Body or committee should ensure that it properly documents its decision. The record should generally include an evaluation of the physician and the basis for determining the physician's compensation.

Under federal law, directors, officers, and physicians who participate in transactions involving unreasonable or excessive compensation will be subject to penalty taxes. Anyone with concerns in connection with any transaction or agreement involving physicians should report concerns to the Compliance and Ethics Officer.

6). *Grants from Vendors:* The Company will accept grants, rebates, or other similar gifts ("Grant Money") from vendors and other nongovernmental entities (collectively "Vendor Companies") only for use in connection with the Grant Money's stated business purposes. The Company will not accept Grant Money as an inducement to generate business for the grantor. However, The Company is free to negotiate discounts on its purchases of equipment or supplies from any vendor, but all such discounts must be reflected in any applicable cost reports filed by The Company.

Grant Money may be accepted only under the following conditions:

a. The Grant Money is used only for the stated purpose for which it is provided
b. When Grant Money is provided for educational, research, or other programs, the programs must be bona fide programs with real scientific or educational value
c. Educational programs sponsored with Grant Money may not address the drugs, devices, or products manufactured or distributed by the grantor Vendor Company, and the programs must be made available to attendees free of charge or at a nominal cost and without regard to whether the attendees are customers or prospective customers of The Company
d. Grant Money cannot be used to relieve The Company of existing obligations or expenses it otherwise would have incurred without the receipt of Grant Money
e. Grant Money from any Vendor Company must be approved by the Compliance and Ethics Officer prior to receipt
f. On a semi-annual basis, and using forms supplied for such reports, The Company's Departments will report any Grant Money received and certify to the Compliance and Ethics Officer that such funds have been, or will be expended and accounted for in accordance with any requirements placed on their use

7). *Contracting with Excluded Physicians:* Federal law prohibits The Company from contracting with physicians who are excluded from participation in Medicare and other federal healthcare programs; all agreements with physicians should be reviewed by the Compliance and Ethics Officer. The Compliance and Ethics Officer or designee will conduct background checks.

8). *Reassignment of Medicare Benefits:* Medicare benefit payments for physician services may normally only be paid to the physician providing services or to the Medicare beneficiary. These benefit payments may, however, be assigned to The Company if The Company employs the physician or if the physician's services are provided in any of The Company's health care facilities. For The Company to receive Medicare benefit payments for physician services, the physician should sign an agreement allowing The Company to receive payment for the services. If the physician is an independent contractor, in order for The Company to receive payment for the physician's services, the services must be provided within The Company's healthcare company, and the physician must sign an agreement whereby The Company submits the bill for the services.

All arrangements involving reassignment to The Company of Medicare benefit payments for physician services should be reviewed by the Compliance and Ethics Officer to ensure compliance with an appropriate exception. Suspected violations of the reassignment rules should be reported to the Compliance and Ethics Officer in accordance with the Compliance and Ethics Program's Reporting Policy.

9). *Physician Recruitment:* All agreements involving physician recruitment incentives, whether in the form of income guarantees, discounted office space, subsidized services, or discounted equipment, should be reviewed by the Compliance and Ethics Officer and the Compliance and Ethics Attorney. The recruitment incentives should be structured so as to minimize risks of violating the Stark II Self-Referral law and the Anti-kickback law.

Policy Number: VC 2.1

Policy Title: Business Associates

Policy Statement/Purpose: To protect The Company by assuring that business associates will appropriately safeguard Protected Health Information (PHI) and will not use or disclose PHI other than permitted by the business associate agreement and/or applicable regulations.

Policy Interpretation and Implementation: The Company shall identify all persons and entities that serve as a business associate. The Company shall require that all business associates execute a Business Associate Agreement (BAA).

Definitions:

Business Associate -

a. As defined under the Health Insurance Privacy and Accountability Act (HIPAA), "Business Associate" is a person who acts in a capacity other than as a member of the workforce of The Company to perform or assist in the performance of a function or activity involving the use or disclosure of individual health information, or any other function or activity otherwise governed by the privacy regulations.
b. A person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. This includes persons and entities that perform the following functions:
    1. Data aggregation, analysis, processing, or administration
    2. Accounting, billing, claims processing, or financial services or administration
    3. Utilization review
    4. Quality assurance
    5. Benefit management
    6. Practice management
    7. Re-pricing
    8. Legal
    9. Actuarial
    10. Consulting
    11. Administrative
    12. Accreditation

Examples of Business Associates:

a. Third party administrators that assist with claims processing
b. Patient Safety Organizations
c. Health Information Organizations
d. Data Storage Companies, whether electronic or hard copy
e. Data Destruction Companies (e.g., shredding)
f. Subcontractors that create, receive, or transmit PHI on behalf of the business associate (e.g., legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, and financial services)

g. Note that a covered entity may be a business associate of another covered entity (e.g., pharmacy consultant)

Business Associates Exclude:
a. Healthcare providers, where the use or disclosure is for the purpose of treatment (ex. attending physicians and other providers).
b. Members of The Company workforce (e.g., medical director).
c. Oversight agencies, both federal and state.
d. Persons and organizations that act as a conduit (e.g., USPS, courier, and electronic equivalents)
e. Persons/entities whose functions and services do not involve the use/disclosure of PHI and any access would be incidental (ex. janitorial, construction, electrician).

Examples of Business Associate Relationships:
a. A long-term care company enters in a vendor relationship with a billing company. Because the billing company is acting on behalf of the provider and is receiving PHI in the form of patient billing information, the billing company is a business associate
b. An outpatient rehab clinic enters into a contract with a vendor to outsource certain information technology services, such as claims processing and data warehousing. The IT vendor is a business associate
c. A medical group enters into a management contract with a physician practice management company that will provide various administrative services to the group, including billing. The management company is a business associate
d. A healthcare provider hires a consultant to review the accuracy of its billing and coding practices. The consultant is a business associate

Reference *Typical Business Associates Charts* below

Procedure:
Covered Entity Business Associates: (Covered entity provider directly bills for federal reimbursement such as Medicare and Medicaid).
a. The Company shall have a *Business Associate Agreement* with all business associates
b. The contract must provide that the business associate will
    1. comply with the applicable privacy and security requirements;
    2. ensure that any subcontractors that create, receive, maintain, or transmit electronic protected health information (e-PHI) on behalf of the business associate agree to comply with applicable privacy and security requirements by entering into a compliant contract or other arrangement; and
    3. report to the covered entity any security incident of which it becomes aware, including breaches of unsecured protected health information.
c. Further, all business associates must contractually agree to the following:
    1. Not use or further disclose the information other than as permitted under the contract or as required by law
    2. Use appropriate safeguards to prevent use or disclosure of the information other than as provided by its contract
    3. Report to The Company any use or disclosure not provided for by its contract of which it becomes aware

4. Ensure that any agents to whom it provides protected health information agree to the same restrictions and conditions that apply to the business associate with respect to such information
5. Afford residents access to their protected health information
6. Make information available for amendment and incorporated amendments
7. Make available the information to provide an accounting of disclosures
8. Make its internal practices, books and records relating to the use and disclosures of protected health information received from, or created or received by the business associate on behalf of The Company available to the Secretary of the Department of Health and Human Services for the purposes of assessing The Company's compliance with the privacy regulations
9. At the termination of the contract, if feasible, return or destroy all protected health information received from or created or received by the business associate on behalf of The Company
10. Report to the covered entity and business associate any security incident of which it becomes aware, including breaches of unsecured protected health information

Non-Covered Entity Business Associates: (Provides services for covered entity but does not itself bill for federal reimbursement such as Medicare or Medicaid).

a. The Company shall have a *Business Associate Agreement* with all subcontractors, meeting all requirements that apply to contracts or other arrangements between a covered entity and business associate, including that the subcontractor will
    1. comply with the applicable privacy and security requirements;
    2. ensure that any subcontractors that create, receive, maintain, or transmit electronic protected health information (e-PHI) on behalf of the subcontractor agree to comply with applicable privacy and security requirements by entering into a compliant contract or other arrangement; and
    3. report to the covered entity and business associate any security incident of which it becomes aware, including breaches of unsecured protected health information.
b. Further, all subcontractors must contractually agree to the following:
    1. Not use or further disclose the information other than as permitted under the contract or as required by law
    2. Use appropriate safeguards to prevent use or disclosure of the information other than as provided by its contract
    3. Report to covered entity and business associate any use or disclosure not provided for by its contract of which it becomes aware
    4. Ensure that any agents to whom it provides protected health information agree to the same restrictions and conditions that apply to the subcontractor with respect to such information
    5. Afford residents access to their protected health information
    6. Make information available for amendment and incorporate amendments
    7. Make available the information to provide an accounting of disclosures
    8. Make its internal practices, books and records relating to the use and disclosures of protected health information received from, or created or received by the subcontractor on behalf of The Company available to the Secretary of the Department of Health and Human Services for the purposes of assessing The Company's compliance with the privacy regulations
    9. At the termination of the contract, if feasible, return or destroy all protected health information received from or created or received by the subcontractor on behalf of The Company

TYPICAL BUSINESS ASSOCIATES FOR A LONG-TERM CARE COMPANY

Vendor Type	Business Associate Agreement
Administrative Support	YES
Clinical Support	YES
Consultants	YES
Dental Consultants	YES
Dietitian Consultant	YES
Hair Care Services	YES
Pharmacy Consultant	YES
Medical Director	YES
Physician Services (Attending Physician)	NO
Therapists	NO
IT- Information Technology (claims progressing/data warehousing)	YES
Medical Billing Software Supplier/Programmer	YES
Management Company	YES
Webmaster	YES
Nursing Agencies (Temp Staffing)	YES
Nursing Placement Companies (Permanent)	YES
Ambulance	NO
Hospitals	NO
Beds	YES
Billing Company	YES
Cleaning	YES
DME	YES
Enteral Feeding	YES
Food	YES
Laboratory	YES
Pharmacy	NO
Podiatry Services	NO
Prosthetics and Orthotics	NO
Radiology Services (X-Ray)	NO
Security Services	YES

4. BUSINESS PRACTICES (BP)

4. BUSINESS PRACTICES (BP)

Policy Number	Policy
BP 1.0	ADMISSIONS PLAN A. ADMISSION POLICIES B. ADMISSION TO COMPANY C. AGE RESTRICTIONS D. AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES E. COMMUNICATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP) F. NON-DISCRIMINATION POLICY • DISSEMINATION OF NONDISCRIMINATION POLICY • NONDISCRIMINATION & ACCESSIBILITY REQUIREMENTS G. DISCRIMINATION AGAINST RESIDENTS AND PAY MENT PROVISIONS H. SECTION 504 NOTICE OF PROGRAM ACCESSIBILITY • SECTION 504 GRIEVANCE PROCEDURE
BP 2.0	BUSINESS RELATIONS PRACTICES A. GIFTS MADE BY RESIDENTS TO STAFF AND AGENTS B. RECEIVING AND EXTENDING BUSINESS COURTESIES C. MARKETING LUNCHES D. CHARITABLE CONTRIBUTIONS E. CAMPAIGN AND ELECTION LAW GUIDELINES
BP 2.1	DOCUMENT MANAGEMENT A. RECORDS RETENTION B. ELECTRONIC SIGNATURE POLICY C. FACSIMILE TRANSMISSION OF MEDICAL RECORDS
BP 2.2	WORKFORCE DATA MANAGEMENT A. MANDATORY SUBMISSION OF STAFFING INFORMATION

Policy Number: BP 1.0

Policy Title: Admissions Plan

Policy Statement/Purpose: The Company has systems in place to ensure compliance with applicable state and federal laws and regulations, and The Company Compliance and Ethics Program.

Policy Interpretation and Implementation: The admission plan and its protocols are components of The Company Compliance and Ethics Program.

A. ADMISSION POLICIES

1). *Overview:* It is the policy of The Company to admit and to treat all residents without regard to race, color, national origin, sex (including pregnancy, sexual orientation, and gender identity), age, disability, religion, ancestry, marital or veteran status, domestic violence victim status, and/or payment source.

2). Requirements:
   a. There is no distinction in eligibility or in the manner of providing resident services provided by The Company.
   b. All services of The Company are available without distinction to all residents and visitors regardless of race, color, national origin, sex (including pregnancy, sexual orientation, and gender identity), age, disability, religion, ancestry, marital or veteran status, domestic violence victim status, and/or payment source.
   c. All persons and organizations that have occasion either to refer residents for admission or recommend The Company are advised to do so without regard to the resident's race, color, national origin, sex (including pregnancy, sexual orientation, and gender identity), age, disability, religion, ancestry, marital or veteran status, domestic violence victim status, and/or payment source.

3). Inquiries: Please stop in and visit us or call for information and a tour. The Admissions Coordinator will be pleased to show you around and answer your questions concerning our admission policy.

B. ADMISSION TO COMPANY

1). *Overview:* The Company will admit only those residents whose medical and nursing care needs can be met.

2). *Admission Policy Objectives:*
   a. Provide uniform guidelines for admitting residents to The Company.
   b. Admit residents who can be adequately cared for by The Company.
   c. Address concerns of residents and families during the admission process.
   d. Review with the resident, and/or his/her representative (sponsor), The Company's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.
   e. Ensure that The Company receives appropriate medical and financial records prior to, or upon the resident's admission.

3). *Admission Requirements:*

a. Prior to, or at the time of admission, the resident's attending Physician must provide The Company with information needed for the immediate care of the resident, including orders covering at least:
   1. type of diet (e.g., regular, mechanical, etc.);
   2. medication orders, including (as necessary) a medical condition or problem associated with each medication; and
   3. routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary Care Plan.

b. Residents will be admitted to this company if their nursing and medical needs can adequately be met by The Company.

c. The acceptance of residents with certain conditions or needs may require authorization or approval by the Medical Director, Director of Nursing Services, and/or the Administrator.

d. Company admission policies apply to all residents admitted to The Company regardless of race, color, creed, national origin, age, sex (including pregnancy, sexual orientation, and gender identity), religion, disability, ancestry, marital or veteran status, domestic violence victim status, and/or payment source.

e. The Administrator, through the Admissions Department, shall ensure that the resident and The Company follow applicable admission policies.

C. Age Restrictions Statement

(Select one Statement)

1) *No Age Restriction*: It is the policy of The Company to not deny or restrict access to services based on an individual's age, unless age is a factor necessary to normal operations or the achievement of any statutory objective.

2). *Age Requirement 18 or Older - Scope of Company Operations:*

a. It is the policy of The Company to extend services to persons over the age of 18 years.

b. The Company does not extend services for pediatric care. The Company is not properly equipped, and staff members are not trained to cater to this demographic.

D. Auxiliary Aids and Services for Persons with Disabilities

1). *Overview:* The Company will take appropriate steps to ensure that persons with disabilities, *including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments,* have an equal opportunity to participate in our services, activities, programs, and other benefits. Company procedures are intended to ensure effective communication with residents/clients involving their medical conditions, treatment, services, and benefits. The procedures apply to communication of information contained in important documents, including waivers of rights, consent to treatment forms, financial and insurance benefit forms, authorization to dispense medical information, handling of personal valuables, etc. All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notice of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques,

including the effective use of interpreters.

2). *Services for Persons with Disabilities:*

a. Identification and Assessment of Need: The Company provides notice of the availability of a procedure for requesting auxiliary aids and services through notices in Company brochures, letters, and written advertisements, etc.
   - Through notices posted in the lobby, nursing station, and all other posting areas. When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

b. Provision of Auxiliary Aids and Services: The Company shall provide the following services or aids to achieve effective communication with persons with disabilities:

1. AN INTERPRETER FOR PERSONS WHO ARE DEAF OR HARD OF HEARING
   - For persons who are deaf/hard of hearing, and who use sign language as their primary means of communication, the Administrator of Record* is responsible for providing effective interpretation or arranging for a *qualified* interpreter when needed.
   - If an interpreter is needed, the Administrator of Record* is responsible for:
     - Maintaining a list of qualified interpreters on staff showing their names, phone numbers, qualifications, and hours of availability
     - Contacting the appropriate interpreter on staff to interpret, if one is available and qualified to interpret; or obtaining an outside interpreter if a qualified interpreter on staff is not available
     - If an outside interpreter is required, the Administrator of Record* is responsible for arranging for interpreter services through the Language Line at www.language-line.com or (1-800-752-6096)

*The Administrator of Record, or designee can be reached at _____

2. AUXILIARY AIDS AND SERVICES FOR COMMUNICATING WITH PERSONS WHO ARE DEAF OR HARD OF HEARING
   - The Company utilizes relay services for external telephone with TTY users. The Company can accept and make calls through a relay service. The state relay service number is 711.
   - For the following auxiliary aids and services, staff will contact the Administrator of Record* who is responsible for providing the aids and services, as appropriate, in a timely manner: Note-takers, computer-aided transcription services, telephone handset amplifiers, written copies of oral announcements, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDDs), videotext displays, or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.
   - Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by The Company.

Such an offer, and the response, will be documented in the person's file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

NOTE: Children and other residents will not be used to interpret, to ensure confidentiality of information and accurate communication and interpretation.

*The Administrator of Record, or designee can be reached at _____

3. AUXILIARY AIDS AND SERVICES FOR PERSONS WHO ARE BLIND OR WHO HAVE LOW VISION
   - Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
   - Large print taped/recorded, Braille, and electronically formatted materials are available on an as-needed basis. These materials may be obtained by calling the Administrator of Record*.
   - Staff will contact the Administrator of Record* for auxiliary aids and services. The Administrator of Record* is responsible for providing the aids and services, as appropriate, in a timely manner: Qualified readers, reformatting into large print, taping or recording of print materials not available in alternate format, or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff are available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

*The Administrator of Record, or designee can be reached at _____

4. FOR PERSONS WITH SPEECH IMPAIRMENTS
   - To ensure effective communication with persons with speech impairments, staff will contact the Administrator of Record* who is responsible for providing the aids and services, as appropriate, in a timely manner: Writing materials, typewriters, TDDs, computers, flashcards, alphabet boards, communication boards, and other communication aids are to be made available on an as-needed basis.

*The Administrator of Record, or designee can be reached at _____

5. FOR PERSONS WITH MANUAL IMPAIRMENTS
   - Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following: note-takers, computer-aided transcription services, speaker phones, or other effective methods that help to ensure effective communication by individuals with manual impairments.
   - For these and other auxiliary aids and services, staff will contact the Administrator of Record* who is responsible for providing the aids and services, as appropriate, in a

timely manner.

*The Administrator of Record or designee can be reached at _____

E. COMMUNICATING WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

1). *Overview:* The Company will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs, and other benefits. The policy of The Company is to ensure meaningful communication with LEP residents/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, authorization to dispense medical information, handling of personal valuables etc. All interpreters, translators, and other aids needed to comply with this policy shall be provided without cost to the person being served, and residents/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

The Company will conduct a regular review of the language access needs of the patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

2). *Communicating with Persons with Limited English Proficiency (LEP):*

a. Identifying LEP Persons and their Language
    1. The Company will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language.
    2. In addition, when records are kept of past interactions with residents (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.
b. Obtaining a Qualified Interpreter (One who is experientially prepared and unbiased in the outcome of the discussion)
    1. The Administrator of Record* is responsible for:
        - Maintaining an accurate and current list showing the name, language, phone number, and hours of availability of bilingual staff (attach list)
        - Contacting the appropriate bilingual staff member to interpret, if an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret
        - Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or qualified or does not speak the needed language. The Administrator of Record* is

responsible for arranging for interpreter services as appropriate through Language Line at www.languageline.com or (1-800-752-6096).

2. Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by The Company. Such an offer, and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.
3. Children and other clients/residents/residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.

c. Providing Written Translations
   1. When translation of vital documents is needed, each unit in The Company will submit documents for translation into frequently-encountered languages to the Administrator of Record*. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.
   2. Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.
   3. The Company will set benchmarks for translation of vital documents into additional languages over time.

d. Providing Notice to LEP Persons
   1. The Company will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the lobby, nursing station, and all other posting areas in The Company. Notification will also be provided through one or more of the following: brochures, letters, and written advertisements.

e. Monitoring Language Needs and Implementation
   1. On an ongoing basis, The Company will assess changes in demographics, types of services, or other needs that may require reevaluation of this policy and its procedures.
   2. In addition, The Company will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from residents and community organizations, feedback from staff, regular company-wide self-audits.

*The Administrator of Record or designee can be reached at _____

F. NONDISCRIMINATION POLICY

1). *Overview:* As an equal opportunity employer and recipient of Federal financial assistance, The Company does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, age, sex (including pregnancy, sexual orientation, and gender identity), mar-

ital status, religion, creed, disability, national origin, or veteran status, in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by The Company directly, or through a contractor or any other entity with which The Company arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

2). *Implementation:*

1. The Company will not consider the race, color, age, sex (including pregnancy, sexual orientation, and gender identity), marital status, religion, creed, disability, national origin, or veteran status, of an applicant.
2. The Company and its employees will not discharge or cause an employee to resign on the basis of race, color, age, sex (including pregnancy, sexual orientation, and gender identity), marital status, religion, creed, disability, national origin, or veteran status.
3. The Company will not base pay rates, salary, benefits, or other employee privileges on the basis of race, color, age, sex (including pregnancy, sexual orientation, and gender identity), marital status, religion, creed, disability, national origin, or veteran status.
4. The Company will not tolerate any jokes or insensitive comments relating to race, color, age, sex (including pregnancy, sexual orientation, and gender identity), marital status, religion, creed, disability, national origin, or veteran status. Any such statements are to be reported to a Department Head and the Administrator.
5. All complaints of discrimination are to be made to the employee's Department Head and then forwarded to the Administrator.

In case of questions, please contact:

Company Name: _____

Contact Person/Section 504 Coordinator: Administrator of Record

Telephone number: _____

TDD or State Relay number: 7-1-1

2). *Dissemination of Nondiscrimination Statement*

a. For the public:
    1. A copy of the nondiscrimination statement is posted in The Company for visitors and clients/residents to view.
    2. The nondiscrimination statement is printed in The Company brochure and is routinely distributed to residents, referral sources, and the community.
    3. The nondiscrimination statement is included in newspaper advertisements for The Company.
b. For the residents:

1. The nondiscrimination statement is included in resident admissions packet.
2. The nondiscrimination statement is discussed with residents upon their initial visit with The Company.
3. A copy of the nondiscrimination statement is available upon request.

c. For the employees:
1. The nondiscrimination statement is included in employee advertisements.
2. The nondiscrimination statement is included in the employee handbook.
3. The nondiscrimination statement is discussed and distributed during employee orientation.
4. The nondiscrimination statement is posted in employee break rooms.

The Company Nondiscrimination Policy is posted on The Company website. Please visit our website for more details and to find additional information about The Company.

The Company Nondiscrimination clause is incorporated into the accompanying documents.

3). *Nondiscrimination & Accessibility Requirements:* The Company complies with applicable Federal civil right laws and does not discriminate based on race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

4). *Auxiliary Aids and Services:* This company provides the following:

a. Free aids and services to people with disabilities for effective communications with The Company include:
1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

b. Free language services to people whose primary language is not English, such as:
1. Qualified interpreters
2. Information written in other languages

To access these services, contact the Administrator of Record or designee at _____

G. Discrimination Against Residents and Payment Provisions

1). *Overview:* It is the policy of The Company to maintain identical policies and practices for all individuals regarding transfer and discharge, regardless of payment sources, and to comply with all applicable law with respect to admissions decisions, as well as the provision of services under the state Medicaid plan.

2). *Implementation:* Providers may wish to include the following suggested elements as part of their corporate compliance policy:

a. The Company will not require residents or potential residents to waive their rights under Medicaid or Medicare, and not require oral or written assurances that residents or potential residents are not eligible or will not apply for Medicaid or Medicare benefits.

b. The Company will not require a third-party guarantee of payment as a condition of admission, expedited admission, or continued stay at The Company. The Company may require a person who has legal access to and/or control over a resident's income or resources to pay for Company care or sign a contract to provide payment for the resident's services, without requiring the person to assume personal financial liability for such care.
c. For Medicaid eligible residents, The Company will not charge, solicit, accept, nor receive for services covered by Medicaid any gift, money, donation, or other consideration, in addition to any amount required to be paid under the state Medicaid plan, as a precondition of admission, expedited admission, or continued stay at The Company.
d. The Company may charge residents amounts above and beyond payment received by Medicaid for items and services required by the resident and not included in the Medicaid package of "nursing company services" as long as The Company gives proper notice of the availability and cost of such services or items and does not condition the resident's admission and continued stay on the purchase of such items or services.
e. The Company may solicit, accept, or receive charitable, religious, or philanthropic contributions from an organization or a person unrelated to a Medicaid resident as long as such contribution is not a condition of a resident's admission or continued stay. All offers for the donation of such contributions shall be reported to The Company Administrator, Corporate Compliance and Ethics Officer, or other person designated by The Company for a determination that such contribution is allowed under applicable law.

H. Section 504 Notice of Program Accessibility

1). *Overview:* The regulation implementing section 504 requires that an agency/company "…adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons." **(45 C.F.R. §84.22(f))**

2). *Program Accessibility:* The Company and all of its programs and activities are accessible to and useable by disabled persons, including persons who are deaf, hard of hearing, blind, or who have other sensory impairments. Access features include:
   a. Convenient off-street parking designated specifically for disabled persons.
   b. Curb cuts and ramps between parking areas and buildings
   c. Level access into first floor level with elevator access to all other floors
   d. Fully accessible offices, meeting rooms, bathrooms, public waiting areas, cafeteria, patient treatment areas, including examining rooms, and patient wards
   e. A full range of assistive and communication aids provided to persons who are deaf, hard of hearing, blind, or who have other sensory impairments. There is no additional charge for such aids. Some of these aids include:
      1. Qualified sign language interpreters for persons who are deaf or hard of hearing
      2. A twenty-four-hour (24) telecommunication device (TTY/TDD) which can connect the caller to all extensions within The Company and/or portable (TTY/TDD) units, for use by persons who are deaf, hard of hearing, or speech impaired
      3. Readers and taped material for the blind, and large print materials for the visually impaired
      4. Flash cards, Alphabet boards, and other communication boards
      5. Assistive devices for persons with impaired manual skills

If any of the aids listed above are needed, contact the receptionist, nurse, or the Administrator of record.

3). *Section 504 Grievance Procedure:* It is the policy of The Company not to discriminate based on the person's disability. The Company has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1972 (29 U.S.C. §794) or the U.S. Department of Health and Human Services regulations implementing the individual "…shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…."

a. The Law and Regulations may be examined in the office of the Administrator of Record* who has been designated to coordinate the efforts of The Company to comply with Section 504.
b. Any person who believes she or he has been subjected to discrimination based on disability may file a grievance under this procedure. It is against the law for The Company to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.
c. If you believe that this Company has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Administrator of Record*.

_____
(Company Address)

_____
(Company Phone Number)

_____
(Company Email)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Administrator of Record is available to help you.

d. You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for the Civil Rights Complaint Portal, available at http://ocrportal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW / Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE INTERPRETIVE ASSISTANCE FOR THE PROVISION OF HEALTHCARE SERVICES
(State Specific)

4). *Filing a grievance:* Grievances must be submitted to the Section 504 Coordinator within thirty (30) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
   a. A complaint must be in writing, containing the name and address of the person filing it
   b. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought
   c. The Section 504 Coordinator (or her/his designee) shall investigate the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint
   d. The Section 504 Coordinator will maintain the files and records of The Company relating to such grievances
   e. The Section 504 Coordinator will issue a written decision on the grievance no later than thirty (30) days after its filing
   f. The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the Administrator, who shall issue a written decision in response to the appeal no later than thirty (30) days after its filing

5). *Grievance Considerations:*
   a. The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination based on disability with the U.S. Department of Health and Human Services, Office for Civil Rights
   b. The Company will make appropriate arrangements to ensure that disabled persons are provided other accommodations, if needed, to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of materials for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements

   *The Administrator of Record or designee can be reached at _____

Policy Number: BP 2.0

Policy Title: Business Relations Practices

Policy Statement/Purpose: The Company has policies in place to ensure business practices are compliant with Laws, Rules, and Regulations and other directives of federal, state, and local governments, departments and agencies and the requirements of The Company Compliance and Ethics Program.

Policy Interpretation and Implementation: Business practices are components of The Company Compliance and Ethics Program.

A. Gifts Made by Residents to Staff and Agents

1). *Overview:* Company employees and agents shall not obtain any improper personal benefit from his or her employment or association with The Company. Company Associates may not accept gifts from residents or family members, unless the gift is a non-cash gift of nominal value (e.g., cookies baked by a family member or fruit and vegetables grown in a family member's garden).

2). *Protocol for Accepting and Giving Gifts:* Skilled Nursing Company protocols must specify, at a minimum, that:

a. No Associate shall solicit, receive, or accept from any person or entity, nor offer or give to any person or entity, anything of material value if that person or entity is in a position to refer business to The Company, or if The Company is in a position to refer business to that person or entity except as permitted by law.
b. No Associate shall accept any gift, hospitality, or entertainment in any amount from, or on behalf of, a resident of The Company; and shall not accept from any other person any cash or cash equivalents, any gift of more than the nominal value of fifty dollars ($50) per gift, or an aggregate of fifty dollars ($50) per year from any particular person or entity, or any hospitality or entertainment that, because of its source or value, might influence the employee's independent judgment in transactions involving The Company. If any gift is received as allowed under the terms of this provision, employee shall notify his or her immediate supervisor promptly.
c. No Associate shall provide any gifts or gratuities to any government or public agency representatives except as permitted by law.
d. No Associate shall make payments for a physician's travel to, or for, participation in conferences, unless the subject matter of the conference is of direct benefit to The Company. Similarly, there shall be no payments of a physician's continuing education fees, no discounted billing services, no interest-free loans, and no forgiveness of loans as part of any gift to a physician, unless such benefits are specifically allowed as part of a permissible physician agreement.
e. No Associate shall pay or receive anything of financial benefit in exchange for Medicare or Medicaid referrals, such as receiving non-covered medical products at no charge in exchange for ordering Medicare-reimbursed products.
f. No gift or loan of cash or cash equivalents (e.g., gift certificates or gift cards) may be accepted.
g. Associates will discourage residents or family members from giving gifts of greater than a nominal value. If a resident or family member insists that the employee/agent accept a gift

that is of greater than nominal value, then, prior to accepting the gift, the employee/agent will report the offer to the Compliance and Ethics Officer.

h. The Compliance and Ethics Officer, in conjunction with the Compliance Attorney, will determine the appropriateness of accepting the gift and any action to be taken. The Compliance and Ethics Officer may require the resident and employee/agent to sign a statement attesting that the gift is given voluntarily and with no direct bearing on the services provided to the resident by the employee/agent.

i. Employees/agents are absolutely and unconditionally prohibited from selling merchandise to residents or family members under any circumstances.

j. Should a resident ask an employee/agent of The Company whether he or she would like to be a beneficiary under the resident's will, the employee/agent will be required to immediately inform the Compliance and Ethics Officer. The Compliance and Ethics Officer will then be obligated to advise the resident to consult with his or her attorney prior to making any disposition to the employee/agent.

B. Receiving and Extending Business Courtesies

1). *Overview:* Company policies provide employee guidance on receiving and giving business courtesies. Employees must contact the Compliance and Ethics Officer if there are questions regarding business courtesies that are not addressed in this policy.

2). *Receiving Business Courtesies:*

a. Social Events/Entertainment

1. Invitations to social events may be accepted from current or potential business associates to further develop a business relationship under the following conditions:
   - The event must not include any travel costs (other than travel by car), or overnight lodging. The cost associated with the event must be reasonable and appropriate (i.e., less than one hundred dollars ($100) per person). Such social events with respect to any individual should not occur more frequently than quarterly. All exceptions to the above-mentioned conditions must be approved by the Administrator
2. Employees shall not accept business courtesies to the extent that their decision making might be improperly influenced.

a. Training/Education

1. Attendance at a vendor sponsored workshop, seminar, or training session is permitted. Arrangements that include travel and overnight lodging at no cost to the employee must be approved in advance by the Administrator.
2. Attendance at an event at a vendor's expense to receive information about new products or services must be approved in advance by the Administrator.

b. Gifts

1. Employees may accept a gift with a total value of fifty dollars ($50) or less in any one (1) year from any individual vendor that has a business relationship with The Company.
   - Attending physicians at The Company are considered, for purposes of this policy, to be vendors that have a business relationship with The Company
2. Employees may not accept cash, or cash equivalents such as gift certificates or gift cards.
3. A unit or group within The Company may accept a general gift of perishable or consumable gifts.

3). *Extending Business Courtesies to Non-Referral Sources (Sources not in a position to make resident referrals):*

a. Social Events/Entertainment
    1. Invitations extended to nonreferral sources to attend social events to develop a business relationship must be approved in advance by the Administrator.
    2. Additionally, the following conditions apply:
        - During these events, topics of a business nature must be discussed and the representative from The Company must be present
        - The non-referral source's travel expenses should not be paid for by The Company (other than travel by car). The cost associated with such an event must be reasonable and appropriate (i.e., less than one hundred dollars ($100) per person)
        - Business entertainment with respect to any individual must be infrequent (less than quarterly)
        - Any exceptions to the above conditions must be approved by the Administrator. If the approved amount is inadvertently exceeded, a report after the fact will be submitted to the Compliance and Ethics Officer in addition to the Administrator

b. Business Events
    1. Reasonable and appropriate meals may be offered in conjunction with a business event.
    2. Transportation and lodging are reimbursable by The Company with appropriate receipts.
    3. Gifts
        - Gifts or other incentives must never be used to improperly influence relationships or business outcomes
        - Gifts to business associates who are not government employees must not exceed fifty dollars ($50) per year per recipient
        - Cash or cash equivalents, such as gift certificates or gift cards, must never be given
        - All exceptions to this policy must be approved by the Administrator and a report submitted to the Compliance and Ethics Officer

4). *Extending Business Courtesies to Referral Sources (Sources that may be able to make resident referrals):*

a. Extending Business Courtesies to Possible Referral Sources:
    1. Reasonable and appropriate meals may be offered in conjunction with a business event.
    2. Transportation and lodging for a business event are reimbursable by The Company.
    3. Any entertainment (business or social) or gifts involving physicians or other persons who can refer residents to The Company must be approved by the Administrator.

5). *Business Courtesies with Government Employees:*

a. Providing gifts, entertainment, or anything else of value to any employee of the federal or state government is prohibited.
b. Modest meals and refreshments in connection with business discussions may be provided.

C. MARKETING LUNCHES

1). *Overview:* The Company occasionally offers light lunches in conjunction with specific events. These events must include a specific educational purpose that does not include fostering goodwill

among clients or residents. Lunches can never be provided in exchange for referrals or with the hope of obtaining referrals. Lunches cannot accompany recreational or client relation meetings. They can only be provided in addition to discussions of a scientific or otherwise educational nature.

The lunches must be modest. Exuberant lunches suggest that the lunch is the main attraction of the event and therefore serves the purpose of encouraging referrals.

2). *Marketing Lunches:*

a. When a staff member recognizes an opportunity to include a lunch, they should prepare a description of the event. The description should include the purpose of the event, the agenda for the event, and the intended participants in the event. A history of similar events should be listed as well.
b. The description should be provided to the Compliance and Ethics Officer. The Company administration will add background information on the relationship between The Company and the client.
c. Compliance counsel will be available to provide a legal analysis of a proposed event.
d. The staff member organizing the event will document any changes made to the event for further review by Company administration.

D. CHARITABLE CONTRIBUTIONS

1). *Overview:* The Company complies with applicable laws, rules, and regulations governing charitable contributions, and ensures that Associates do not offer or give anything of value in exchange for referral of any item or service furnished under federal or state healthcare programs.

The Company requires that Associates be aware of laws and regulations governing the support of charitable and cultural institutions and ensure that charitable contributions are appropriately extended to and received from charitable and cultural institutions.

2). *Charitable Contributions:*

a. The Company shall provide its Associates access to the Charitable Contributions policy.
b. The Company shall revise this policy as necessary to comply with changes in the law and shall document and implement any changes.
c. Charitable contributions must be to a public charity, recognized as tax exempt by the Internal Revenue Service (IRS).
d. All proposed contributions to The Company referral, or potential referral, sources must be expressly consented to by the Compliance and Ethics Officer.
e. Contributions must be unconditional; i.e., not tied to the referral of residents to The Company.
f. The size of the contribution must not be dependent upon the volume of business with, or the number of resident referrals by, the charity.
g. The charity must substantiate the gift in writing and certify that it did not and will not take fundraising participation or the size of donations into account when awarding contracts, purchasing items, or making resident referrals. Such substantiation must be made by the charity contemporaneously with the award of the charitable gift, and in no event any more than thirty (30) days after the gift is awarded.

h. The fundraising solicitation by the charity should be one that is being made broadly to the public and not just to vendors and business associates.
i. Incidental benefits offered in exchange for the donation, such as attendance at a fundraising event, may be used by The Company Associates. Such benefits shall not be given away to others to generate business or referrals.
j. Associates must identify and report potential issues immediately to their immediate supervisor or the Compliance and Ethics Officer when appropriate. If the Associate is not comfortable speaking to the supervisor or if the supervisor fails to respond quickly and appropriately to the concern, then the individual with the concern should report the concern through the confidential Compliance Hotline.
k. Associates should be aware of The Company's Code of Conduct.
l. A copy of the Code of Conduct is available from any supervisor, as well as from the Compliance and Ethics Officer.

E. Campaign and Election Law Guidelines

1). *Overview:* The Company is committed to complying with all federal, state, and local campaign and election laws. Further, The Company recognizes that individual employees are voters who are free to make personal financial contributions to the election campaigns of candidates of their choice. This policy establishes guidelines for ensuring the appropriateness of political activities on the part of The Company or its employees.

2). *Corporate Activity:* The Company will comply with all applicable federal, state, and local campaign and election laws.

3). *Employee Activity:* While The Company does not discourage individual political activity, these activities should be at the employee's sole expense and reimbursement is not available from The Company in any form. Employees of The Company should refrain from partisan political activities on Company premises, on Company time, or under any circumstances that could create the appearance that such activities are sponsored by The Company.

4). *Gifts to, and Entertainment of, Government Officials:* Gifts given to, and entertainment of, government officials must comply with Policy BP 2.0 Section B - *Receiving and Extending Business Courtesies*.

Policy Number: BP 2.1

Policy Title: Document Management

Policy Statement/Purpose: The Company has policies and procedures for document management consistent with rules, regulations, requirements, and standards.

Policy Interpretation and Implementation: Document management is component of The Company Compliance and Ethics Program.

A. RECORDS RETENTION

1). *Overview:* Documents (including computer records) relating to uses and disclosures, authorization forms, business partner contracts, notices of privacy information practice, response to a resident who wants to amend or correct his/her information, patient's statement of disagreement, complaint record, or any other written communication required by HIPAA, as well as any other documents generated pursuant to the Privacy Compliance Program, including meeting minutes, investigatory documents, review reports and supporting documentation, authoritative documentation, corrective action plans, and educational materials, shall be maintained by the Privacy Officer according to the guidelines set forth below. The document management program will be documented in a form which has been approved by Legal Counsel and must be maintained for a minimum seven (7) years, unless otherwise specified by state or local law, from its date of creation or the date when it was last in effect, whichever is later. Records must also be retained for two (2) years after a patient's death. Documented Company policies and procedures must be maintained for a minimum of seven (7) years, unless otherwise specified by state or local law. The Company specifies retention periods related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2). *Retention:* All records developed in accordance with the operation of this Program shall be maintained for a minimum seven (7) years, unless otherwise specified by state or local law; provided, however, that if there is any ongoing internal or external investigation, including cost report reviews, Department of Health and Human Services (DHHS) investigations, lawsuits, or similar actions, then those records relevant to the action shall be retained until the action is concluded. Documents may be retained for longer periods upon the decision of the Privacy Officer. In such event, the Privacy Officer shall adopt a Compliance Office schedule setting forth the type of record and the length of retention. Additional records include, but are not limited to:

a. All records and documentation required by federal or state law for the protection of resident privacy and confidentiality;
b. Medicare requires long-term care facilities to retain clinical records on each resident for the period required by state law, or, if there is no state requirement, for five years from the date of discharge for adults; and three years after the resident reaches legal age under state law for a minor (42 C.F.R. § 483.75(1)) all records necessary to protect the integrity of the compliance process and confirm the effectiveness of The Company's Privacy Compliance Program, including:
    1. documentation that employees were adequately trained;
    2. reports from the hotline, including the nature and results of any investigations conducted;

3. documentation of corrective action, including disciplinary action taken;
4. policy improvements introduced in response to any internal investigation or audit;
5. modifications to the Privacy Compliance Program;
6. self-disclosures; and
7. the results of auditing and monitoring efforts.

The Privacy Officer will audit The Company's document management program, and, as appropriate, the Privacy Officer will update the document management program to ensure that the policies meet at least the following minimum requirements:

a. All records will be retained for at least the minimum period as stated in applicable state or federal law or regulation
b. All records that may substantially affect the obligations of The Company will be retained for a period of time that will reasonably assure the availability of those records when needed
c. Adequate records will be developed and maintained to document The Company's compliance with all relevant laws
d. All records related to reports of violations will be preserved in accordance with law and in a manner, which will assure maximum protection under the attorney-client privilege and attorney work product doctrine

Documents created by The Company, or submitted to The Company, are to be retained for the time required by law and in the manner required by law.

Documents that are no longer needed on a daily basis are to be preserved and stored in accordance with The Company's document management program.

Documents may be held beyond the legal minimum only if required for reasons set forth in The Company's document management program. Anyone who fails to surrender documents for destruction in accordance with the Privacy Compliance Program will be subject to disciplinary action. No employee may retain documents contrary to the document management program, or which otherwise belong in archives.

NOTE: As a best practice, Med-Net recommends at least ten-year retention periods for medical records. In some situations, there may be even longer required retention periods to minimize potential legal exposure. HIPAA also mandates additional requirements for storage in order to safeguard the security of documents for both on-site and off-site storage.

3). *Method of Retention:*

a. Records shall be maintained in their original form for a minimum seven (7) years, unless otherwise specified by state or local law. Documents retained for periods greater than for a minimum seven (7) years, unless otherwise specified by state or local law, at the discretion of the Privacy Officer, may be retained in a format other than the original format, provided that such format allows for the accurate reproduction of the record.
b. Records maintained on magnetic tape or other electronic data processing storage media will be preserved and stored appropriately.

c. Informational copies (so-called "FYI" copies) and the like will be discouraged. Documents may be distributed only to the addressee(s) and those expressly identified as requiring a copy. Any other copying, distribution, or possession of documents is prohibited.
d. Employees are not authorized to receive or possess documents that are not necessary to their regular job performance. Ordinarily, an employee should not have a copy of a document unless he or she created the document, is the intended addressee (or designated recipient of a copy), or the document was transmitted as an attachment to a document sent to the employee. Unauthorized possession of The Company documents is a violation of The Company policy.

4). *Filing Systems:* The Compliance and Ethics Officer should establish and maintain a filing system for all compliance-related documents. The following seven files should be established:
a. Compliance Manual – Regulatory codes, and Policies: This file shall contain this compliance manual and any amendments, the Code of Conduct, all conflict of interest statements, and any compliance program policy statements issued after the program's initiation.
b. Oversight - This file should document the appointment of the Compliance and Ethics Officer, non-privileged communications to the Compliance and Ethics Officer, all Governing Body minutes in which compliance issues are discussed, and any other oversight records.
c. Information and Education Campaign - This file shall contain signed affirmation statements, all employee training records, educational materials provided to employees, notices and fraud alerts that have been posted or placed in payroll envelopes (and the dates and locations of such notices), and all other written records of training activities.
e. Monitoring and Auditing - This file shall contain all employment contracts and all other documents relating to employment relationships with employees. Finally, opinion letters from Legal Counsel approving physician contracts shall be included.
f. Enforcement - This file shall contain all documents pertaining to the enforcement of the compliance program, such as disciplinary action taken, policies regarding graduated punishment, and informal and formal reprimands issued.
Note: Files containing information relating to employee sanctions or disciplines present special legal issues. As such, access to these files should be controlled. With regard to notices related to an employee's failure to follow the compliance program, access should be limited to the Compliance and Ethics Officer and others whose access is approved by the Human Resources Department. Additional language can be inserted in the Enforcement file policy, reading "The Enforcement File shall be maintained by the Compliance and Ethics Officer and the Human Resources Department, and access shall be limited to the Compliance and Ethics Officer and individuals approved by the human resources director."
g. Response - This file shall contain all documents reflecting actions taken after an issue has been detected, as well as efforts to deter and prevent future violations.
h. Privileged - This file shall include a record of requests for legal assistance or legal opinions in connection with all reports received via the hotline, and any other means used to report to the Compliance and Ethics Officer, and the response from legal counsel. This file shall be privileged and confidential; its content shall be kept in a secure location and only the Compliance and Ethics Officer, administrator and legal counsel shall have access. All material in this file shall be treated subject to the attorney-client and/or work product privilege and shall not be disclosed to people outside the privileged relationship.

5). *Destruction Schedule:* Destruction of records will take place pursuant to a standard policy which has been developed for business reasons so that it cannot be said that The Company deliberately destroyed records in anticipation of a specific problem. Premature destruction is a violation of Company policy.

a. Records shall be uniformly destroyed in a manner determined by the Privacy Officer upon the expiration of the retention period. However, prior to the destruction of any records, the Privacy Officer shall institute a program of notification whereby the destruction schedule can be interrupted for cause by someone in a position of authority, including the Privacy Officer, to interrupt the destruction process. *For cause* shall include, but is not limited to, service of legal process, notification from governmental agency, or request of the Compliance and Ethics Committee or Legal Counsel.
b. The Company employees and agents will create only those documents which are:
    1. required to be created by law;
    2. necessary for the performance of their jobs, or otherwise compelled by reason of business necessity; or
    3. needed to obtain or follow legal advice.

Documents not meeting those requirements will not be created.

c. The creation of memos or letters for the sole purpose of recording the employee's version of events (commonly called "CYA" memos) are discouraged. All memos or letters created by employees must accurately reflect the events.
d. Documents created by The Company, or submitted to The Company, may be distributed to those persons within and outside of The Company on a need-to-know basis.
e. A document which is clearly marked as a "cc" may be destroyed by the designated recipient of the copy if he or she no longer has a need for that document.
f. All records which have been the subject of an incident that could lead to litigation, and all records which have been requested by an attorney or an administrative agency should be excepted from the general retention policy. These records should not be destroyed until the matter is fully resolved.

6). *Removal or Theft:*

a. Documents created by The Company, or provided to it by others, are the property of The Company. No employee is authorized to remove a document—whether an original or a copy—from The Company's offices or computer systems. This prohibition applies to documents "created" by the employee him or herself.
b. Therefore, removal of documents from The Company premises, offices, or computer systems is strictly prohibited. Exceptions to this policy require the express authorization of the Administrator.

7). *Medical Records:* The Company's document management program must incorporate the statutes and regulations concerning retention of medical records that apply to The Company. Reference Section 13 for *State Specific Requirements*.

Unless specified by state law or regulation, a general retention period of seven (7) years has been chosen for medical records of adult residents that do not fall within specific exceptions or state specific exceptions *as noted below*. Records known to be subject to an actual or potential claim

or investigation are to be retained indefinitely or until the matter is known to be finally resolved. Retention of records of minors is to be dictated by state statutes of limitations for claims brought by minors but in no event less than seven (7) years, or until a minor reaches the majority age of 21, whichever is longer. Employee health records must be retained according to specific state and federal retention and statute of limitations requirements. Requests to review or copy patient medical records must be responded to in strict compliance with applicable statutes and regulations.

8). *State Specific Medical Records Retention Requirements*:

9). *Privacy and Security:* The Privacy Officer, in conjunction with the Compliance and Ethics Committee, shall take reasonable steps to ensure that the records are secured and retained in private. Such steps shall include assurance that the document destruction procedure is equally secure. When implementing a protocol to maintain security, the Privacy Officer shall ensure that the protocol integrates steps to limit access to documents during the retention period to authorized individuals.

10). *Communications:*
All communications with government authorities, including but not limited to: Equal Opportunity Commission, Unemployment Divisions, and Department of Labor, shall be documented at the time of the communication. This documentation shall include:

a. The date, time, and method of the communication
b. The names and titles (if known) of the individuals engaged in the communication, and the employee preparing this documentation
c. A detailed description of the billing advice received, including citations to regulations, provider letters, or other bulletins
d. Any other information conveyed by federal and state authorities
e. A confirmation letter shall be sent to federal and state authorities documenting or confirming the communication received
f. The documentation and copies of the confirmation letters shall be given to the Compliance and Ethics Officer promptly, who shall retain them permanently

Reference FI 1.0 Section C, *Medical Record Monitoring*

B. Electronic Signature Policy

1). *Overview:* Electronic signatures are acceptable for the Minimum Data Set (MDS) as permitted by state and federal laws. When electronic signatures are used, safeguards to prevent unauthorized access, reconstruct information, and minimize fraud must be in place.

2). *Safeguards include, but are not limited to:*

a. Verification of a person's identity before assigning the unique qualifier
b. Acknowledgement in writing that the user is the only person authorized to use the unique qualifier assigned to him/her and may not allow anyone to access or alter information using his/her unique qualifier
c. Certification in writing that the user will not release his/her unique identifier (user ID and password) to anyone

d. Certification in writing by the administrator/designee and the user that the electronic signature is as legally binding as the user's traditional handwritten signature
e. Certification in writing that if the user discloses his/her unique identifier (username and password) to another person he/she will be subject to progressive discipline that may result in termination
f. Passwords must be revised at least every ninety (90) days
g. System security roles to control what sections/areas individuals can access or enter data based on the individual's role, security role and unique identifier
h. A specific computer "lock out" time that is activated when there has been no activity
i. A process for maintaining electronic back up of the electronic MDS
j. A process to allow for the printing of all records as necessary
k. System security that prevents a record from being changed once it is electronically signed and requires any corrections to be entered as amendments to the record
Reference BP Appendix 2.1 B *Electronic Signature for the MDS Acknowledgement/Certification Form* and DI 2.3 B *Password Standards*

C. Facsimile Transmission of Medical Records

1). *Overview:* The Company shall protect the confidentiality, integrity, and availability of Electronic Protected Health Information (ePHI) it creates, receives, maintains, or transmits. The information released will be limited to the minimum necessary to meet the requestor's needs. Whenever possible, de-identified information will be used. The Company has procedures to ensure the appropriate use of the facsimile system when transmitting Protected Health Information (PHI).

2). *Procedure:*
a. The fax machine shall be located in an area that is not easily accessible to unauthorized persons. If not possible, a sign should be posted regarding access to the documents.
b. Received documents shall be removed promptly from the fax machine. To promote secure delivery, instructions on the cover page shall be followed.
c. A cover page shall be attached to a facsimile document that includes PHI. The cover page shall include:
    1. Destination of the fax, including name, fax number, and phone number
    2. Name, fax number, and phone number of sender
    3. Date
    4. Number of pages transmitted
    5. Confidentiality statement. Suggested language:
        - The documents accompanying this transmission contain confidential protected health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.
        - If you are not the intended recipient, you are hereby notified that any disclosure, copying, disseminating, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please

notify the sender immediately and arrange for the return or destruction of these documents.

d. The PHI disclosed will be the minimum necessary to meet the requestor's needs.
e. If a fax transmission fails to reach a recipient, or if the sender becomes aware that a fax was misdirected, the internal logging system shall be checked to obtain the incorrect recipient's fax number. A letter shall be faxed to the inadvertent recipient, asking that the material be returned or destroyed.

Policy Number: BP 2.2

Policy Title: Workforce Data Management (See DI 2.3)

Policy Statement/Purpose: The Company establishes policies and procedures to maintain the integrity of Workforce Data Management systems consistent with requirements, regulations, and standards.

Policy Interpretation and Implementation: Workforce Data Management is a component of The Company Compliance and Ethics Program and includes Acceptable Use, Password Standards, Workstation use, Unacceptable Use, Workstation Security, and Server Security

A. Mandatory Submission of Staffing Information: Payroll-Based Journal

Policy Statement/Purpose: The Centers for Medicare & Medicaid Services (CMS) utilizes staffing as a key factor in determining a nursing home's ability to provide quality care. CMS has studied staffing to accurately and effectively gauge impact on quality of care and is utilizing the data in the Nursing Home Five Star Quality Rating System to assist consumers in understanding the level and differences of staffing in nursing homes. The Affordable Care Act (2010) required facilities to submit direct care staffing information (including agency and contract staff) in an electronic format based on the facilities' payroll and other auditable data. The submitted payroll data, in conjunction with the census information, can then be used to report on the level of staffing in each nursing home, but can also report employee turnover and tenure, which also can impact the quality of care delivered.
The final rule, published on August 4th, 2015, established the requirement for Long-Term Care (LTC) facilities to submit staffing data and was amended (42 CFR §483.75) to require all LTC facilities to electronically submit to CMS complete and accurate direct staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. Based on the final rule, the Electronic Payroll Based Journal (PBJ) was established.

Policy Interpretation and Implementation: The mandatory submission of staffing information is based on payroll data, submitted based on the specifications established by CMS as follows:

(1) Direct Care Staff are persons who provide interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This category does not include staff whose primary duty is maintaining the physical environment of the LTC facility (for example, housekeeping.)
(2) Submission requirement: The facility must electronically submit to CMS complete and accurate direct care staff information, including the following:
    (i) Category of work for each person in direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical person as specified by CMS);
    (ii) Resident census data; and
    (iii) Information on direct care staff turnover and tenure, and on hours of care provided by each category of staff per resident per day, including but not limited to start date, end date (if applicable), and hours worked for each individual.

(3) Distinguish employee(s) from agency and contract staff. The facility must specify whether the individual is an employee of the facility or is engaged by the facility under contract or through an agency.
(4) Data format: The facility must submit direct care staff information in the uniform format specified by CMS.
(5) Submission schedule: The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

Submission Timeliness and Accuracy: Direct care staffing and census data will be collected quarterly and is required to be timely and accurate. Staffing and census data will be collected each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day with the quarter. The Census data includes the facility's census on the last day of each three months in the quarter.

Deadline: Submissions must be received by the end of the 45th calendar day after the last day in each fiscal quarter to be considered timely. Data may be entered and submitted at any frequency though out a quarter. The last accepted submission received prior to the deadline will be considered the facility's final submission. Facilities may view their data submitted through Certification and Survey Provider Enhanced Reports (CASPER) and via the PBJ Online System. The facilities must check their data and the validation report to allow time to correct any errors and resubmit, if needed. The PBJ system will accept submissions after deadline, but these submissions will not be considered timely and will not be used to calculate a facility's staffing measures.

Accuracy: Staffing information is required to be accurate and a complete submission of the facility's staffing records. CMS will conduct audits to assess a facility's compliance related to this requirement. Facilities that do not meet the requirements will be considered noncompliant and subject to enforcement actions by CMS.
For Additional Information and Technical Specifications:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Nursing-HomeQualityInits/Downloads/PBJ-Policy-Manual-Final-V25-11-19-2018.pdf

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Nursing-HomeQualityInits/Staffing-Data-submission-PBJ.html

5. PRIVACY PLAN (PP)

5. PRIVACY PLAN (PP)

Policy Number	Policy
PP 1.0.0	NO INFORMATION BLOCKING RULE
PP 1.0	PRIVACY PLAN A. HIPAA PRIVACY PREFACE B. OVERSIGHT AND RESPONSIBILITY C. ROLE OF A PRIVACY OFFICER D. PRIVACY POLICY REVIEW AND REVISION
PP 1.1	PRIVACY OFFICER A. ROLE RESPONSIBILITIES B. QUALIFICATIONS
PP 2.0	PRIVACY PLAN: POLICIES AND PROCEDURES A. CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION B. SAFEGUARDING PROTECTED HEALTH INFORMATION C. MINIMUM NECESSARY D. USES AND DISCLOSURES TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS E. SECURING CONSENT/RESTRICTIONS/REQUESTS F. USES AND DISCLOSURES REQUIRING *OPPORTUNITY TO AGREE OR OBJECT* G. USES AND DISCLOSURES FOR CARE AND NOTIFICATION PURPOSES H. REQUESTS FOR AMENDMENT I. REPORTING PRIVACY CONCERNS J. RESPONDING TO PRIVACY CONCERNS K. BREACH DISCOVERY AND NOTIFICATION L. DISCIPLINARY STANDARDS FOR HIPAA PRIVACY VIOLATION M. PRIVACY EDUCATION AND TRAINING N. CONFIDENTIAL INFORMATION TRAINING
PP 2.0.1	TELEHEALTH SERVICES
PP 2.1	WORKFORCE PRIVACY PRACTICES A. PRIVACY B. NOTICE OF PRIVACY PRACTICES POLICY

	C. RESPONDING TO GOVERNMENT INQUIRIES • SUBPOENAS AND COURT ORDERS FOR MEDICAL AND PERSONNEL RECORDS • PROCEDURES FOR ASSURING COMPLIANCE WITH ALL COMPLAINTS, SUBPOENAS, SUMMONSES, AND COURT ORDERS • SUBPOENAS • COURT ORDERS D. PRIVACY COMPLAINTS
PP 2.2	MAINTAINING RESIDENT PRIVACY A. REQUESTS FOR INSPECTION AND COPYING B. USES AND DISCLOSURES FOR RESIDENT DIRECTORIES C. WHITE BOARDS D. EMAIL PRIVACY E. MAILING TO RESIDENTS F. PHOTOGRAPHING, FILMING, AND RECORDING OF RESIDENTS • PROHIBITION OF PHOTOGRAPHS AND AUDIO/VIDEO RECORDINGS G. INSTALLATION OF PERSONAL RECORDING DEVICES
PP 2.3	SOCIAL MEDIA AND NETWORKING A. SOCIAL MEDIA/NETWORKING AND INTERNET COMMUNICATIONS B. COMPUTER AND INTERNET USAGE C. VIDEO SURVEILLANCE POLICY
PP 2.4	IDENTITY THEFT A. IDENTITY THEFT PREVENTION PLAN B. IDENTITY THEFT PREVENTION PROGRAM GOVERNING BODY RESOLUTION C. VERIFYING PERSONAL IDENTITY D. RED FLAGS FOR IDENTITY THEFT E. INVESTIGATION OF SUSPECTED IDENTITY THEFT F. DISPOSITION OF MEDICAL RECORDS WHEN IDENTITY THEFT IS CONFIRMED

Policy Number: PP1.0.0

Policy Title: No Information Blocking Policy

Policy Statement/Purpose: The purpose of this policy is to support CompanyName's commitment to facilitating the timely Access, Exchange, and Use of Electronic Health Information (EHI) in compliance with federal and state law ("Applicable Law"). CompanyName will implement this policy in a consistent and non-discriminatory manner.

Policy Interpretation and Implementation:

This policy applies to CompanyName's workforce members, including Company employees, volunteers, interns, appointees, associates, consultants, vendors, agents, executives, and Governing Body members (collectively, "Workforce Members"). CompanyName's Privacy Officer has general responsibility for implementation of CompanyName's policies and procedures relating to health information, including this No Information Blocking Policy.

CompanyName and its Workforce Members will comply with CompanyName's health information policies and procedures and all Applicable Law in connection with the Access, Exchange, or Use of EHI, including this No Information Blocking Policy and the Information Blocking Rule.

The Information Blocking Rule prohibits Actors—including CompanyName and its Workforce Members—from engaging in practices (such as acts and omissions) that are likely to interfere with the Access, Exchange, or Use of EHI, unless the practice is required by law or covered by a regulatory exception (collectively, "Safe Harbors"). **The Information Blocking Rule does not require CompanyName to disclose EHI if doing so would violate other Applicable Law, such as HIPAA or other state or federal privacy laws applicable to CompanyName.**

The Information Blocking Rule is intent based. That means failure to satisfy a Safe Harbor does not mean that there is a violation of the Information Blocking Rule. However, CompanyName strives to satisfy the conditions of any applicable Safe Harbor when engaging in practices that might implicate the Information Blocking Rule. Accordingly, Workforce Members will follow this policy and all relevant procedures when engaging in practices that involve the Access, Exchange, or Use of EHI over which CompanyName has control.

I. KEY DEFINITIONS

A. **Access** means the ability or means necessary to make electronic health information available for Exchange, or Use.

B. **Actor** means a health care provider (as defined in 42 U.S.C. § 300jj), a health IT developer of certified health IT or a health information network/health information exchange, all as defined by the Information Blocking Rule at 45 C.F.R. § 171.102.

C. **Applicable Law** means federal and state statutes and regulations that apply to CompanyName.

D. **Designated Record Set (DRS)** means medical records, billing records, or any other group of records maintained by or for a covered health care provider to make decisions about individuals.

E. **Electronic Access** means an internet-based method that makes EHI available at the time the EHI is requested and where no manual effort is required to fulfill the request.

F. **Electronic Health Information (EHI)** means Electronic Protected Health Information contained in a Designated Record Set. It does not include Psychotherapy Notes or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding. EHI also excludes any information that has been de-identified in accordance with HIPAA's de-identification standards. And until May 2, 2022, the definition of EHI may be further limited to those data elements represented in the USCDI (version 1).

G. **Electronic Protected Health Information (ePHI)** means individually identifiable health information (as defined by HIPAA) that is transmitted by electronic media or maintained in electronic media.

H. **Exchange** means the ability for EHI to be transmitted between and among different technologies, systems, platforms, or networks.

I. **Fee** means any present or future obligation to pay money or provide any other thing of value.

J. **HIPAA** collectively refers to the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and their implementing regulations (see 45 C.F.R. Parts 160, 162, and 164), all as amended from time to time.

K. **Information Blocking Rule** collectively refers to 42 U.S.C. § 300jj-52 and its implementing regulations 45 C.F.R. Part 171.

L. **Interoperability Element** means hardware, software, integrated technologies or related licenses, technical information, privileges, rights, intellectual property, upgrades, or services that may be necessary to Access, Exchange, or Use EHI; and are controlled by the Actor, which includes the ability to confer all rights and authorizations necessary to use the element to enable the Access, Exchange, or Use of EHI.

M. **Required by Law** means a practice that is explicitly required by state or federal law, including statutes, regulations, court orders, binding administrative decisions or settlements, as well as tribal law (as applicable). Required by Law does not mean practices permitted by law or engaged in pursuant to a law, such as privacy laws that require an individual's consent or authorization prior to disclosing EHI to the requestor.

N. **United States Core Data for Interoperability (USCDI) (version 1)** means the standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange, which are published by The Office of the National Coordinator for Health Information Technology on its USCDI website.

O. **Use** means the ability for EHI, once Accessed or Exchanged, to be understood and acted upon.

II. SAFE HARBORS

If a practice falls within a Safe Harbor, it will not violate the Information Blocking Rule. All of the regulatory conditions must be met in order for a Safe Harbor to apply. More than one Safe Harbor may apply.

A. **Preventing Harm Safe Harbor**

1. So long as the conditions of the Preventing Harm Safe Harbor are met, it will not be information blocking if a practice substantially reduces a regulatory cognizable risk of harm to a natural person.

2. **Application to individuals and legal representatives.** CompanyName will follow its HIPAA ("Privacy Plan") Policies and related procedures with respect to granting, delaying, or denying an individual's (or legal representative's request to access the individual's EHI, including any rights such individuals'/legal representatives' might have to have a denial determination reviewed and potentially reversed.

3. **Application to other EHI requestors.** For requestors other than an individual or legal representative, CompanyName may delay, deny, or otherwise interfere with the requestor's Access, Exchange, or Use of EHI, if CompanyName holds a reasonable belief that the practice will substantially reduce a risk of harm to the life or physical safety of a natural person under one of the following circumstances:
   a. A licensed health care professional—who has a current or prior clinical-patient relationship with the individual whose EHI is affected—makes this risk of harm determination on an individualized basis and in the exercise of professional judgment; or
   b. This risk of harm arises from data that is known or reasonably suspected to be misidentified or mismatched, corrupt due to technical failure, or erroneous for another reason (collectively, "Corrupted Data"). An incomplete medical record or sporadic data entry errors do not constitute Corrupted Data.
   c. Under either circumstance, CompanyName's practice will be no broader than necessary in order to substantially reduce the risk of harm to the life or physical safety of a natural person. This risk of harm must be reasonably likely to occur but for CompanyName's interference with the Access, Exchange, or Use of EHI. The Workforce Member who makes the risk of harm determination will document this determination. If it is appropriate to do so, this documentation may be kept in the affected individual's medical record.

4. CompanyName will also follow other applicable Safe Harbors—such as the Content and Manner Safe Harbor or Infeasibility Safe Harbor—in circumstances where the Preventing Harm Safe Harbor applies to only a portion of the EHI requested but it is not feasible for CompanyName to provide Access, Exchange, or Use of the rest of the requested EHI in the manner it is requested due to technical or administrative limitations (such as lacking data segmentation capabilities to sequester only the Corrupted Data).

5. CompanyName will implement its practices under this Safe Harbor (including any applicable HIPAA policies and procedures) in a consistent and non-discriminatory manner.

B. **Privacy Safe Harbor**

1. It will not be information blocking if CompanyName engages in privacy-related practices, so long as the conditions of the Privacy Safe Harbor are met.

2. CompanyName will follow its HIPAA Individual Access Policies and related procedures with respect to granting, delaying, or denying an individual's (or personal representative's) request to access the individual's EHI, including those circumstances where the HIPAA right to access denial is not reviewable or it is not appropriate to treat a person as an individual's personal representative.

3. CompanyName will follow its HIPAA Use and Disclosure Policies and related procedures with respect to granting, delaying, or denying a third-party's request for Access, Exchange, or Use of EHI, including when a legal precondition must be met.
   a. CompanyName's practices are tailored to satisfy applicable legal preconditions and are implemented in a consistent and non-discriminatory manner.
   b. Examples of legal preconditions for compliance with health information privacy laws that apply to CompanyName include, but are not limited to:
      1. **Authorizations/Consents**. Depending on who is requesting the EHI and for what purpose, CompanyName may be required by state or federal privacy laws to obtain a signed authorization or consent from the individual or the individual's personal representative. The state or federal privacy law might require that the authorization or consent used meet certain requirements.
         i. CompanyName has a policy or procedure that sets forth the necessary elements of any required authorizations or consents.
         ii. When a requestor submits an authorization or consent that CompanyName determines pursuant to this policy or procedure is not valid, CompanyName will use reasonable efforts within its control to provide the requestor with a consent or authorization form that satisfies the requirements or otherwise provide reasonable assistance with respect to the deficiencies.
         iii. CompanyName will not improperly encourage or induce an individual to withhold the authorization or consent.

      2. **Verification of Identity and Authority**. CompanyName may be required by state or federal privacy laws to verify the identity and authority of a person requesting access to EHI. CompanyName tailors its verification practices to meet legal requirements and health care industry standard security procedures (see the Security Safe Harbor).

4. CompanyName may also elect to not provide Access, Exchange, or Use of EHI if the following conditions are met:
   a. The individual, who is the subject of the EHI, requests that CompanyName not provide such Access, Exchange, or Use of the individual's EHI.

1. CompanyName will not improperly encourage or induce an individual to make such a request.
2. CompanyName will follow any applicable HIPAA policies and procedures when evaluating whether to grant the request.
3. CompanyName will document the request within a reasonable time period after the request is made.
4. CompanyName will implement any practice of granting an individual's request not to share EHI in a consistent and non-discriminatory manner.
5. CompanyName may terminate an individual's request for a restriction only under one of the following circumstances:
   i. The individual agrees to the termination in writing or requests the termination in writing;
   ii. The individual orally agrees to the termination and CompanyName documents the oral agreement; or;
   iii. CompanyName informs the individual that it is terminating its agreement, except that such termination is not effective to the extent prohibited by Applicable Law and only applicable to EHI created or received after CompanyName has informed the individual of the termination.

5. CompanyName will also follow other applicable Safe Harbors—such as the Content and Manner Safe Harbor or Infeasibility Safe Harbor—in circumstances where the Privacy Safe Harbor applies to only a portion of the EHI requested, but it is not feasible for CompanyName to provide Access, Exchange, or Use of the rest of the requested EHI due to technical or administrative limitations (such as lacking data segmentation capabilities to sequester only the EHI subject to the Privacy Safe Harbor).

C. **Security Safe Harbor**

1. It will not be information blocking if CompanyName engages in practices that protect the security of EHI, so long as the conditions of the Security Safe Harbor are met.

2. CompanyName will follow its HIPAA security policies, procedures and security risk analyses and risk management plans with respect to granting, delaying, denying, or otherwise interfering with the provision of Access, Exchange, or Use of EHI.

3. CompanyName's security practices will be:
   a. Directly related to safeguarding the confidentiality, integrity, and availability of EHI;
   b. Tailored to the specific security risk being addressed; and
   c. Implemented in a consistent and non-discriminatory manner across similarly situated persons or entities whose interactions pose the same level of security risk.

4. In the event CompanyName's HIPAA security policies and procedures do not sufficiently address a known security risk, CompanyName will document its security practice based on particularized facts and circumstances surrounding the security risk, including:
   a. Why the security practice was necessary to mitigate the security risk to EHI; and

b. That there were no reasonable and appropriate alternatives that would address the security risk and would be less likely to interfere with the Access, Exchange, or Use of EHI. This last factor will be highly dependent on the urgency and nature of the security threat in question.
    1. In the event of exigent circumstances, CompanyName may implement in good faith a security practice without first considering whether there are reasonable and appropriate alternatives that are less likely to interfere with the Access, Exchange, or Use of EHI.
        i. However, the initial-response practice may be in place for only a short time and contingent upon CompanyName more fully identifying and assessing current risks in context or as follow-up to the exigent circumstances.
        ii. If appropriate, CompanyName will modify or replace its initial-response practice with a less onerous alternative that is reasonable and appropriately tailored to the specific risk addressed.

5. CompanyName also may (but is not required to) give individuals educational information about the privacy and security risks posed by third-party applications.
    a. Such educational information will not rise to the level of an interference with the Access, Exchange, or Use of EHI so long as all three of the following requirements are met:
        1. The information focuses on current privacy and/or security risks of the technology or the third-party developer;
        2. The information is factually accurate, unbiased, objective, and is not unfair or deceptive; and
        3. The information is provided in a non-discriminatory manner.
    b. CompanyName may provide this education through an automated attestation and warning process upon request from an individual to transmit data to a third-party application.
    c. CompanyName will not prevent an individual from deciding to provide its EHI to a technology developer or third-party application despite any risks noted regarding the application itself or the third-party developer.

6. CompanyName will not engage in security practices that have the practical effect of disadvantaging competitors or steering referrals.

D. **Content and Manner Safe Harbor**

1. CompanyName strives to fulfill requests for Access, Exchange, or Use of EHI in the manner it is requested and in compliance with Applicable Law. If CompanyName fulfills such an EHI request in the manner it is requested any fees charged or licensing requirements imposed on the Interoperability Elements used are not required to comply with the Fees Safe Harbor or Licensing Safe Harbor. However, it will not be information blocking if CompanyName fulfills an EHI request in an alternative manner, so long as the conditions of the Content and Manner Safe Harbor are met.

2. **Content Limitation**: Until May 2, 2022, CompanyName may (but is not required to) limit its response to an EHI request to only those data elements represented by the data elements in the USCDI (v1) standard. This option will not be available after May 2, 2022.

3. **Alternative Manner Option**. CompanyName may respond to an EHI request in an alternative manner if one of the following circumstances applies:
   a. CompanyName is technically unable to fulfill the request; or
   b. CompanyName is unable to reach agreeable terms with the requestor.
   c. If CompanyName is technically unable to fulfill the request in the manner requested or cannot reach agreeable terms with the requestor, CompanyName will fulfill the request in an alternative manner and without unnecessary delay, unless it is infeasible for CompanyName to do so (see the Infeasibility Safe Harbor).
   d. CompanyName will notify the requestor within ten (10) business days of the request if fulfilling the EHI request in the manner requested or in an alternative is infeasible.
   e. If responding in an alternative manner is feasible, CompanyName will technically fulfill the request using the technical standards listed below in the following order of priority, only proceeding to the next technical standard if CompanyName is technically unable to fulfill the request using the higher priority standard:
      1. Using certified technology specified by the requestor (e.g., via application programming interface (API), Direct protocol);
      2. Using content and transport standards specified by requestor and published by the federal government or standards development organization accredited by the American National Standards Institute (ANSI); or
      3. Using an alternative machine-readable format agreed upon with the requestor (e.g., Portable Document Format (PDF), comma-separated value (CSV) files).

4. CompanyName may also require the requestor to first agree to licensing terms for the Interoperability Elements and/or fees in accordance with the Licensing Safe Harbors and Fees Safe Harbor.
   a. If applicable, CompanyName will begin negotiating any licensing terms within ten (10) business days of the request and offer a negotiated license within thirty (30) business days of the request.

E. Infeasibility Safe Harbor

1. It will not be information blocking if CompanyName faces legitimate practical challenges that may limit CompanyName's ability to comply with a request for Access, Exchange, or Use of EHI, so long as the conditions of the Infeasibility Safe Harbor are met.

2. If CompanyName makes an infeasibility determination for any of the three reasons stated below in E(2)(a)-(c), i.e. Uncontrollable Events, Data Segmentation, or Infeasible Under the Circumstance, CompanyName will notify the requestor of the infeasibility determination in writing, to include the reason(s) for the infeasibility determination, within 10 business days of the EHI request. It may be infeasible for CompanyName to fulfill a request for Access, Exchange, or Use of EHI under the following circumstances:

a. **Uncontrollable Events.** CompanyName may not be able to fulfill an EHI request due to a natural or human- made disaster, public health emergency, public safety incident, war, terrorist attack, civil insurrection, strike or other labor unrest, telecommunication or internet service interruption, or act of military, civil or regulatory authority.
b. **Data Segmentation**. CompanyName may not be able to fulfill an EHI request because CompanyName cannot unambiguously segment the requested EHI from EHI that cannot be disclosed due to an individual's privacy preferences or legal requirements (see the Privacy Safe Harbor), or because the EHI may be withheld under the Preventing Harm Safe Harbor.
c. **Infeasible under the Circumstances**. CompanyName may determine based on the following factors that complying with the EHI request is not feasible:
    1. The type of EHI and the purposes for which it may be needed;
    2. The cost of complying with the request in the manner requested;
    3. The financial and technical resources available to CompanyName;
    4. Whether CompanyName's practice is nondiscriminatory in its application to others with whom CompanyName has a business relationship;
    5. Whether CompanyName owns or has control over a predominant technology or platform through which the EHI is Accessed or Exchanged; and
    6. Why CompanyName could not make the EHI available under the Content and Manner Safe Harbor.
    7. In making such a determination of infeasibility, CompanyName must not consider any of the following factors:
        i. Whether complying with the EHI request in the manner requested would facilitate competition with CompanyName;
        ii. Whether complying with the EHI request would prevent CompanyName from charging a fee or will result in a reduced fee to CompanyName.

3. CompanyName will document its consideration of these factors in writing and prior to responding to the EHI request. CompanyName will apply these factors consistently and in a non-discriminatory manner.

F. Fees Safe Harbor

1. CompanyName is not required to comply with the Fees Safe Harbor if CompanyName is able to provide Access, Exchange, or Use of EHI in the manner it is requested under the conditions of the Content and Manner Safe Harbor. However, if CompanyName will respond to the EHI request in an alternative manner, CompanyName will not violate the Information Blocking Rule by charging a reasonable fee, so long as conditions of the Fees Safe Harbor are met. This Safe Harbor does not permit or support the sale of EHI.

2. CompanyName will follow its HIPAA Individual Access Policies and related procedures with respect to any fees charged to an individual's (or personal representative's) request to access the individual's EHI. CompanyName will not charge any fees that are prohibited by HIPAA or based in any part on the Electronic Access of an individual's EHI by the individual, their personal representative, or another person or entity designated by the individ-

ual. For example, CompanyName will not charge fees for Electronic Access if an individual directs CompanyName to disclose the individual's EHI to a biomedical research program, a personal health application or a personal health record of the individual's choosing.

3. For requestors other than an individual or personal representative, CompanyName may (but is not required to) impose a fee on the Access, Exchange, or Use of EHI, so long as the fee is based on the following:
   a. Objective and verifiable criteria that are uniformly applied for all similarly situated classes of persons or entities and requests;
   b. Reasonably related to CompanyName's costs of providing the type of Access, Exchange, or Use of EHI to, or at the request of, the person or entity to whom the fee is charged;
   c. Reasonably allocated among all similarly situated persons or entities to whom the technology or service is supplied, or for whom the technology is supported; and
   d. Costs not otherwise recovered for the same instance of service to a provider and third-party.
   e. Any fees charged will not be based on any of the following (if applicable):

4. Whether the requestor or other person is a competitor, potential competitor, or will be using the EHI in a way that facilitates competition with CompanyName;

5. Sales, profit, revenue, or other value that the requestor or other persons derive or may derive from the Access, Exchange, or Use of the EHI;

6. Costs CompanyName incurred due to the health IT being designed or implemented in a non-standard way, unless the requestor agreed to the fee associated with the non-standard design or implementation to Access, Exchange, or Use the EHI;

7. Costs associated with intangible assets other than the actual development or acquisition costs of such assets;

8. Opportunity costs unrelated to the Access, Exchange, or Use of EHI;

9. Any costs that led to the creation of intellectual property, if CompanyName charged a royalty for that intellectual property under the Licensing Safe Harbor and that royalty included the development costs for the creation of the intellectual property; or

10. Fees to perform an export of EHI via certified health IT for the purposes of switching health IT or to provide patients their EHI, or a fee to export or convert data from an EHR technology that was not agreed to in writing at the time the technology was acquired.

G. **Licensing Safe Harbor**

1. CompanyName is not required to comply with the Licensing Safe Harbor if CompanyName is able to provide Access, Exchange, or Use of EHI in the manner it is requested under the conditions of the Content and Manner Safe Harbor. However, if CompanyName

will respond to the EHI request in an alternative manner, CompanyName will not violate the Information Blocking Rule by imposing terms and conditions (e.g., a license or non-disclosure agreement) on the requestor's use of Interoperability Elements to Access, Exchange, or Use EHI, if the requirements of the Licensing Safe Harbor are met.

2. In the event CompanyName licenses the use of Interoperability Elements to Access, Exchange, or Use EHI in an alternative manner, CompanyName will:
   a. Begin license negotiations with a requestor within ten (10) business days of the request; and
   b. Negotiate in good faith a license within thirty (30) business days of the request.
   c. The license will meet all of the following requirements (as applicable):
      1. **Scope of License**. It will provide all rights necessary to enable the Access, Exchange, or Use of EHI achieve the intended Access, Exchange, or Use of EHI via the Interoperability Elements.
      2. **Royalty**. If a royalty is charged, the royalty will be reasonable, non-discriminatory, and based solely on the independent value of CompanyName's technology to the licensee's products. A royalty will not be based on any strategic value stemming from CompanyName's control over essential means of Accessing, Exchanging, or Using EHI. If CompanyName has licensed the Interoperability Element through a standards developing CompanyName, CompanyName may charge a royalty that is consistent with such policies. However, CompanyName will not charge a royalty for intellectual property if CompanyName recovered any development costs that led to the creation of the intellectual property.
      3. **Non-Discriminatory**. The licensing terms will be based on objective and verifiable criteria that are uniformly applied for all similarly situated classes of persons and requests. The terms will not be based on whether the requestor or other person is a competitor, potential competitor, or will be using EHI obtained in a way that facilitates competition with CompanyName or the revenue or other value the requestor may derive from the Access, Exchange, or Use of EHI obtained via the Interoperability Elements.
      4. **Collateral Terms**. CompanyName will not require the requestor to do any of the following:
         i. Execute a non-compete in any product, service, or market;
         ii. Deal exclusively with CompanyName in any product, service, or market;
         iii. Obtain additional licenses, products, or services that are not related to or can be unbundled from the requested Interoperability Elements;
         iv. License, grant, assign, or transfer to CompanyName any intellectual property of the licensee; or
         v. Pay a fee of any kind unless the Fees Safe Harbor is met.
   d. If CompanyName will require the use of a non-disclosure agreement in connection with the use of Interoperability Elements to Access, Exchange, or Use EHI, the NDA must meet the following requirements:
      1. It must be reasonable; and
      2. No broader than necessary to prevent the unauthorized disclosure of CompanyName's trade secrets. The information CompanyName claims as trade secrets must

be stated with particularity in the NDA and such information must meet the definition of a trade secret under Applicable Law.

e. Finally, when provisioning a requestor with use of CompanyName's Interoperability Elements, CompanyName will not engage in any practice that has any of the following purposes or effects:
   1. Impedes the efficient use of the Interoperability Elements to Access, Exchange, or Use EHI for permissible purposes;
   2. Impedes the efficient development, distribution, deployment, or use of an interoperable product or service for which there is actual or potential demand; and/or
   3. Degrade the performance or interoperability of the licensee's products or services, unless necessary to improve CompanyName's technology and after affording the licensee a reasonable opportunity to update its technology to maintain interoperability.

II. EDUCATION AND TRAINING ON THE INFORMATION BLOCKING RULE

A. CompanyName will provide appropriate training to Workforce Members on this policy and the Information Blocking Rule. CompanyName will perform this training on a periodic and ongoing basis.
   1. **Initial Training**. CompanyName will ensure Workforce Members receive training appropriate to the Workforce Member's position and responsibilities concerning the Information Blocking Rule. All Workforce Members will participate in training when requested by CompanyName.
   2. **Periodic and Ongoing Training**. Workforce Members will receive periodic or updated training concerning the Information Blocking Rule appropriate to the Workforce Member's position and responsibilities. If there is a material change in this policy, CompanyName will provide re-training to all affected Workforce Members within a reasonable period of time after the effective date of the material change. CompanyName's Privacy Official will determine the frequency of training, which may differ for certain Workforce Members depending on the Workforce Member's role and responsibilities. Compliance and education are an ongoing process and any compliance issues will be addressed as they arise.

B. **Training and Education Format and Content**
   1. CompanyName will prepare education and training materials tailored to Workforce Members' role, level of education, primary language, and that are mindful of cultural diversity.
   2. Workforce Members will receive a copy of this No Information Blocking Policy and CompanyName's HIPAA policies and procedures.
   3. Workforce Members will be educated on the Information Blocking Rule and the Safe Harbors applicable to CompanyName.
      a. CompanyName will instruct Workforce Members on how to identify and report noncompliance with this No Information Blocking Policy and the Information Blocking Rule.
      b. Workforce Members will be informed of CompanyName's sanctions policy for noncompliance with this No Information Blocking Policy, the Information Blocking Rule and CompanyName's HIPAA policies.

c. Workforce Members will be provided an opportunity to ask questions and receive answers. CompanyName will encourage Workforce Members to ask questions as they arise after the conclusion of training.
d. Upon completion of training, Workforce Members will complete an assessment evaluating their comprehension of this No Information Blocking Policy and the Information Blocking Rule.
e. CompanyName will maintain a written record of the content of any training provided and a written acknowledgement by the Workforce Members that they participated in the training. The written acknowledgement may be in the form of the Workforce Member's signature on a sign-in sheet or any other written form that the Workforce Member signs.

IV. INFORMATION BLOCKING REPORTING

A. **Information Blocking Reporting and No Retaliation**.

1. Workforce Members that reasonably believe CompanyName or one of its Workforce Members (including any affiliate, agent, or vendor) is violating this No Information Blocking Policy or the Information Blocking Rule must promptly notify CompanyName.
2. Anonymous reports may be made via CompanyName's corporate compliance hotline.
3. CompanyName will not retaliate against any Workforce Member for reporting a suspected or actual violation of this No Information Blocking Policy or the Information Blocking Rule.

B. **Investigations**

1. CompanyName's Privacy Official (or designee) will respond to all allegations of information blocking and, where appropriate, investigate such allegations within a reasonable period of time.
2. As part of the investigation, the Privacy Official (or designee) will:
   a. Identify all persons who were involved in the alleged information blocking practice and interview them;
   b. Identify, review, and preserve all relevant documentation, including relevant policies and procedures, e-mails, correspondence, notes, files, and other documents that may have been created by those involved in the matter;
   c. Assess whether the practice complained of implicates the Information Blocking Rule and whether the practice is required by law or falls into one or more Safe Harbors;
   d. Address and mitigate any compliance issues, including but not limited to disciplining any Workforce Members who have violated this No Information Blocking Policy or the Information Blocking Rule;
   e. Document all of the above, including the final disposition of the complaint and any disciplinary actions.

C. **Sanctions**.

1. CompanyName may discipline Workforce Members who violate this No Information Blocking Policy or the Information Blocking Rule, including Workforce Members who:

a. Fail to report actual or suspected violations of this No Information Blocking Policy or the Information Blocking Rule;
b. Engage in retaliatory behavior.

2. CompanyName will discipline Workforce Members in accordance with its sanctions policies and procedures. The level of disciplinary action imposed will depend on the severity of the violation and may include termination of employment.

Policy Number: PP 1.0

Policy Title: Privacy Plan

Policy Statement/Purpose: The Company is committed to compliance with privacy standards contained in the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

Policy Interpretation and Implementation:

A. HIPAA PRIVACY PREFACE

HIPAA privacy regulations govern the use and disclosure of unsecured Protected Health Information (PHI). To ensure the security of PHI, The Company must adhere to the requirements of the HIPAA privacy regulations:

1. Ensure the confidentiality, integrity, and availability of all PHI that The Company creates, receives, maintains, or transmits.
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted by or required under HIPAA.
4. Ensure compliance by its workforce.

The Company may use PHI for purposes of treatment, payment, and healthcare operations. For any other purpose, The Company must have the individual's authorization to disclose PHI.

In using or disclosing PHI, The Company must restrict the use or disclosure to the minimum amount necessary to accomplish the purpose of the use or disclosure. To do so, employees will be granted access only to information that they need to perform their job duties.

Pursuant to HIPAA, The Company must:

1. Designate a Privacy Officer and Security Manager. *(Reference Section C, below)*
2. Develop a committee to assist in oversight; *(Reference Section B, below)*
3. Develop and implement policies and procedures to appropriately safeguard PHI. (Reference PP 2.0 *Privacy Policies and Procedures*)
4. Train employees as to HIPAA requirements appropriate to each employee's job. (Reference PP 2.0 Privacy Policies and Procedures, *Section M, Privacy Education and Training*)
5. Have an appropriate reporting system. (Reference PP 2.0 Privacy Policies and Procedures, *Section I, Reporting Privacy Concerns*)
6. Respond to report breaches, as appropriate. (Reference PP 2.0 Privacy Policies and Procedures, *Section K, Breach Discovery and Notification*)
7. Document efforts to achieve compliance.

B. Oversight and Responsibility

1). *Overview:* The Company has a designated Privacy Committee, which has overall responsibility for oversight of privacy issues. The Privacy Committee can be a component of The Company QAA/QAPI Committee only if the Privacy Committee meeting minutes, attendance, and related activities are documented separately.

The Committee will meet as needed to review reports on The Company's privacy concerns and alleged breaches.

The Privacy Committee has specific responsibilities:

a. Analyze The Company's environment, the legal requirements with which it must comply, current governmental enforcement initiatives and specific risk areas.
b. Assess and modify existing policies and procedures that address these areas for possible incorporation into the Privacy Program.
c. Work with management to develop, review, and approve policies and procedures to promote compliance with the Privacy Program.
d. Recommend and monitor, in conjunction with relevant departments, the development of internal systems and controls to carry out The Company's standards, policies, and procedures as part of its daily operations.
e. Determine the appropriate strategy/approach to promote compliance with the program, and detection of any potential breach through hotlines and other inappropriate privacy disclosure reporting mechanisms.
f. Develop a system to solicit, evaluate, and respond to complaints and problems.
g. The Privacy Officer will provide an internal activity report to the Privacy Committee at its request. A new plan of action will be collectively decided upon by the entire Committee, to address any concerns or issues raised.

C. Role of a Privacy Officer

The Privacy Officer, appointed by the Governing Body, is responsible for enacting preventative measures, including education and policy, to ensure that PHI is kept secure and is limited to the minimum amount necessary to accomplish the purpose of the use or disclosure and that such preventative measures do not violate CompanyName's No Information Blocking Policy. In addition, working in collaboration with the Compliance and Ethics attorney and The Company's Privacy Committee, the Privacy Officer is directly involved with investigations of potential PHI breaches and reporting any confirmed breaches together with investigations and reporting of violations of CompanyName's No Information Blocking Policy. The Privacy Officer ensures the planning, coordination, implementation, evaluation, analysis, and reporting of activities, policies, procedures, and standards pertaining to The Company Privacy Plan.

The Privacy Officer role may be subsumed in a discipline/department specific title and job description and be accountable to a direct supervisor, but, in collaboration with the Compliance and Ethics Officer, is accountable to the Governing Body for all compliance and ethics management activities.

D. Privacy Policy Review and Revision

(CHANGES TO PRIVACY POLICY, PROCEDURE, FORMS, LOGS, AND AGREEMENTS)

1). *Overview:* The Privacy Committee shall review the Privacy Plan at least annually to reflect changes to Company business practices as well as changes to applicable laws, rules, and regulations. The review and revision include *changes to privacy, policy, procedure, forms, logs, and agreements* and the Privacy Committee shall document any such changes. Revised policies and procedures shall become effective upon approval by the Privacy Officer and Privacy Committee.

2). *Procedure:*

a. The Privacy Officer is responsible for developing and maintaining all appropriate privacy policies and procedures.
b. All policies and procedures must be in written form.
c. The Privacy Officer, Compliance and Ethics Officer, Legal Counsel, and Compliance and Ethics Committee must approve all policies and procedures for privacy and security.
d. If there are material changes in policies and procedures, the affected workforce must be trained.

Policy Number: PP 1.1

Policy Title: Privacy Officer

Policy Statement/Purpose: To oversee the implementation of The Company Privacy Program and make recommendations to The Company regarding changes that must be made to enhance compliance and update the Program, as necessary, to reflect updates in expectations enumerated in applicable laws, rules, and regulations. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

Policy Interpretation and Implementation: Privacy concerns the protecting and control of individually identifiable health information. The Company recognizes the increased complexity of protecting patient privacy while managing access to, and release of, information about residents. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and rules promulgated under the Act require a Privacy Officer. In addition, there are other federal and state laws and applicable regulatory and accreditation standards that have an impact on privacy. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy (See Policy 1.0.0)

The Privacy Officer establishes and maintains accountability for privacy in The Company by ensuring the planning, coordination, implementation, evaluation, analysis, and reporting of activities, policies, procedures, and standards pertaining to The Company Privacy Plan.

Authority: The Privacy Plan is a component of The Company Compliance and Ethics Program. The Privacy Officer is appointed by the Governing Body. The Privacy Officer role may be subsumed in a discipline/department specific title and job description and be accountable to a direct supervisor, but the Privacy Officer, in collaboration with the appointed Compliance and Ethics Officer, is accountable to the Governing Body for all compliance and ethics management activities.

The Privacy Officer, or his or her designee, is responsible for:

a. Receiving and processing complaints from employees and others internal to The Company and from residents and others external to The Company. Refer to Policy PP 2.1 Section D. *Privacy Complaints*.
b. Providing further information about matters covered by the *Notice of Privacy Practices*. Refer to Policy PP 2.1 Workforce Privacy Practices, Section B.
c. Mitigating the effects of all disclosures that are contrary to The Company's Privacy Policy and Procedures or otherwise fail to comply with the law.
d. Receiving and processing restrictions on consents and revocation of consents. Refer to Policy PP 2.0 Policies and Procedures, Section E - *Securing Consent/Restrictions/Requests*.
e. Receiving and processing revocation of authorizations. Refer to Policy PP 2.0 Policies and Procedures, Section E - *Securing Consent/Restrictions/Requests*.
f. Conducting, at least annually, a review of the implementation of the minimum necessary provision. Refer to PP 2.0 Policies and Procedures, Section C, *Minimum Necessary*.
g. Conducting, at least annually, a review of access control logs.

A. Role Responsibilities of the Appointed Privacy Officer

The Privacy Officer oversees the implementation of The Company Privacy Program, makes recommendations to The Company regarding changes that must be made to enhance compliance and update the Program, as necessary, to reflect updates in expectations enumerated in applicable laws, rules, and regulations. Specific responsibilities include:

1. Maintain an accurate inventory of:
   a. all individuals who have access to The Company's confidential information, including PHI; and
   b. all uses and disclosures of The Company's confidential information by any person or entity.
2. Work with personnel in the appropriate departments to protect The Company's confidential information from unauthorized use or disclosure and compliance with Company's No Information Blocking Policy
3. Develop specific policies and procedures mandated by state and federal laws
4. Develop additional relevant policies, such as policies governing the inclusion of confidential data in emails, and access to confidential data by telecommuters.
5. Draft and disseminate the privacy notice required by the Privacy Rule
6. Determine when The Company is required under HIPAA and other state or federal law to obtain consent or authorization for use or disclosure of PHI, and draft forms as necessary
7. Determine when a request for release, use or disclosure of EHI does not fall under one of the safe harbors of the federal Information Blocking Rule and therefore must be released in accordance with the Company's No Information Blocking Policy
8. Ensure that any research efforts conducted or supported by The Company comply with appropriate privacy laws and policies and adequately protect the privacy of the data subjects
9. Review all contracts under which access to confidential data is given to outside entities, bring those contracts into compliance with the Privacy Rule and The Company's No Information Blocking Policy, and ensure that The Company's confidential data is adequately protected in compliance with the Company's No Information Blocking Policy when such access is granted
10. Ensure that all policies, procedures, and notices are flexible enough to respond to new technologies and legal requirements, or, if they are not, amend as necessary
11. Ensure that future Company initiatives are structured in such a way to ensure patient privacy
12. Conduct periodic privacy audits and take remedial actions as necessary
13. Oversee privacy training for all members of the workforce who come in contact with protected health information
14. Guard against retaliation against individuals who seek to enforce their own privacy rights or those of others
15. Remain up-to-date and advise on new technologies to protect data privacy
16. Remain up-to-date on laws, rules, and regulations regarding data privacy and right to access, and update The Company's policies and procedures as necessary
17. Track pending legislation regarding data privacy and, if appropriate, seek to influence that legislation
18. Anticipate residents' concerns and questions about The Company's use of their confidential information and develop policies and procedures to respond to those concerns and questions
19. Evaluate privacy implications of any future on-line, web-based applications
20. Monitor any data collected by, or posted on The Company's web sites for privacy concerns

21. Serve as liaison to government agencies, industry groups, and other interest groups in matters relating to The Company's privacy practices

B. Qualifications for a Privacy Officer

1. Familiarity with all federal, state, and local statutes and regulations concerning privacy
2. Familiarity with The Company's systems and operations
3. Ability to work with complex statutory schemes
4. Ability to work with complex information systems
5. Ability to manage large projects
6. Ability to write concisely, to express thoughts clearly, and to develop ideas in a logical sequence
7. Ability to make presentations to large groups
8. Ability to influence decision makers
9. Ability to compromise and think creatively when faced with difficult situations
10. Ability to supervise, motivate, and coordinate the efforts of subordinates and colleagues
11. Strong organizational and problem-solving skills
12. Strong leadership skills
13. Strong interpersonal skills
14. Ability to effectively communicate both technical and legal information to non-technical and non-legal staff

Policy Number: PP 2.0

Policy Title: Privacy Policy and Procedures

Policy Statement/Purpose: The Company written policies and procedures that describe relevant regulations and how they should be implemented. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

Policy Interpretation and Implementation: The Privacy Officer is responsible for developing and maintaining all privacy-related policies and procedures. Written policies and procedures are reviewed and revised periodically to reflect changes to Company business practices as well as changes to applicable laws, rules, and regulations. Revised policies and procedures shall become effective upon approval by the Privacy Officer and Privacy Committee. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

A. CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

1). Overview: The Company protects personal health information to ensure that residents are not afraid to seek healthcare or to disclose sensitive information to The Company. Personal health information is protected during its collection, use, disclosure, storage, and destruction within The Company in accordance with the provisions of state and federal regulations.

2). Definitions:

a. **Personal Health Information (PHI)** – All information, recorded or exchanged verbally about an identifiable patient:
   1. That can identify an individual including, but not limited to, name, birthdate, social security number, diagnosis, or medical record number. The patient's health and healthcare history, including genetic information about the patient or the patient's family.
   2. What The Company has learned or observed, including conduct or behavior that may be a result of illness or the effect of treatment.
   3. The provision of healthcare to the patient.
   4. Payment for healthcare provided to the patient, and includes:
      - The Personal Health Identification Number and any other number, symbol, or identifier assigned to a patient
      - Any identifying information about the patient that is collected during, and is incidental to, the provision of healthcare or payment for healthcare
   5. The patient's personal information, including financial position, home conditions, domestic difficulties, or any other private matters relating to the patient which have been disclosed to staff or persons associated with The Company.

b. **Electronic Access -** means an internet-based method that makes EHI available at the time the EHI is requested and where no manual effort is required to fulfill the request.

c. **Electronic Health Information (EHI) -** means Electronic Protected Health Information contained in a Designated Record Set. It does not include Psychotherapy Notes or information compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding. EHI also excludes any information that has been de-identified in accordance with

HIPAA's de-identification standards. And until May 2, 2022, the definition of EHI may be further limited to those data elements represented in the USCDI (version 1).

d. **Privacy Officer** – The employee, designated by The Company, whose responsibilities include dealing with requests from residents who wish to examine and copy, or to collect, personal health information collected and maintained by The Company.
e. **Persons Associated with The Company** – Includes all contracted individuals, volunteers, students, researchers, Company Medical Staff, members of the Governing Body of The Company, information managers, employees of The Company, Business Associates, or agents of any of the above.
f. **Information Manager** – The individual, corporate organization, business, or association who processes, stores, or destroys personal health information for The Company, or provides information management or information technology for The Company.

3). Confidentiality of Personal Health Information:

a. All Company employees and Persons Associated with The Company are responsible for protecting the security of all personal health information (oral or recorded in any form) that is obtained, handled, learned, heard, or viewed during his or her work or association with The Company.
b. Personal health information shall be protected during its collection, use, storage, and destruction within The Company.
c. Use or disclosure of personal health information is acceptable only in the discharge of one's responsibilities and duties (including reporting duties imposed by legislation) and based on the need to know except where otherwise prescribed by the Company's No Information Blocking Policy. Discussion regarding personal health information shall not take place in the presence of persons not entitled to such information or in public places (elevators, lobbies, cafeterias, off premises, etc.) or on social media sites.
d. The execution of a Personal Health Information Privacy Plan Acknowledgment (PP Appendix 2.0.1 C *Acknowledgement of The Company Privacy Plan*) is required as a condition of employment with The Company and signed:
    1. At the commencement of their relationship with The Company
    2. Each time there is a substantial change in an individual's position, as determined by the department, program, or division responsible for the individual
    3. For reasons, and at intervals as deemed appropriate by the department, program, or division
e. Unauthorized use or disclosure of confidential information, except where otherwise prescribed by the Company's No Information Blocking Policy, shall result in a *disciplinary response* up to and including termination of employment. A person convicted of an offense under the Health Insurance Portability and Accountability Act may be required to pay a fine. A confirmed breach of confidentiality may be reported to the individual's professional regulatory body.
f. All individuals who become aware of a possible breach of the security or confidentiality of personal health information shall follow the procedures outlined in the "Procedure if a Breach is Alleged" section below.

4). Privacy Plan Acknowledgement Procedure:

a. All Company employees, as a condition of employment, shall sign a *Privacy Plan Acknowledgment*. Administration of this pledge is handled by the employee's department, program, or

division and the original forwarded to the employee's Human Resources file. The Privacy Officer shall retain a copy.

b. All contractors engaged in providing a service for The Company, where the service provided would expose them to confidential information shall sign a *Privacy Plan Acknowledgment*. The administration of this pledge is handled by the individual in charge of contracts and the original retained by that individual. The Privacy Officer shall retain a copy.
c. All Company Governing Body members shall sign a *Privacy Plan Acknowledgment*. The administration of this pledge is handled by the Corporate Secretary who shall retain the original. The Privacy Officer shall retain a copy.
d. All Company agents who are regularly associated with The Company shall sign a *Privacy Plan Acknowledgment*. The administration of this pledge is handled by Human Resources and the original retained by Human Resources. The Privacy Officer shall retain a copy.
e. All employees of other agencies (such as nurses from temporary agencies, or employees in physicians' billing offices) who regularly associate with The Company shall sign a *Privacy Plan Acknowledgment*. The administration of this pledge is handled by the Department with which the agency has an association and the original retained in that Department. The Privacy Officer shall retain a copy.

B. Safeguarding Protected Health Information

1). *Overview:* The Company is committed to compliance with privacy laws, rules, and regulations. As such, The Company provides guidelines for safeguarding Protected Health Information (PHI) and to limit unauthorized disclosures of PHI except where required by the Company's No Information Blocking Policy. The Company shall have in place appropriate administrative, physical, and technical safeguards to protect the privacy of PHI as required by HIPAA and/or state privacy laws in accordance with the Company's No Information Blocking Policy.

The Company shall ensure, to the extent possible, that PHI is not intentionally or unintentionally used or disclosed in a manner that would violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or any other federal or state regulation governing confidentiality, privacy, and disclosure of health information.

2). *Procedure:*

a. The Company shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements, considering:
    1. The size, complexity, and capabilities of The Company
    2. The Company's technical infrastructure, hardware, and software security capabilities
    3. The costs of security measures
    4. The probability and criticality of potential risks to Electronic Protected Health Information (ePHI)
b. The Company may change its policies and procedures at any time, provided that the changes are documented and are implemented in accordance with applicable laws, rules, and regulations.
c. The Company shall maintain the policies and procedures in written (which may be electronic) form and, if an action, activity, or assessment is required to be documented, it shall be maintained in written (which may be electronic) form.

d. The Company shall retain all documentation for six (6) years from the date of its creation or the date when it last was in effect, whichever is later. This includes policies and procedures as well as records relating to implementation, such as log-in audit information, logs of security incidents, and documentation of training.
e. The Company shall make documentation available to those persons responsible for implementing the procedures to which the documentation pertains.
f. The Company shall review documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the e-PHI.
g. Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information it holds.
h. Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level.
i. Identify an employee as a Privacy Officer/Security Manager who is responsible for the development and implementation of these policies and procedures.
j. Apply appropriate sanctions against workforce members who fail to comply with The Company's security policies and procedures.
k. Implement procedures to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports.

3). *Oral Disclosures:* Reasonable measures shall be taken to assure that unauthorized persons do not overhear conversations involving PHI.

4). *Written Disclosures:* All documents containing PHI shall be stored appropriately to reduce the potential for incidental use or disclosure. Documents shall not be easily accessible to any unauthorized staff or visitors.

5). *Computer Access:*
a. Only staff members who need to use computers to accomplish work-related tasks shall have access to computer workstations or terminals.
b. All users of computer equipment must have unique login and passwords.
c. It is recommended that passwords be changed every ninety (90) days.
d. Posting, sharing, and any other disclosure of passwords and/or access codes is **strongly discouraged.**
e. Access to computer-based PHI shall be limited to staff members who need the information for treatment, payment, or healthcare operations.
f. Staff members shall log off their workstation when leaving the work area.
g. Computer monitors shall be positioned so that unauthorized persons cannot easily view information on the screen.
h. Employee access privileges will be removed promptly following their departure from employment.
i. Employees will immediately report any violations of this Policy to their supervisor or Privacy Officer/Security Manager.

6). *Printers, Copiers, and Fax Machines*:
a. Printers and fax machines will be in areas not easily accessible to unauthorized persons.

b. If equipment cannot be relocated to a secure location, a sign will be posted near the equipment indicating that unauthorized persons are prohibited from viewing documents from the equipment. Sample language: "Only authorized staff may view documents generated by this (indicate printer, copier, fax, etc.). Access to such documents by unauthorized persons is prohibited by federal law."
c. Documents containing PHI will be promptly removed from the printer, copier, or fax machine and placed in an appropriate and secure location.
d. Documents containing PHI that must be disposed of due to error in printing will be destroyed by shredding or by placing the document in a secure recycling or shredding bin until destroyed.

7). *Destruction:*
Written: Documentation shall be destroyed promptly when it is no longer needed by shredding or placing the information in a secure recycling or shredding bin until the time that it is destroyed.

Electronic: Prior to the disposal of any computer equipment, including donation, sale, or destruction, The Company must determine if PHI has been stored in this equipment and will delete all PHI prior to the disposal of the equipment.

8). *Monitoring Compliance:* Compliance with The Company's privacy policies and procedures shall be monitored on an ongoing basis to ensure compliance. In the event The Company identifies noncompliance through report or audit, the Privacy Officer shall immediately investigate and correct the noncompliance as well as put into place necessary corrective action, such as review and modification of policies and procedures as well as training for appropriate individuals.

C. Minimum Necessary

1). *Overview:* The HIPAA Privacy Rule requires The Company to make reasonable efforts not to use or disclose more than the minimum amount of Protected Health Information (PHI) necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. When using or disclosing PHI, or when requesting PHI from another covered entity or business associate, The Company must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the HIPAA Privacy Rule and the Company's No Information Blocking Policy.

The Company has processes in place to implement policies and procedures that comply with the Minimum Necessary provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Minimum necessary provisions do not apply to treatment. Healthcare cannot stop while decisions are being made. Healthcare often requires easy access to information, especially in urgent or emergent situations. The HIPAA Privacy Rule minimum necessary standard also does not apply to the following:
a. Disclosures to or requests by a health care provider for treatment purposes.
b. Disclosures to the individual who is the subject of the information.
c. Uses or disclosures made pursuant to an individual's authorization.
d. Uses or disclosures required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Rules.

e. Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the Privacy Rule for enforcement purposes.
f. Uses or disclosures that are required by other law.

2). *Procedure:* All new workflow and information systems are designed/acquired to meet the minimum necessary provisions of HIPAA. The Company removes identifiers and removes data fields that are not necessary to fit the purpose of the use or disclosure.
a. Diagnoses do not generally have to be exposed to administrators dealing with billing amounts.
b. The De-Identification and Establishing Access Control policies and procedures are the principal policies and procedures through which the minimum necessary provisions are implemented.
c. The Privacy Officer will review the compliance with the Minimum Necessary provisions annually and recommend actions to senior management.
d. When using or disclosing PHI subject to the HIPAA Privacy Rule minimum necessary standard, The Company must identify those persons or classes of persons, as appropriate, in its workforce who need access to PHI to carry out their duties and, for each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.
1. The Company shall limit access to PHI to that which is appropriate for the person or class of persons to carry out their duties.
2. The Company shall review requests for disclosure on an individual basis to ensure that the PHI disclosed is limited to the amount reasonably necessary to achieve the purpose of the disclosure.
3. The Company shall limit any request for protected health information to that which is reasonably necessary to accomplish the purpose for which the request is made, when requesting such information from other covered entities.
- The Company shall not use, disclose, or request an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request and in accordance with the Company's No Information Blocking Policy.

e. The Company may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:
1. Making disclosures to public officials, so long as (1) the disclosure is otherwise permitted under The Company policies and procedures as well as applicable laws, rules, and regulations, and (2) the public official represents to The Company in writing that the information requested is the minimum necessary for the stated purpose
2. The information is requested by another covered entity
3. The information is requested by a professional who is a member of The Company's workforce or is a business associate of The Company for the purpose of providing professional services to The Company, so long as the professional represents that the information requested is the minimum necessary for the stated purpose
4. The requested EHI is required to be released pursuant to the Company's No Information Blocking Policy and is not protected under the policy's safe harbors.

f. Exceptions to the Minimum Necessary Requirement:
1. Disclosures to, or requests by, a healthcare provider for treatment
2. Uses or disclosures made to the individual

3. Uses or disclosures made pursuant to a valid authorization
4. Disclosures made to the Secretary HHS
5. Uses or disclosures that are required by law including, but not limited to, the 21st Century Cures Act and its Information Blocking Rule
6. Other uses and disclosures that are required for compliance with HIPAA requirements

Employees who use or access PHI for reasons not related to their job duties, or who disclose PHI to any party for any reason not related to their job duties and in violation of state and federal law shall be subject to discipline, up to and including termination.

D. Uses and Disclosures to Carry Out Treatment, Payment, or Healthcare Operations

1). *Overview:* The Company may use or disclose PHI for treatment, payment, or healthcare operations, unless the use/disclosure requires authorization or is prohibited by law, rule, or regulation. The Company provides guidance for uses and disclosures of Protected Health Information (PHI) that do not request consent.

Designated types of medical records are considered more sensitive and, therefore, are not governed by this policy: communicable disease information (including HIV/AIDS information), mental health records, genetic testing information, and drug and alcohol abuse records.

2). *Procedure:*

a. Before disclosing PHI for treatment, payment, or healthcare operations, The Company must verify the identity and authority of the recipient, in accordance with The Company's policy.
b. The Company shall disclose the minimum necessary amount of PHI, in accordance with The Company's policy.
c. The Company may, but need not, obtain consent of the individual to use or disclose PHI to carry out treatment, payment, or healthcare operations.
    1. Consent is not effective to permit the use or disclosure where authorization is required.

3). *Definitions*:

Treatment - Provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for healthcare from one healthcare provider to another.

Payment - Activities undertaken by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or activities by a healthcare provider or health plan to obtain or provide reimbursement for the provision of healthcare, including but not limited to determining eligibility or coverage; coordination of benefits; adjudication or subrogation of health benefit claims; risk adjusting amounts due based on enrollee health status and demographic characteristics; billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related healthcare data processing; review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification

of charges; utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and disclosure of certain information to consumer reporting agencies.

Healthcare Operations - Any of the following activities undertaken by The Company:

a. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, except where the primary purpose is research.
b. Reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance, and health plan performance; conducting training programs in which students, trainees, or practitioners in areas of healthcare learn under supervision to practice or improve their skills as healthcare providers; training of non-healthcare professionals; and accreditation, certification, licensing, or credentialing activities.
c. Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for healthcare (including stop-loss insurance and excess of loss insurance).
d. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
e. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.
f. Business management and general administrative activities of the entity including, but not limited to:
    1. Management activities relating to implementation of, and compliance, with the requirements of this subchapter
    2. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer
    3. Resolution of internal grievances
    4. The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that, following such activity, will become a covered entity and due diligence related to such activity
    5. Creating de-identified health information or a limited data set
    6. Fundraising for the benefit of The Company

E. SECURING CONSENT/RESTRICTIONS/REQUESTS

1). *Overview:* The Company may request that residents sign an acknowledgment form, explaining that The Company may use or disclose protected health information to carry out treatment, payment, or healthcare operations prior to the use or disclosure. The form shall also refer to the Notice of Privacy Practices (Refer Appendix PP 2.0.1, Section C, *Privacy Plan Acknowledgment Form*).

The Company communicates Protected Health Information (PHI) through various means to ensure confidentiality.

2). *Procedure:* The law currently does not require that The Company obtain a signed consent for treatment, payment, or healthcare operation purposes. However, obtaining the resident's signature on an acknowledgment form ensures that the resident is aware of the provider's option to use or disclose health information for treatment, payment, or healthcare operation purposes. Additionally, it informs the resident of his/her right to request that the use or disclosure of his/her health information be restricted in some way.

Residents have the right to request that The Company communicate with them about PHI by alternative means or at alternative locations, for the communications to remain confidential. The Company shall accommodate all requests.

a. The Company must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of PHI from The Company by alternative means or at alternative locations.
b. All requests for confidential communications must be in writing.
c. The Company shall not require an explanation from the individual as to the basis for the request as a condition of providing communications on a confidential basis.
d. The Company may condition the provision of a reasonable accommodation on:
    1. when appropriate information as to how payment, if any, will be handled; and
    2. whether resident has an alternative address or other acceptable method of contact.

3). *Requests for Restriction of Use and Disclosure:* Residents may ask to restrict the way in which their health information is used or disclosed. The request must be in writing and signed and dated by the same person that signed the consent unless he or she is incapacitated. The Privacy Officer, or his or her designee, must receive the written request and determine whether it will be approved. If approved, The Company must implement the restriction. Otherwise, the person asking to restrict the use of information must be sent a denial letter. If The Company does agree to a restriction that you request, such restriction will be binding.

In any case, the Privacy Officer, or his or her designee, will retain the original and a copy of the denial letter if this should be necessary.

4). *Termination of a Restriction of Use and Disclosure:* The Company may terminate its agreement to a restriction if:

a. The resident agrees to or requests the termination in writing
b. The resident orally agrees to the termination and the oral agreement is documented
c. The Company informs the resident that it is terminating its agreement to a restriction, except that such termination is only effective with respect to protected health information created or received after the resident has been so informed

If the above criteria are met, the consent will be amended to remove the restriction.

5). *Revocation of Consent:* Residents have the right to revoke a previously signed consent. The request must be in writing and signed by the same person who signed the consent unless he or she is incapacitated. The Privacy Officer, or his or her designee, must receive the written request and determine whether it is complete. If approved, the Privacy Officer, or his or her designee, will cancel the consent; otherwise, the person asking to restrict the use of information will be sent a

denial letter. In any case, the Privacy Officer will retain the original and a copy of the denial letter should one be necessary.

F. USES AND DISCLOSURES REQUIRING *OPPORTUNITY TO AGREE OR OBJECT*

1). *Overview:* The Company may use or disclose Protected Health Information (PHI), provided that the individual is informed in advance of the use or disclosure and can agree, prohibit, or restrict the use or disclosure, in accordance with applicable laws, rules, and regulations.

The Company may orally inform the individual of and obtain the individual's oral agreement or objection to an otherwise permitted use or disclosure.

2). *Procedure:* To ensure the security of PHI, The Company must:

a. ensure the confidentiality, integrity, and availability of all PHI that The Company creates, receives, maintains, or transmits;
b. protect against any reasonably anticipated threats or hazards to the security of such information;
c. protect against any reasonably anticipated uses or disclosures of such information that are not permitted by or required under HIPAA; and
d. ensure compliance by its workforce.

G. USES AND DISCLOSURES FOR CARE AND NOTIFICATION PURPOSES

1). *Overview:* The Company may use or disclose Protected Health Information (PHI), provided that the individual is informed in advance of the use or disclosure and can agree, prohibit, or restrict the use or disclosure, in accordance with applicable laws, rules, and regulations.

The Company may orally inform the individual of and obtain the individual's oral agreement or objection to an otherwise permitted use or disclosure.

2). *Permitted Uses and Disclosures:*

a. The Company may disclose to a family member, other relative, close personal friend of the individual, or any other person identified by the individual, the PHI directly relevant to such person's involvement with the individual's healthcare or payment related to the individual's healthcare.
b. The Company may use or disclose PHI to notify or assist in the notification of (including identifying or locating), a family member, personal representative of the individual, or another person responsible for the care of the individual, of the individual's location, general condition, or death, consistent with this policy.
    1. Uses and Disclosures for Disaster Relief Purposes: The Company may use or disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for coordinating with such entities the use of disclosure for the abovementioned purposes.
        - If the individual is present, The Company shall comply with the requirements set forth below.

- If the individual is not present, The Company may, in the exercise of professional judgment, determine whether the disclosure is in the best interest of the individual and, if so, disclose only the PHI that is directly relevant to the person's involvement with the individual's care or payment related to the individual's healthcare or needed for notification purposes.

3). *Uses and Disclosures with Individual Present:*

a. If the individual is present for, or otherwise available prior to, a use or disclosure permitted by this policy, and has the capacity to make healthcare decisions, The Company may use or disclose the PHI if it:
   1. obtains the individual's agreement;
   2. provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or
   3. reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure.

4). *Limited Uses and Disclosures when the Individual is Not Present:* If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, The Company may, in the exercise of professional judgment, determine whether the disclosure is in the best interest of the individual and, if so, disclose only the PHI that is directly relevant to the person's involvement with the individual's care or payment related to the individual's healthcare or needed for notification purposes except where otherwise prescribed by the Company's No Information Blocking Policy.

5). *Uses and Disclosures when the Individual is Deceased:* If the individual is deceased, The Company may disclose to a family member, other relative, close personal friend of the individual, or any other person identified by the individual, who was involved in the individual's care or payment for healthcare prior to the individual's death, PHI of the individual that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known by The Company.

The HIPAA Privacy Rule allows disclosure of deceased residents' PHI to healthcare providers for the purposes of treatment. If the PHI about the deceased resident is relevant to the treatment of a family member, the family member's healthcare provider may obtain that information.

PHI about a deceased resident must be protected in the same manner and to the same extent as required for the PHI of living residents.

Executors, administrators, or other persons who have authority to act on behalf of a deceased resident must be treated as a personal representative with respect to PHI. In other words, The Company must treat the personal representative of a resident as the resident.

The Company may use professional judgment and its experience with common practice to make reasonable inferences of the individual's best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI.

H. REQUESTS FOR AMENDMENTS

1). *Overview:* A patient has the right to have The Company amend PHI or a record about the resident in a designated record set for as long as the PHI is maintained in the designated record set. The Company will support a resident's right to request an amendment of Protected Health Information (PHI).

2). *Request for Amendments:*

a. All requests for amendment shall be in writing to the Privacy Officer.
b. The Company may require residents to provide a reason to support a requested amendment if it informs residents in advance of such a requirement.
c. Timely action by the covered entity:
    1. The Company must act on the resident's request for an amendment no later than sixty (60) days after receipt of such a request, as follows:
        - If The Company grants the requested amendment, in whole or in part, it must make the amendment and notify the resident that the amendment has been accepted
            - The Company shall obtain the resident's identification of an agreement to have the covered entity notify the relevant persons with which the amendment needs to be shared
        - If The Company denies the requested amendment, in whole or in part, it must provide the resident with a written denial, as outlined below
        - If The Company is unable to act on the amendment within thirty (30) days, The Company may extend the time for such action by no more than thirty (30) days provided that:
            - The Company provides the resident with a written statement of the reasons for the delay and the date by which The Company will complete its action on the request; and
            - The Company shall have only one such extension.

3). *Denial of Amendment:* The Company may deny a resident's request for amendment, if it determines that the PHI or record that is the subject of the request:

a. was not created by The Company, unless the resident provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
b. is not part of the designated record set;
c. would not be available for inspection (i.e., is a psychotherapy record or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding); or
d. is already accurate and complete.

If The Company denies the requested amendment, in whole or in part, The Company must provide the resident with a timely, written denial. The denial must use plain language and contain:

a. the basis for the denial;
b. information regarding the resident's right to submit a written statement disagreeing with the denial and how the resident may file such a statement;

c. a statement that, if the resident does not submit a statement of disagreement, the resident may request that The Company provide the resident's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment; and
d. a description of how the resident may complain to The Company or to the Secretary of HHS. The description must include the name, or title, and telephone number of the Privacy Officer.

The Company shall permit the resident to submit to the covered entity a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement.
a. The Company may reasonably limit the length of a statement of disagreement.

The Company may prepare a written rebuttal to the resident's statement of disagreement. Whenever such a rebuttal is prepared, The Company shall provide a copy to the resident who submitted the statement of disagreement.

4). *Recordkeeping:* The Company must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append, or otherwise link, the resident's request for an amendment, The Company's denial of the request, the resident's statement of disagreement, if any, and The Company's rebuttal, if any, to the designated record set.

5). *Future Disclosures:*
a. If a statement of disagreement has been submitted by the resident, The Company shall identify the record or PHI in the designated record set that is the subject of the disputed amendment and append, or otherwise link, the resident's request for an amendment, The Company's denial of the request, the resident's statement of disagreement, if any, and The Company's rebuttal, if any, to the designated record set.
    1. Alternatively, at the election of The Company, an accurate summary of any such information, with any subsequent disclosure of the PHI to which the disagreement relates.
b. If the resident has not submitted a written statement of disagreement, The Company shall include the resident's request for amendment and its denial, or an accurate summary of such information, with any subsequent disclosure of the PHI only if the resident has requested such action.

6). *Actions on Notices of Amendment from Other Covered Entities:* Where The Company is informed by another covered entity of an amendment to a resident's PHI, The Company must amend the PHI in designated record sets in accordance with the amendment.

The Company shall document the titles of the persons or offices responsible for receiving and processing requests for amendments by residents and retain the documentation.

I. *REPORTING* PRIVACY CONCERNS

1.) *Overview:* The Company Privacy Program rests on the ability of staff to openly and freely communicate issues of concern to their supervisors, the Privacy Officer, and the Privacy Committee. The Company is committed to developing and supporting all lines of communication to support our efforts to detect, address, and prevent privacy breaches, including a method of anonymous reporting.

2). *Implementation:* The Company has established reporting procedures, readily accessible to all employees, vendors, executives, governing body members, and residents. Reports of privacy concerns and breaches are taken seriously and investigated accordingly. This policy includes reporting intimidation or retaliation to the Privacy Officer.

The Company's Privacy Officer is contacted with questions about applicable laws, rules, or regulations, or to report potential breaches or any concerns regarding privacy. To the extent possible, all communications to the Privacy Officer will remain confidential.

Should any individual feel uncomfortable making a report to the Privacy Officer, he/she has the option of making a report to The Company Compliance Hotline (800-557-1066), which allows for anonymous reporting of issues without fear of retribution. Signs with information for contacting the Hotline are visible throughout The Company.

All reports must be made in good faith. There will be no adverse action or retaliation against any staff member who makes a good faith report of a privacy concern. (Reference CP 2.0, *Section B, Compliance Reporting System).*

J. *RESPONDING* TO PRIVACY CONCERNS

1). *Overview:* The Company takes reasonable steps to respond appropriately to a privacy offense and prevent future similar offenses. The Company has established a system for responding to privacy issues as they arise, including investigating, retaining legal consultation, updating policies and procedures, implementing corrective action plans, notifying affected individuals, and, when appropriate, reporting misconduct to local media as well as appropriate authorities. It is the responsibility of all associated with The Company to assist in resolving issues by participating in good faith in The Company's response to potential breaches, including cooperating when The Company is conducting investigations and abiding by corrective action.

2). *Responding:* Reports received through either a reporting mechanism or through some other mechanism shall be documented and assessed initially by the Privacy Officer. If the initial assessment indicates that there is a basis for believing that the conduct reported constitutes a breach, the matter shall be reported to the Privacy Committee for review.

All alleged breaches shall be evaluated carefully to determine whether the allegation appears to be well-founded. The Privacy Officer shall promptly begin an investigation in accordance with the following procedure:

a. Privacy Officer shall commence an investigation as soon as reasonably possible, but in no event more than thirty (30) days following reasonable suspicion of an alleged breach
b. The investigation shall include a risk assessment to determine whether a breach took place

Every effort to investigate an alleged breach shall be documented and kept with the original report.

If there was a breach, Privacy Officer shall determine, depending on the number of individuals affected:

a. Appropriate notification to affected individuals
b. Reporting to appropriate officials
c. Reporting to local media, if appropriate

3). *Corrective Action:* Corrective action shall be imposed to assist Company employees, vendors, or business associates to understand specific issues and reduce the likelihood of future breaches. Corrective action, however, shall be sufficient to effectively address the instance of breach, and should reflect the severity of the breach and/or the past adherence to standards.

The corrective action plan should identify the nature of the breach and immediate correction of any harm resulting from the breach, as well as the resolution of specific problems identified. The plan may include:

a. A recommendation to revise applicable policies and procedures to clarify proper protocols and/or development of new systems to safeguard against future breaches of a similar nature
b. Additional mandatory training for employees, contractors, vendors, and/or business associates
c. Focused review of records made by employees, contractors, vendors, or business associates for a defined period following discovery of breach
d. A recommendation to report to appropriate authorities
e. Enforcement of disciplinary standards
f. Other reasonable corrective measures calculated to ensure adherence to applicable federal and state laws, rules, regulations, and The Company Program

For a defined period following the implementation of a corrective action plan, the Privacy Officer shall follow up and audit the corrective action to determine whether it is being followed as well as its effectiveness in preventing the recurrence of similar breaches.

If an alleged breach is not substantiated, the Privacy Officer shall keep a clear record of the investigation's conclusion as well as what factors were considered in making that determination. (Reference CP 2.0, *Section H, Compliance Response and Prevention).*

K. Breach Discovery and Notification

1). *Overview:* The Company shall notify appropriate individuals and entities, following the discovery of a breach of unsecured Protected Health Information (PHI).

2). *Procedure:*

a. An allegation of a breach of confidentiality of Protected Health Information (PHI) may be made to any Company staff member/healthcare professional. Any individual receiving an allegation of a breach of confidentiality or having knowledge or a reasonable belief that a breach of confidentiality of PHI may have occurred, shall immediately notify his/her supervisor, or where this is not possible, shall notify The Company's Privacy Officer or designee. The person so notified shall in turn, notify the supervisor of the alleged violator of this policy and The Company's Privacy Officer or designee.
b. The supervisor and/or Human Resources, in consultation with the Privacy Officer, or designee, shall decide whether to proceed with an investigation. It may be decided that a complaint does not require investigation if, after consultation, the consultees believe:

1. the subject matter of the complaint is trivial, or the complaint is not made in good faith or is frivolous; or
2. the circumstances of the complaint do not require investigation.

c. If the decision is made to proceed with an investigation, it shall be the responsibility of the supervisor, in consultation with the Privacy Officer, or designee, to investigate the allegation (this process will include obtaining the alleged violator's version of events), consult with the appropriate resources, document findings, and make a determination as to whether there has been a breach of confidentiality of PHI.
d. If it is determined that a breach of confidentiality of PHI has occurred, disciplinary action, up to and including termination, shall be taken. Such action may include termination of employment/contract/association/appointment with The Company. The supervisor shall consult with the designated representative in Human Resources and the Privacy Officer or designee, to establish the appropriate level of disciplinary action to be applied.
e. The Company's Privacy Officer shall be informed in writing of all allegations that have been made and their outcome and shall maintain a database of this information. (Reference CP 2.0 Section, I. *Compliance Investigation)*

3). *Determining Discovery of a Breach*:

a. A breach is discovered as of the first day on which the breach is known to The Company, or, by exercising reasonable diligence, would have been known to The Company.
b. A breach is discovered if the breach is known, or, by exercising reasonable diligence, would have been known to any person, other than the person committing the breach, who is a workforce member or agent of The Company.

4). *Breach Notification:* For a breach of unsecured PHI involving fewer than five hundred (500) individuals in a state or jurisdiction, The Company shall:

a. Notify the affected individual(s) within sixty (60) days
b. Breach notification shall be made through written notice, in plain language, and shall include the following, to the extent possible:
    1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known
    2. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved)
    3. Any steps individuals should take to protect themselves from potential harm resulting from the breach
    4. A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches
    5. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address
c. Notice shall be sent by first-class mail to the individual's last known address, or if the individual agrees to electronic notice (and such agreement has not been withdrawn), by electronic mail
d. Insufficient or Out-of-Date Contact Information: If insufficient or out-of-date information precludes written notification, substitute notification (e.g., by telephone) may be made in a form reasonably calculated to reach the individual

1. If there is insufficient or out-of-date contact information for ten (10) or more individuals, substitute notice shall:
    - be in the form of either a conspicuous posting for a period of ninety (90) days on the home page of The Company's website, or a conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside; and
    - include a toll-free phone number that remains active for at least ninety (90) days, where an individual can learn whether the individual's unsecured PHI may be included in the breach.
2. Incapacitated Individuals. Written notice shall be made to the individual's personal representative
3. Deceased Individuals: If The Company knows the individual is deceased and has the address of the next of kin or personal representative, written notice by first class mail may be made to either the next of kin or personal representative of the individual. Such notification may be made in one (1) or more mailings, as information becomes available. If the next of kin or personal representative's information is insufficient or out-of-date, precluding written notice, substitute notice need not be made
    - Urgent Notification Required. Where The Company deems notice urgent because of possible imminent misuse of unsecured PHI, The Company may provide information to affected individuals by telephone or other means, as appropriate, in addition to written notice
    - Maintain a log or other documentation of such breaches and, no later than sixty (60) days after the end of each calendar year, shall provide notification to the Secretary of HHS of all breaches discovered during the preceding calendar year, by going to http://ocrnotifications.hhs.gov/ and filling out the form, as fully as possible

e. For a breach of unsecured PHI involving more than five hundred (500) residents of a state or jurisdiction, The Company shall:
    1. Notify the affected individual(s) within sixty (60) days
f. Breach notification shall be made through written notice, in plain language, and shall include the following, to the extent possible:
    1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known
    2. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved)
    3. Any steps individuals should take to protect themselves from potential harm resulting from the breach
    4. A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches
    5. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address
g. Notice shall be sent by first-class mail to the individual's last known address. or if the individual agrees to electronic notice (and such agreement has not been withdrawn), by electronic mail

1. Insufficient or Out-of-Date Contact Information: If insufficient or out-of-date information precludes written notification, substitute notification (e.g., by telephone) may be made in a form reasonably calculated to reach the individual.
    - If there is insufficient or out-of-date contact information for ten (10) or more individuals, substitute notice shall:
        - be in the form of either a conspicuous posting for a period of ninety (90) days on the home page of The Company's website or a conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside; and
        - include a toll-free phone number that remains active for at least ninety (90) days where an individual can learn whether the individual's unsecured PHI may be included in the breach.
    - Incapacitated Individuals. Written notice shall be made to the individual's personal representative
    - Deceased Individuals: If The Company knows the individual is deceased and has the address of the next of kin or personal representative, written notice by first class mail may be made to either the next of kin or personal representative of the individual. Such notification may be made in one (1) or more mailings, as information becomes available. If the next of kin or personal representative's information is insufficient or out-of-date, precluding written notice, substitute notice need not be made

h. Urgent Notification Required. Where The Company deems notice urgent because of possible imminent misuse of unsecured PHI, The Company may provide information to affected individuals by telephone or other means, as appropriate, in addition to written notice.
    1. Notify prominent local media outlets serving the state or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after discovery or a breach

i. Notification to the media shall include the following, to the extent possible:
    1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known
    2. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved)
    3. Any steps individuals should take to protect themselves from potential harm resulting from the breach
    4. A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches
    5. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address
        - Notify the Secretary of the Department of Health and Human Services (HHS) contemporaneously with notice to the affected individuals, by going to http://ocnotifications.hhs.gov/ and filling out the form, as fully as possible

5). *Delay of Notification for Law Enforcement:* If a law enforcement official tells The Company that a required notification, notice, or posting would impede a criminal investigation or cause damage to national security, The Company shall:

a. if the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; or

b. if the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily, but no longer than thirty (30) days from the date of the oral statement, unless a written statement is submitted by law enforcement during that time.

L. Disciplinary Standards for HIPAA Privacy Violation

1). *Overview:* The Company has established a disciplinary policy and corresponding procedures for when the Health Insurance Portability and Accountability Act (HIPAA) Privacy Program policies and procedures are suspected of being violated. Adherence to applicable laws, rules, and regulations as well as The Company's Privacy Program is mandatory. Failing to report suspected noncompliance, participating in noncompliant behavior, or encouraging, directing, facilitating, or permitting, either actively or passively, noncompliant behavior may result in disciplinary action, up to and including termination. Also, if The Company learns that an individual knowingly fabricated, distorted, exaggerated, or minimized a report of misconduct, either to injure someone else or to protect himself or herself, the individual will be subject to disciplinary action, up to and including termination. (Link to WP 2.9 *Disciplinary Standards*).

2). *Implementation:* Anyone can file a complaint (refer to the Policies and Procedures for Privacy and Security Complaints). The Privacy Officer/Information Security Manager, or his or her designee, will process all privacy and security complaints.

If the Privacy Officer, or designee, determines per the Complaint process that there are violations of The Company policies and procedures, members of the workforce are to be disciplined. The discipline will be based on the severity and the number of times the same policy and procedure has been violated, consistent with The Company's Human Resource policies. The *Disciplinary Standards Policy* identifies examples of infractions and their corresponding disciplinary actions that apply to The Company's Privacy Program. The Company will impose the disciplinary actions identified beside the respective infractions. The disciplinary actions are listed as guidelines to be considered in determining the disciplinary action to be taken in response to infractions. The Company, in its sole discretion, may impose discipline less or more stringent than that called for by these guidelines, as set forth in the disciplinary protocol established under the Privacy Program

3). Non-Intimidation and Non-Retaliation: The Company has a policy of non-intimidation and non-retaliation for good faith participation in the Privacy Program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials. (Link to WM 2.9 *Disciplinary Standards, Section C, Non-Retaliation and Non-Retribution)*

Reference Appendix PP 2.1 D- *Discipline for HIPAA Privacy Violation Log*.

M. Privacy Education and Training

1.) *Overview:* All Company employees are responsible for ensuring that protected health information is used and disclosed appropriately. Company employees means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for The Company, is under the direct

control of The Company, whether or not they are paid by The Company. The Company ensures that employees are effectively trained about The Company's Privacy Program and other relevant policies, specific regulatory compliance issues, and their responsibilities.

2). *Implementation:* The Company maintains an ongoing privacy training program, which includes:

a. Our Privacy Program - For existing members of the workforce:
    1. Training must be completed as expeditiously as possible
    2. Training must be completed within sixty (60) days if their functions are affected by a material change in the policies and procedures
b. Checklist Orientation, including Privacy-specific education - During new hire orientation, all new hires, regardless of position and seniority, are trained on the Privacy Program and specific requirements and expectations under the program. For a new member of the workforce, training must be completed within thirty (30) days after the person joins the workforce
c. Regular Privacy Training

The Company's training and education program is designed to communicate The Company's Privacy Program standards and procedures to employees in a meaningful and effective manner, and to ensure consistent application of the Program's policies. The Company training program is geared to the level of responsibility and job function.

Training sessions utilize classroom, lecture, recorded instruction, and/or other means of communication, as appropriate, to accommodate the skills, experience, and knowledge of the trainees. Other forms of education are employed, including the use of posters, bulletin boards, paycheck stuffers, etc., to inform employees of new privacy issues or to reinforce aspects of past training. No matter how the information is presented, the training is documented, including the date, attendees, and agenda.

It is the Privacy Officer's responsibility to establish and coordinate training activities, and to maintain a library of privacy-related information and training materials. Human Resources administers the training program.

All privacy trainings are mandatory.

N. CONFIDENTIAL INFORMATION TRAINING

1). *Overview:* All employees and volunteers are required to participate in The Company's confidentiality training program. All employees and volunteers are required to sign a *Confidential Information Agreement*.

2). *Procedure:* Confidentiality training will be provided to new hires during orientation. Employees and volunteers are required to attend review sessions annually. Topics to be covered in training include:

1. The responsibility of employees to maintain privacy of residents
2. Company's policies regarding the release of private information
3. Consequences for breach of privacy/confidentiality

Additional training may be provided to employees who deal directly with the distribution of private information.

1. A *Confidential Information Agreement* must be signed by all employees and volunteers following their initial training session
2. Agreements will be stored in employee's personnel files
3. Employees may be re-trained following changes to the above policy and/or procedures

Policy Number: PP 2.0.1

Policy Title: Telehealth Services

Policy Statement/Purpose: The company has policies to ensure compliance with federal and state laws and regulations related to maintaining privacy and security for telemedicine services to residents/patients/clients/individuals within the current 1135 Blanket Waiver information found here.

Policy Interpretation and Implementation:

Definitions:

- Telemedicine: The practice of healthcare delivery, diagnosis, consultation, treatment, transfer of data, and education using interactive audio, video, or data communications.
  - Interactive: Is an audio, video, or data communication involving real-time two-way transfer of medical data and information.
  - Neither a telephone conversation nor an electronic mail message between a healthcare provider constitutes "telemedicine."
- Protected Health Information (PHI): Patient identifiable information found in medical records, test results, video, reports, or any other communication.
- Electronic Health Record (EHR): Any electronic platform where PHI is stored.
- Definitions and guidance provided by Telemedicine | Medicaid

Required Components: The Company has effective processes that maintain, at a minimum, the following components:

(1) Provider Licensure: Providers must be licensed in the state where the resident/patient/client/individual resides. The Company is responsible for validation of all credentialing and clinical qualifying requirements. The provider is responsible for knowing the current rules and laws of the governing state regarding telehealth. The provider must already have an established physician/extender-patient relationship.
(2) Informed Consent: The Company will consult with all state requirements regarding obtaining written informed consent for the treatment of the resident/patient/client/individual. At a minimum, a verbal consent is recommended to be documented in the patient record or EHR prior to beginning treatment or services. The provider must advise the patient about the proposed use of telemedicine, any potential risks, consequences, and benefits, and obtain the resident/patient/client/individual's or the resident/patient/client/individual's legal representative's consent.
(3) Privacy: Transmission of Protected Health Information (PHI) including, but not limited to, patient records, diagnostic results, and videotapes must be secure on both the transmitting and receiving ends. Devices should have the most up-to-date security software that will protect against cyberattacks. For this reason, personal devices should not be used. It is recommended that The Company and the provider communicate on the platform used for telehealth visits to allow download in advance of visits. The Company will have a backup plan on how to communicate in the event of a technology failure.
(4) Security and Exchange of Information: Documentation on behalf of the resident/patient/client/individual will be maintained in the medical record. All communication with the provider will be compliant with Health Insurance Portability and Accountability Act (HIPAA), including all copies of communication. Use of the Electronic Health Record (EHR) is acceptable for storage.

(5) Documentation: The medical record or EHR will contain detailed information regarding the telehealth visit. The Provider may communicate written documentation to The Company following the telehealth visit. The Company will ensure that documented evidence is placed in the medical record or EHR in real-time. The Company will provide guidance for specific information to be contained within the medical record or EHR, but at a minimum will contain the following:

- Name of the Provider
- Verified consent from the resident/patient/client/individual or legal representative
- Chief complaint
- Instructions or details given by the Provider
- Follow-up instructions

The resident/patient/client/individual or their legal representative have the right to withhold or withdraw from telehealth services at any time without affecting any present or future treatment they would otherwise be entitled to.

(6) Guidance and Regulation: The Company is required to understand and be compliant with all federal and state directives related to telehealth and the treatment of the resident/patient/client/individual.

Current CMS guidance can be found at: Telehealth | CMS

Current guidance by state can be found at: COVID-19 State Actions for Telehealth Policy - CCHP (cchpca.org)

Current 1135 Blanket Waiver guidance can be found at: Coronavirus Waivers | CMS

Current MLN factsheet reference guide can be found at: Telehealth Services (cms.gov)

Policy Number: PP 2.1

Policy Title: Workforce Privacy Practices

Policy Statement/Purpose: The Company must have workforce privacy practices in place to be compliant with Privacy laws promulgated by the federal and state governments. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

Policy Interpretation and Implementation: Workplace privacy practices are components of The Company's Compliance and Ethics Program. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

A. PRIVACY

1). *Overview:* In companies of all sizes, employees and managers are likely to engage in communication and other activities that are not directly related to their jobs. For instance, a worker might check his personal email at work, or talk to a friend or family member on his work phone during his lunch hour. Workplace privacy describes the extent to which employers monitor and collect information on the activities, communications, and private lives of workers.

2). *Procedure:* The Company may monitor employee activities in a variety of ways, many of which are related to the use of computers. Methods of employee monitoring may include tracking internet usage, archiving computer files, storing employee emails and instant messages, logging keystrokes, recording phone conversations, testing for drugs, and maintaining video surveillance. The Company may track the use of key cards of satellite technology that keep track of the use of Company property such as cars and phones.

a. Communication - The purpose of workplace policies governing communication is to establish acceptable employee behavior online, on the phone, or through other communication channels. Policies may establish that employers reserve the right to monitor communication to determine whether it is used appropriately. Employers not actively monitoring communication may still record and store emails, text messages, and other Company property in the event of future disputes or litigation. The Company policy may also guide content exchanged between employees during business hours; for example, off-color jokes, racial slurs, pornography, trade secrets, or chain mail may be explicitly prohibited. Policies regarding acceptable use of social networking media may help employees navigate the difference between professional and personal use of such sites.

b. Substance Use - Company policies regarding the use of alcohol, some prescription drugs, and illegal drugs help maintain a safe environment for employees, coworkers, and customers. While they may reinforce existent government laws prohibiting the use of illegal drugs, workplace policies may outline additional stipulations regarding employee use. Insurance carriers may require substance policies as a condition of coverage. Businesses outline consequences of substance use on the job to standardize procedures, so they are protected when penalizing employees for operating machinery, interacting with customers, or representing The Company while under the influence of substances. Formalizing punitive procedures through workplace policies

helps to protect The Company from employee claims, resulting in dismissals related to substance use.

c. Relations Policy - Workplace policies concerning employee relations function as a guide for people developing personal or romantic relationships with coworkers, whether they are individuals in an equal, superior, or subordinate position. Critics of employee relations policies argue that they inappropriately encroach upon the private lives of workers, forcing people to sneak around.

3). *Process Policy:* Some policies standardize business functions by outlining specific processes for things such as dealing with disgruntled employees, managing routine employee evaluations, or submitting budget requests. These workplace policies reduce the volume of questions concerning expectations for specific tasks. Formally specifying expectations gives employees a resource for finding answers to commonly asked questions.

B. NOTICE OF PRIVACY PRACTICES POLICY

1). *Overview:* Pursuant to laws promulgated by the federal and state governments, The Company will provide Appendix PP 2.0.1 A, *Notice of Privacy Practices* to our residents and/or their personal representatives. The *Notice* serves to ensure that residents are informed about what Protected Health Information (PHI) is collected, and to have some control over how the information is used.

2). *Policy:* The Company has the responsibility to:

a. maintain the privacy of residents' PHI;
b. provide residents with a written notice as to The Company's legal duties and privacy practices with respect to collecting and maintaining information about residents;
c. abide by the terms of this notice;
d. notify residents if The Company is unable to agree to a requested restriction; and
e. accommodate reasonable requests that residents may have to communicate PHI by alternative means, or at alternative locations.

3). *Notice of Privacy Practices:* Upon admission, The Company will provide a notice to each resident and make a good faith effort to obtain a signed acknowledgement of the receipt of Appendix PP 2.0.1 A, *Notice of Privacy Practices* from the resident. The notice shall include all elements and statements that are required by law. The notice shall inform the residents of:

a. Uses and disclosures of PHI that may be made by The Company
b. The resident's rights with respect to his/her PHI
c. The Company's legal duties with respect to such PHI

The Company will not use or disclose a resident's PHI without his/her consent or authorization, except as described in the notice.

4). *Procedure:* The notice and acknowledgement forms will be given to the resident at the time of admission. **Note:** In the case of an emergency treatment situation, The Company will provide the notice to the resident as soon as reasonably practicable after the emergency treatment situation has ended.

a. The Company will provide a copy of the written notice to residents.

b. The Company will provide a copy of the written notice when additional consent is sought from a resident.
c. The Admissions Staff will make a good faith effort to obtain the resident's signature on the acknowledgement at the time the notice is provided. The notice and signed acknowledgement will be kept in the resident's Business Office File.
d. If the resident refuses or is otherwise unable to sign the acknowledgement, the Admissions Staff will document, on the acknowledgement form, what actions were taken to obtain the resident's signature and the reason(s) why a signed acknowledgement was not obtained. This document will then be placed in the resident's Business Office File.
e. To avoid interfering with a resident's access to quality healthcare or the efficient payment for such healthcare, The Company may use or disclose PHI, with certain limits and protections, for treatment, payment, and healthcare operations activities.
    1. Any use or disclosure of PHI for reasons other than treatment, payment, healthcare operations, and disclosure of PHI to a third party specified by the resident will require authorization
    2. Any use of PHI for marketing purposes, as well as disclosures that constitute a sale of PHI, by The Company will require the resident's express, written authorization
    3. The resident may revoke his/her given authorization, as provided by applicable regulations
f. The Company may use a resident's demographic information and the dates that the resident received treatment, as necessary, in order to contact the resident as part of a fundraising effort.
    1. **Note:** Residents have a right to opt-out of receiving PHI in such communications
    2. The Company will include in any fundraising materials sent to a resident, a description of how the resident may opt-out of receiving any further fundraising communications
    3. The Company will make reasonable efforts to ensure that residents who decide to opt-out of receiving future fundraising communications are not sent such communications
g. Uses and disclosures of psychotherapy notes by The Company will require advance, written authorization by the resident.
    1. Exception: Authorization is not required to carry out the following treatment, payment, or healthcare operations:
        - Use by the originator of the psychotherapy notes for treatment
        - Use or disclosure by The Company for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling
        - Use or disclosure by The Company to defend itself in a legal action or other proceeding brought by the resident
    2. Exception: A use or disclosure that is required by or permitted by the applicable regulations with respect to the oversight of the originator of the psychotherapy notes
h. Residents have a right to restrict certain disclosures of PHI to a health plan where the resident pays out of pocket, in full for the healthcare item or service.
i. Residents will be notified following a breach of unsecured PHI.
j. The Company shall post a copy of the notice in a clear and prominent location such as the entrance lobby or similar location.
k. A current version of the notice will be maintained on The Company's website, if any.
l. Whenever the notice is revised, The Company's Privacy Officer shall assure that:
    1. The revised notice is made available upon request on or after the effective date of the revision

2. The revised notice is posted in a clear and prominent location
3. The revised notice is posted on The Company's website, if any

m. Material changes shall not be implemented prior to the effective date of the revised notice.
n. A copy of each notice issued by The Company will be maintained for at least six (6) years from the date it was last in effect.
o. Any member of the workforce who has knowledge of a violation, or potential violation, of this Policy must make an immediate report directly to the Privacy Officer.

C. RESPONDING TO GOVERNMENT INQUIRIES

1). *Overview:* The Company has procedures for protecting protected health information while dealing with legal documents.

2). *Policy:* The Company is subject to government reviews and/or litigation, thus, may periodically receive legal documents (e.g.; subpoenas and court orders) demanding the production of medical or personnel records. The Privacy Officer must receive and respond to legal documents immediately because the documents may contain deadlines that The Company is legally responsible to meet.

3). *Procedures:*

a. Subpoenas and Court Orders for Medical and Personnel Records - If you are served with a routine subpoena or court order for medical or personnel records, respond as indicated below. If an issue of privacy is raised which requires assistance, notify Legal Counsel immediately. If the subpoena or court order is non-routine, it is very important that you do not turn over documents called for in a subpoena, do not discuss the case with the individual who served you with the subpoena, and do not discuss the subpoena with anyone other than Legal Counsel.
b. Procedures for Assuring Compliance with all Complaints, Subpoenas, Summonses, and Court Orders - The Privacy Officer will maintain a record of every subpoena and court order served on The Company with respect to medical or personnel records. The Privacy Officer with the Administrator will be responsible for coordinating with Legal Counsel as needed. The Privacy Officer and the Administrator, with assistance from the Legal Counsel, will be primarily responsible for a timely and appropriate response to the served documents.
c. Subpoenas - If a law firm representing a current or former resident submits a subpoena for medical records for that resident, the following steps should be taken:
    1. Inspect the subpoena to determine if it contains a HIPAA compliant authorization
    2. If not, contact the law firm and request a HIPAA compliant authorization
    3. Do not provide a copy of medical or personnel records without such an authorization
    4. If the authorization is complete, provide only that which is required in the subpoena; no more and no less
d. Court Orders - If you receive a court order for the release of medical or personnel records, the following steps should be taken:
    1. Inspect the court order to ensure that it is authentic and signed by a judge
    2. Adhere to the terms and conditions of the court order
    3. Provide only that which is required in the court order; no more and no less

4). *Guidelines for responding to all types of government inquiries:* The Company is to cooperate fully with all government inquiries and ensures appropriate and consistent responses to contact by government auditors and investigators. The Company Compliance and Ethics policy incorporates the following response elements for all types of inquiries:

a. All Company employees should be respectful and courteous to government investigators.
b. As soon as the investigators arrive, immediately notify the Administrator and/or Compliance and Ethics Officer and/or Legal Counsel. If unavailable, then contact the most senior management person in your area. If a senior manager is not on the premises, the investigators should be asked to wait momentarily in an unused office or an area where no Company business is being conducted. Wait with the investigators, but do not discuss anything related to business with the investigators while waiting for a senior manager to arrive.
c. The senior manager should request identification from all investigators, including business cards for each investigator. Enforcement agents should be asked to show their badges.
d. The senior manager should ask the investigators the purpose of their visit and what information they are seeking.
e. Upon receiving this information, the senior manager should immediately contact the Compliance and Ethics Officer and Legal Counsel.
f. If the visit occurs outside of normal business hours, the Administrator and Director of Nursing should be called.

5)**.** *Guidelines for specific types of inquiries:*

a. Routine periodic surveys should be handled in the normal course of business. However, the Administrator and/or Legal Counsel should be contacted in the event there is an unscheduled visit by the state survey team, or agents other than the usual state surveyors are in attendance (including, but not limited to, OIG, FBI, and the State Medicaid Fraud Control Unit).
b. If the inspectors are conducting an OIG Audit:
    1. Notify the Administrator and/or Legal Counsel
    2. The Administrator and/or Legal Counsel should be designated to receive all requests for information or documentation. The investigators should be requested to make all requests for information through this designated individual. A list should be made of all information and documents requested
    3. Original documents should not be given to the investigators. Two copies of all documents taken by the investigators should be made: one copy for the investigator, one for the Administrator and/or Legal Counsel
c. If the investigators arrive with a search warrant:
    1. The senior manager on site should request a copy of the warrant and any accompanying exhibits or attachments. The affidavit in support of the warrant should be specifically requested and then immediately contact the Administrator and/or Legal Counsel and forward a copy of the warrant
    2. The investigators will have the authority to seize original documents – the senior manager should politely request permission to make copies of important documents before they are seized. If permission is not granted, a careful list of documents seized, by category and location, should be made to the extent possible
    3. All employees should be directed to not interfere with investigators conducting a seizure pursuant to a search warrant. Employees perceived by the investigators to be interfering

with the investigation may risk criminal sanctions, including but not limited to obstruction of justice

6) *Employee Rights and Obligations:*
   a. Employees should be advised that they may be contacted individually, at home or at work, by investigators. Individuals should be made aware of the following rights in the event they are contacted by government agents.
      1. Employees have the right to refuse to talk to investigators or to refuse to be interviewed unless they have an attorney to represent them. It is not an indication of guilt to request an attorney, but a common-sense decision to have the assistance of someone who understands the context of government investigators and how to protect individual rights. The Company will provide counsel to represent the employee in appropriate circumstances
      2. Employees have the right to refuse to speak to the investigators. Employees must be advised that making a false statement to a government investigator may subject the employee to criminal sanctions. Once employees become aware of an ongoing government investigation, no documents in any way related to the investigation should be destroyed or discarded; this may subject the employee to criminal sanctions
      3. After an investigation has begun, employees should be instructed:
         - not to speculate about the nature of the investigations; and
         - not to create memoranda, letters, emails, or other electronic or paper documents related to the investigation.
      4. If contacted by government investigators, employees should notify The Company's Administrator and/or Legal Counsel. Employees may not offer to provide access to The Company's documents. All requests for information and documents by government investigators should be processed through the Administrator and/or Legal Counsel

Reference PP Appendix 2.1 A, *Authorization for Compliance with Subpoena*

D. PRIVACY COMPLAINTS

1). *Overview:* The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule affirms the right of a patient to submit a privacy complaint. The Company must provide a process for residents to make complaints concerning Company policies and procedures required by the Privacy Rule.

2). *Procedure:* The procedure for receiving privacy complaints and taking appropriate actions includes:
   a. All Privacy Complaints must be submitted in writing either on paper or electronically.
   b. All Privacy Complaints must be submitted to the Privacy Officer, or his or her designee.
   c. The Privacy Complaint must describe the acts or omissions believed to be in violation of the applicable requirements and be dated. A Privacy Complaint must be filed within 180 days of when the complainant knew, or should have known, that the act or omission complained of occurred, unless the Privacy Officer waives this time limit.
   d. The Privacy Officer will determine the protected health information (PHI) affected by the complaint, including PHI provided to other covered entities and business associates. A log will be kept as to what Privacy Complaints were received and the appropriate status.

e. If the PHI was created and maintained by a business associate, the Privacy Officer will pass the Privacy Complaint to the business associate. The *Business Associate Agreement* provides for this policy. The log will be updated accordingly.
f. It is the responsibility of the Privacy Officer to determine whether there has been a breach of privacy policies and procedures and whether (1) execution needs to be improved, (2) privacy policies and procedure need to be changed, or (3) additional privacy policies and procedures need to be established. The Privacy Officer is responsible for taking actions necessary and appropriate. A log will be kept of these activities.
g. If appropriate discipline must be taken against the workforce, refer to WM 2.9 *Disciplinary Standards for HIPAA Privacy Violation.*
h. The Privacy Officer must close out the complaint noting the actions taken and the dates.
i. Privacy Complaints may also be filed with the Department of Health and Human Services, Office for Civil Rights

https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf

Policy Number: PP 2.2

Policy Title: Maintaining Resident Privacy

Policy Statement/Purpose: The Company must have Resident privacy practices in place to be compliant with Privacy Laws promulgated by the federal and state governments. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

Policy Interpretation and Implementation: Resident Privacy practices are components of The Company Compliance and Ethics Plan. This policy is subject to the requirements, prohibitions, and safe harbors of Company's No Information Blocking policy. (See Policy 1.0.0)

A. Requests for Inspection and Copying

1). *Overview:* A resident has the right to inspect and copy Protected Health Information (PHI) or a record about the resident in a designated record set for as long as the PHI is maintained in the designated record set. The Company has a process for the resident to inspect and copy PHI.

2). *Procedure:* Individuals have the right to access, to inspect, and obtain a copy of the PHI in a designated record set.

a. Requests for access to inspect or obtain a copy of individual's PHI must be made in writing to the Privacy Officer.
b. The Company must act on a request for access no later than thirty (30) days after receipt of the request as follows:
    1. If The Company grants the request, in whole or in part, it must inform the individual of the acceptance of the request and provide the access requested
    2. If The Company denies the request, in whole or in part, it must provide the individual with a written denial
    3. If The Company is unable to act within the time requested, The Company may extend the time for such action by no more than thirty (30) days, provided that:
        - The Company provides the individual with a written statement of the reasons for the delay and the date by which The Company will complete its action on the request; and
        - The Company may have only one such extension of time for action on a request for access.

3). *Access:* If The Company provides an individual with access, in whole or in part, to PHI, The Company must comply with the following requirements:

a. The Company must provide the access requested by individuals, including inspection or obtaining a copy, or both, of the PHI about them in designated record sets
    1. If the same PHI that is the subject of a request for access is maintained in more than one designated record set, or at more than one location, The Company need only produce PHI once in response to a request for access
b. Form of Access Requested

1. The Company must provide the individual with access to PHI in the form and format requested by the individual, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by The Company and the individual
2. If the PHI that is the subject of the request for access is maintained in one or more designated record sets electronically and if the individual requests an electronic copy of such information, The Company must provide the individual with access to the PHI in the electronic form and format requested by the individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by The Company and the individual
3. The Company may provide the individual with a summary of the PHI requested in lieu of providing access to the PHI, or may provide an explanation of the PHI to which access has been provided, if:
   - the individual agrees in advance to such a summary or explanation; and
   - the individual agrees in advance to the fees imposed, if any, by The Company for such summary or explanation.

c. Time and Manner of Access
   1. The Company must provide the access as requested by the individual in a timely manner (30 days), including arranging with the individual for a convenient time and place to inspect or obtain a copy of the PHI or mailing the copy of the PHI at the individual's request
      - The Company may discuss the scope, format, and other aspects of the request for access with the individual as necessary to facilitate the timely provision of access
   2. If an individual's request for access directs The Company to transmit the copy of PHI directly to another person designated by the individual, The Company must provide the copy to the person designated by the individual
      - The individual's request must be in writing, signed by the individual, and clearly identify the designated person and where to send the copy of PHI

d. The Company must document and retain copies of the designated record sets that are subject to access by individuals

4). *Fees:* If the individual requests a copy of the PHI, or agrees to a summary or explanation of such information, The Company may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:
   a. labor for copying the PHI requested by the individual, whether in paper or electronic form;
   b. supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media;
   c. postage, when the individual has requested the copy, or the summary or explanation, be mailed; and
   d. preparing an explanation or summary of the PHI, if agreed to by the individual.

5). *Denial of Access:* The Company may deny an individual access, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
   a. A licensed healthcare professional has determined, in the exercise of a professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.

b. The PHI refers to another person (unless such other person is a healthcare provider) and a licensed healthcare professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
c. The request for access is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.
d. If The Company denies access, in whole or in part, to PHI, The Company must comply with the following requirements:
    1. The Company must, to the extent possible, give the individual access to any other PHI requested, after excluding the PHI to which The Company has a ground to deny access
    2. The Company must provide a timely, written denial to the individual, in plain language, containing:
        - The basis for the denial
        - If applicable, a statement of the individual's review rights, including a description of how the individual may exercise such review rights
        - A description of how the individual may complain to The Company. The description must include the name, or title, and telephone number of the Privacy Officer.
e. If The Company does not maintain the PHI that is the subject of the individual's request for access, and The Company knows where the requested information is maintained, The Company must inform the individual where to direct the request for access.

6). *Review of denial requested:* If the individual has requested a review of a denial, The Company must designate a licensed healthcare professional who was not directly involved in the denial to review the decision to deny access.
a. The Company must promptly refer a request for review to such designated reviewing official.
b. The designated reviewing official must determine, within a reasonable period of time, whether or not to deny the access requested.
c. The Company must promptly provide written notice to the individual of the determination of the designated reviewing official and take action to carry out the designated reviewing official's determination.

7). *Denial without Review:* The Company may deny an individual access without providing the individual an opportunity for review in the following circumstances:
a. The PHI is excepted from the right of access because it is psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
b. The PHI is contained in records that are subject to the Privacy Act if the denial of access would meet the requirements of the Privacy Act.
c. The PHI was obtained from someone other than a health provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

B. USES AND DISCLOSURES FOR RESIDENT DIRECTORIES

1). *Overview:* The Company may use or disclose Protected Health Information (PHI), provided that the individual is informed in advance of the use or disclosure and can agree or to prohibit or restrict the use or disclosure, in accordance with applicable laws, rules, and regulations. The Company may orally inform the individual of and obtain the individual's oral agreement or objection to an otherwise permitted use or disclosure.

2). *Procedure:* General Rule: The Company may maintain a directory of individuals in its company, including:

a. The individual's name
b. The individual's location in The Company
c. The individual's condition, described in general terms that do not communicate specific medical information about the individual
d. The individual's religious affiliation

Use or disclosure of such information for directory purposes may be provided to members of the clergy or, *except for religious affiliation*, other persons who ask for the individual by name.

3). *Individual's Opportunity to Object:* The Company must inform an individual of the PHI that it may include in a directory and the persons to whom it may disclose such information and provide the individual with the opportunity to restrict or prohibit some or all the uses or disclosures listed above.

4). *Emergency Circumstances:* If the opportunity to object to uses or disclosures cannot practicably be provided because of the individual's incapacity or an emergency treatment circumstance, The Company may use or disclose some or all the PHI listed above for The Company's directory, if such disclosure is:

a. consistent with a prior expressed preference of the individual, if any, that is known to The Company; and
b. in the individual's best interest, as determined by The Company, in the exercise of professional judgment.

The Company shall inform the individual and provide an opportunity to object to uses or disclosures for directory purposes when it becomes practicable to do so.

C. WHITE BOARDS

1). *Overview:* In many areas of The Company, there are white boards listing residents by name and other clinical information that may be related to condition. If people other than the workforce have access to the white boards, it is regarded as a disclosure. The Company has procedures in place to prevent disclosures to people other than the workforce in connection with white boards. White boards containing Protected Health Information (PHI) should not be placed in open areas.

2). *Procedure:* Accidental disclosures may happen. It is the responsibility of the workforce to mitigate the impact of accidental disclosures. White boards must be covered from view when not being utilized by workforce having access to PHI needed on white boards (e.g. admissions department).

D. EMAIL PRIVACY

1). *Overview:* The Company shall protect the confidentiality, integrity, and availability of Electronic Protected Health Information (e-PHI) it creates, receives, maintains, or transmits. The information released will be limited to the minimum necessary to meet the requestor's needs. Whenever possible, de-identified information will be used. The Company has procedures in place to ensure appropriate use of the email system when transmitting PHI.

2). *Procedure:*

a. Email users will be set up with a unique identifier complete with unique password and file access controls.
b. Email users may not intercept, disclose, or assist in intercepting or disclosing email communications.
c. Users shall verify the accuracy of the email address before sending any PHI.
d. Every effort shall be made to secure the confidentiality and privacy of PHI. Sample security measures include password protecting the document(s) being sent and/or encrypting the message.
    - The content of email messages shall be limited to the minimum necessary to meet the needs of the recipient
e. All email containing PHI shall contain a confidentiality statement. Suggested language:
    - This email and any documents, files, or previous email messages attached to it are intended only for the use of the person or office to whom it is addressed and contains privileged or confidential information protected by law. If the reader of this message is not the intended recipient, you are hereby notified that any viewing, disclosing, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this email in error, please immediately notify the sender by reply email and erase the email from your system. Thank you.
f. Users should exercise extreme caution when forwarding messages to ensure that sensitive information is not forwarded to any unauthorized user.
g. Users should periodically purge email messages that are no longer needed for business purposes, per The Company's record retention policy.
h. Employee email privileges shall be promptly removed following his/her departure from The Company.
i. Employees shall immediately report any violations to their supervisor, the Privacy Officer, or the Administrator.
j. Resident related *Email Instructions and Consents* are referenced at PP Appendix 2.2 Section C.

E. Mailing to Residents

1). *Overview:* Mailing to residents may, in effect, disclose Protected Health Information (PHI) to others in the household. For example, an explanation of benefit (EOB) or invoice sent to the insured about a spouse, an emancipated child, or another adult could disclose PHI. The Company has established a privacy policy for mailings to the insured, if other than the resident.

2). *Procedure:* If the resident is not the insured, The Company must ask the resident if he or she objects to sending information to the insured. If there is an objection, then a separate mailing to the resident will be made.

Resident will be asked to consent to mailing of PHI to the insured when signing the initial consent form. If the resident objects, the resident will be asked to notify The Company and to complete Appendix PP 2.0.2H *Request for Restriction of Use and Disclosure of Protected Health Information*.

F. Photographing, Filming, and Recording of Residents (Prohibition of Photographs and Audio/Video Recordings)

1). *Overview:* It is the policy of The Company to ensure each resident's right to privacy and confidentiality for all aspects of care and services. The Skilled Nursing Company Conditions of Participation state: "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and exploitation." Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation.

To ensure the provision of each resident's rights to personal privacy, not only of his/her own physical body, but also of his/her personal space, including accommodations and personal care. This policy defines "staff" to include employees, consultants, contractors, volunteers, and other caregivers who provide care and services to residents of The Company.

2). *Procedure:*

a. Taking unauthorized photographs or recordings of a resident in any state of dress or undress using any type of equipment (e.g., cameras, smart phones, and other electronic devices) is a violation of the resident's right to privacy and confidentiality.
b. Photographs and recordings of a resident that contain nudity, sexual and intimate relations, bathing, showering, toileting, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to a resident, showing a body part without the resident's face whether it is the chest, limbs, or back, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, provision of incontinence care exposing perineal areas, fecal material on body parts or bedding/furnishings, and showing the resident in any compromised position are strictly prohibited.
    1. Performing any of these actions has the effect of humiliation and embarrassment and does not promote an environment where the resident's self-worth is being upheld.

c. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident(s), regardless of whether the resident provided consent and regardless of the resident's cognitive status, a full investigation will occur with application of the disciplinary process to the person taking the photograph or making the recording, up to and including termination and reporting to appropriate authorities.
d. In situations where a resident is unable to express him/herself due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), the lack of response by the resident does not mean that mental abuse did not occur. Residents who are cognitively impaired can still suffer public humiliation and dehumanization.
e. Depending on what was photographed or recorded, physical and/or sexual abuse may also have occurred.
f. Upon identification of any allegation of posting an unauthorized photograph or recording of a resident on any form of social media, the alleged violation must be reported to the Administrator and other officials, with initiation of an immediate investigation and actions to prevent further potential abuse.
    1. Actions may include, but not be limited to, staffing changes, increased supervision, protection from retaliation, follow-up counseling for the resident(s), and corrective actions to prevent recurrence
g. Training will be provided initially, annually, in new employee orientation, and periodically as deemed necessary on abuse policies for all staff who provide care and services to residents.
    1. Training will include information describing the prohibition of staff from using any type of equipment to take, keep, or distribute photographs and recordings of residents on social media, or by any other means, that are demeaning or humiliating
    2. Training will include staff reporting responsibilities, including how to identify possible abuse and how to report allegations of abuse
h. The nursing home administration will establish a method of ongoing oversight and supervision of staff under the guidance of the QAA/QAPI Committee or other designated individual(s) to ensure that these policies are communicated and implemented as written.

Reference PP Appendix 2.2 E *Consent to Photograph/Publish*

G. Resident Personal Recording Devices

1). *Overview:* The Company will protect the privacy of residents and staff from unauthorized use of personal recording devices in resident rooms and public areas within the facility by requiring residents and family members to obtain permission from The Company in accordance with federal and state law, prior to use or installation of personal recording devices in resident rooms or public areas in the facility, and by defining the parameters in which personal cell phones with camera or video capability and other personal image recording devices (Alexa etc.) may be used by residents and/or their personal representatives/family members.

2). *Definitions:*
a. **Personnel** – includes all personnel who would appear to the public as an employee or agent of The Company. Personnel includes but is not limited to: employees, physicians and allied health

professionals, volunteers, contractors, vendors, temporary labor, agency personnel, and contract employees.

b. **Personal Recording Device (PRD)** – A personal recording device is any device that:
   1. Is not the property of The Company
   2. Can capture an image, live action or still, of a resident or staff member
   3. Such devices include, but are not limited to: video cameras, cell phones with cameras, cell phones with videotaping capability, digital cameras, and voice activated devices (such as Alexa)
c. **Personal Representative** – The person who is authorized to make decisions on behalf of a resident.

3). *Implementation*:

a. Any resident, personal representative, or family member who wishes to install or use a Personal Recording Device in a resident room or public area within the facility must request and receive permission from the Administrator of the facility, in accordance with federal and state laws, prior to using or installing such Personal Recording Device.
b. If the Administrator grants the request, the resident, personal representative, and/or family member is required to:
   1. obtain consent from the resident's roommate(s) or personal representative(s) for the video recording device to be installed in the resident's room; and
   2. place the video recording device in plain view with some form of notice posted outside the resident's room in order to provide notice to staff.
c. Residents, personal representative(s), and/or family members are responsible for all costs associated with purchase and installation of the device.
d. CompanyName is prohibited from retaliating against those who use a personal recording device after receiving permission from the Administrator.
e. Residents, personal representative(s), and/or family members are expressly prohibited from photographing, recording, or videoing other residents, personal representative(s), or family members without receiving written permission from the Administrator of the facility and in accordance with both, CompanyName's policies regarding the photographing, recording, or video taking of residents and HIPAA.
f. Any exceptions to this Policy must be approved by either the Administrator or the Compliance and Ethics Officer.
g. Noncompliance with this Policy that results in violations of Company HIPAA Privacy and Security Policies and Procedures will subject the violator to either removal for visitors and resident family members, and/or discharge for resident in accordance with federal and state laws and regulations.

I acknowledge that my signature on this Policy signifies I have read, understand, and am committed to its principles.

❑ Resident ❑ Personal Representative ❑ Family Member

Print Name of Individual	Company Name (if applicable)
Signature of Individual	Date

Policy Number: PP 2.3

Policy Title: Social Media and Networking

Policy Statement/Purpose: The Company has policies that specify the obligations of employees authorized to represent The Company in authorized external social media communications consistent with applicable law, regulations, and standards of practice.

Policy Interpretation and Implementation: Managing social media communications is a component of The Company Compliance and Ethics Program.

A. SOCIAL MEDIA/NETWORKING AND INTERNET COMMUNICATIONS

1). *Overview:* The Company formally participates in external Social Media communities through authorized corporate channels. This Policy specifies the obligations of those employees authorized to represent The Company in the Social Media environment. This Policy applies to all types of social media/networking activity (a) using Company computers, mobile devices, or other information technology (IT), and (b) using non-Company technology.

The Administrator shall designate an individual to monitor Social Media using Google alert or other Company approved alert system. Once an account is activated with Google, if The Company is mentioned on the internet, an alert will be generated for review. If any negative reviews are posted, the Administrator and Legal Counsel should be notified immediately

2). *Definitions:*

Company-Sponsored Social Media – An external Social Media site owned or controlled by The Company, including content that is housed on an outside-party Social Media site at The Company's direction.

Social Media – As used in this Policy, "social media" is user-generated web/online content created by individuals using highly accessible and scalable publishing technologies, including but not limited to blogs, chat rooms, wikis, photo-sharing networks, online virtual communities, podcasts, user-generated videos, message boards, and other technologies. For the purpose of this Policy, email communication is not included in this definition of Social Media.

Social Networking – As used in this Policy, "social networking" means communicating with others over the internet for social purposes. Typically, this interaction occurs on sites like Facebook, Twitter, LinkedIn, YouTube, and MySpace, but can also occur on "media sites" that are offered by television networks, newspapers, and magazines and permit readers to post comments.

Web Log (Blog) – A Web log, or "blog," is a public Web page that is written and updated frequently by one or more authors, much like a personal journal or newsletter. Blogs generally consist of commentary on a defined subject and frequently include links to other sites pertaining to the same subject.

3). *Procedure:* Recognizing that employees may participate in various forms of Social Media on their personal time and using their personal communications resources, this policy provides expectations and requirements for responsible use of external Social Media by those employees as such use relates to The Company.

a. While social networking can be useful, if improperly used, it can result in a variety of adverse consequences such as disclosure of sensitive or confidential information; defamation, harassment, discrimination, privacy, and copyright issues being created; and potential damage to The Company's reputation.
b. This Policy applies to all employees as well as agents and contractors of The Company.
c. All employees, agents, and contractors of The Company shall immediately report known, suspected, or potential violations of this Policy to the Privacy Officer. Violations of this Policy may result in disciplinary action.

4). *Company-Sponsored Social Media Sites:*
a. Company-Sponsored Social Media presence must be approved by the Administrator.
b. All employees and/or departments that have a business purpose for developing and maintaining a Company-Sponsored Social Media site/presence must:
    1. Justify the business need
    2. Identify the Site Owner or the individual who is responsible for the content and monitoring of The Company-Sponsored Social Media site or presence
    3. Agree to maintain the requested site
    4. Agree to notify the Administrator if such site is ever abandoned or closed
    5. Comply with any security requirements specified by the Information Technology Department
    6. Submit all the above information to the Administrator for final approval
c. Communications and other interactions by The Company personnel acting on behalf of The Company on Company-Sponsored Social Media sites **must follow** the following provisions:
    1. Users are personally responsible for all content they post
    2. Employees must adhere to The Company's Code of Conduct and policies governing restrictions on disclosure of confidential or other proprietary information, policies prohibiting discrimination, harassment, retaliation or threats, and policies mandating adherence to intellectual property and financial disclosure laws
    3. Do not discuss or disclose any resident protected health information as described in the Confidentiality Policy and Acceptable Use Policy
    4. Identify yourself and your role at The Company when you discuss Company business
    5. Refrain from posting any content that could be characterized as defamation, plagiarism, harassment, advertising, a copyright violation, or claims of special expertise
    6. Identify all copyrighted or borrowed material with citations and links and obtain permissions when necessary
    7. Do not knowingly provide false or misleading information, and use due diligence to ensure that the information you do provide is accurate
    8. Obey the law. Do not post any information or conduct any online activity that may violate applicable local, state, or federal laws or regulations
    9. Information provided must be limited to that which may be spoken in any other public forum
    10. Ensure that your posting is accurate, truthful, respectful, and is spelled correctly with appropriate grammar, language, and tone
    11. All responses to reader postings should be composed in a thoughtful, careful manner

12. Obtain approval from the Administrator before responding to an inaccurate, accusatory, or negative comment about The Company, its employees, or its residents; inquiries from journalists on issues related to The Company, its employees, or its residents; or an inquiry about any other legal matter
13. Do not post anything that would potentially embarrass you or The Company, or call into question The Company's reputation, including photographs or other images
14. Employees shall not post unauthorized images, videos, or recordings of The Company's facilities
15. Employees shall not offer any referral, endorsement, or recommendation for or about others on behalf of The Company without the prior approval from the Administrator
16. Retain online content that is classified as an official record
17. If approached by external media, industry analysts, shareholders, or any company or organization for which there are assigned Company contacts, refer them to the authorized individual or department

d. Disclaimer for Company-approved blog sites. The following should be posted on the "About" page:
    1. The author grants permission to readers to link to this site so long as this site is not misrepresented. The author will remove any link to any site from this site upon request of the linked entity. This site is not sponsored or associated with any other site unless so identified.

e. Privacy Statement for Company-approved blog sites. The following should be posted on the "Privacy Statement" page, which should be linked to the "Home" or "Main" or "About" page:
    1. PRIVACY STATEMENT: The author of this site and The Company value the privacy of their blog viewers. This site does not currently collect personal identifying information (PID), except: (1) to the extent that your browser provides PID, such as your email address or the site you linked from, to this site's server; (2) to the extent that you provide PID to this site in an email; and (3) to the extent that you provide PID to this site in a CGI form (for example, when you complete a search request on this site's "Search this Site" search feature). Your PID will be used only for the specific purpose of which you submitted the PID, except that it may be used in an aggregate form to gauge the popularity of this site.
    2. "Cookies" are pieces of information that some Web sites transfer to the computer that is browsing that Web site and are used for record-keeping purposes. Use of Cookies performs certain functions such as saving your passwords, lists of potential purchases, and your personal preferences regarding your use of the particular Web site. This site does not currently use Cookies; however, the author of this site and The Company may decide to use them in the future in order to make your use of this site more efficient. Your browser is probably set to accept Cookies. However, if you would prefer not to receive Cookies, you can alter the configuration of your browser to refuse Cookies. If you choose to have your browser refuse Cookies, it is possible that, should this site employ Cookies in the future, some areas of the site will not function properly when you view them.
    3. This site may contain links to other sites. The author and The Company do not share your personal information with those sites and are not responsible for their privacy policies. We encourage you to learn about the privacy policies of those entities.
    4. Children under 13 years old are not the target audience of this site. To protect their privacy, the author and The Company prohibit the solicitation of personal information from these children.

5. The author and The Company reserve the right to change this privacy policy at any time by posting a new privacy policy at this location. You can email any further questions to the Privacy Officer.

5). *Participation on Social Media Sites as The Company Representative:*

a. Only employees designated by the Administrator have the authority to speak on behalf of The Company within Social Media.
b. Employees who participate on Social Media sites on The Company's IT systems for work-related reasons, for example on LinkedIn, must have prior approval from the Administrator.
c. Upon approval to participate on Social Media sites, access should be limited and not interfere with or impact normal business operations of The Company.
d. Anyone participating in Social Media for any reason is responsible for reading, understanding, and complying with the site's terms of use. Any concerns about the terms of use for a site should be reported to the Privacy Officer.
e. Many networking sites permit users to search for or import contact information from the user's contact list. Due to confidentiality and privacy concerns, users are prohibited from importing or uploading any contacts to any networking sites.
f. Communications and other interactions by The Company personnel acting on behalf of The Company on outside-party Social Media sites **must follow** the following provisions:
    1. Users are personally responsible for all content they post on Social Media sites. Remember that it is difficult to delete content once posted to a site, so be cautious when writing any posting
    2. Employees must adhere to The Company's Code of Conduct and policies governing restrictions on disclosure of confidential or other proprietary information, policies prohibiting discrimination, harassment, retaliation or threats, and policies mandating adherence to intellectual property and financial disclosure laws
    3. Do not discuss or disclose any resident protected health information as described in the Confidentiality Policy and Acceptable Use Policy
    4. Do not compromise the security or reputation of The Company
    5. Openly identify yourself as a representative of The Company
    6. Refrain from posting any content that could be characterized as defamation, plagiarism, harassment, advertising, a copyright violation, or claims of special expertise
    7. Identify all copyrighted or borrowed material with citations and links, and obtain permissions when necessary
    8. Do not knowingly provide false or misleading information, and use due diligence to assure that the information you do provide is accurate
    9. Obey the law. Do not post any information or conduct any online activity that may violate applicable local, state, or federal laws or regulations
    10. Information provided must be limited to that which may be spoken in any other public forum. Only individuals authorized to speak to the media on behalf of The Company may write in the name of The Company in any chat room or post in the name of The Company on any third-party blog
    11. Ensure that your posting is accurate, truthful, respectful, and is spelled correctly with appropriate grammar, language, and tone
    12. All responses to reader postings should be composed in a thoughtful, careful manner

13. Obtain approval from the Administrator before responding to an inaccurate, accusatory, or negative comment about The Company, its employees, or its residents; inquiries from journalists on issues related to The Company, its employees, or its residents; or an inquiry about any other legal matter
14. Do not post anything that would potentially embarrass you or The Company, or call into question The Company's reputation, including photographs or other images
15. Employees shall not post unauthorized images, videos or recordings of The Company's facilities
16. Employees shall not offer any referral, endorsement, or recommendation for or about others on behalf of The Company without the prior approval from the Administrator
17. If approached by external media, industry analysts, shareholders, or any company or organization for which there are assigned Company contacts, refer them to the authorized individual or department

6). *Employee's Personal Participation in Social Networking:*

a. The Company recognizes that some employees may wish to participate in their individual capacities in various forms of Social Media on their personal time and using their personal communications resources. Following are the expectations and requirements on responsible use of Social Media when employees participate in Social Media and such participation relates to The Company or their employment with The Company.
b. Employees should never attribute postings to The Company or imply that they are endorsed or written by The Company. If work affiliation is listed, or if employees publish content that has anything to do with The Company, the work they perform for The Company, or subjects associated with The Company, the posting should include a disclaimer such as the following to avoid any misinterpretation of their role:
    1. "The postings on this site are my own comments and opinions. I do not represent my employer in my postings on this site and the postings may not represent the views of my employer."
c. Unless previously authorized by The Company, do not use The Company's logo.
d. Nothing in this Policy is intended to restrict an employee's rights under any federal, state, or local labor or employment law or regulation, to discuss his or her salary, wages, hours and other terms and conditions of employment with nonemployees or with other employees.
e. Communications and other interactions by The Company personnel on Social Media sites must follow the following provisions:
    1. Users are personally responsible for all content they post on Social Media sites. Remember that it is difficult to delete content once posted to a site, so be cautious when writing any posting
    2. Employees must adhere to The Company's Code of Conduct and policies governing restrictions on disclosure of confidential or other proprietary information, policies prohibiting discrimination, harassment, retaliation or threats, and policies mandating adherence to intellectual property and financial disclosure laws
    3. Do not discuss or disclose any resident protected health information as described in the Confidentiality Policy and Acceptable Use Policy
    4. Refrain from posting any content that could be characterized as defamation, plagiarism, harassment, advertising, a copyright violation, or claims of special expertise

5. Obey the law. Do not post any information or conduct any online activity that may violate applicable local, state, or federal laws or regulations
6. Employees shall not post unauthorized images, videos or recordings of The Company's facilities
7. Employees shall not offer any referral, endorsement, or recommendation for or about others on behalf of The Company

B. COMPUTER AND INTERNET USAGE

1). *Overview:* Company computers and internet are to be used for business purposes only. All Company policies relating to privacy, harassment, data security, and confidentiality apply to conduct on the Internet.

2). *Procedure:*

a. The Company reserves the right to inspect all files stored on The Company network.
b. Internet usage must abide by all state and federal laws.
c. Company computers are not to be used to view, store, or distribute any sexually explicit material. Employees who find themselves on a website containing such material, must disconnect immediately.
d. Company computers are not to be used for entertainment or games, or to download videos or images not related to business.
e. Any files or software installed or downloaded onto a Company computer become the property of The Company.
    1. Any files or software installed or downloaded onto a Company computer must be used in accordance with their licenses
    2. All downloaded files must be scanned for viruses before use
f. Employees are not to download, possess, or distribute pirated software or data.
g. Employees are not to use Company computers to interfere with the facility computer system or compromise the security of other users. Employees are not to attempt to disable or otherwise compromise computer security systems.
h. Only employees who are authorized to do so may use Company internet to communicate with others in forms other than Company email (chatroom, etc.).
    1. Such employees are to accurately identify themselves when using Company internet to communicate with (chatroom, etc.)
    2. Communication must be related to business
    3. Employees communicating through such mediums are speaking as individuals
    4. Any material communicated by an employee may be copyrighted by Company
    5. Employees are not to disclose any confidential information that may compromise security or privacy of The Company, its employees, or its residents
i. The Administrator must approve the use of any portable storage devices before use. Use without prior authorization may constitute a HIPAA violation.
j. Each employee will receive an individual user ID and password for computer and internet use that must be kept confidential. Employees are not to share their user ID or password with anyone.
k. Files containing sensitive or confidential information must be encrypted before they can be transferred electronically.

l. Any emails received from unknown sources must be left unopened and promptly deleted.
m. All employees must sign the *Acknowledgement of Computer & Internet Usage Form*. The signed form is to be kept in the employee's personnel file.

C. VIDEO SURVEILLANCE POLICY

1). *Overview:* The Company may find it necessary to monitor work areas with video surveillance systems when there is a specific security, employment, or business-related reason. The primary purpose of the video surveillance system is to allow the after-the-fact investigation of crimes committed against The Company or on Company's premises.

Company's use of video surveillance shall be in compliance with all state and federal laws.

2). *Implementation:*

a. Location

Video surveillance cameras are primarily used to record access at building entrances, in public offices, and public spaces, including ceilings and/or Company computers. The main purpose of the video surveillance is to monitor and safeguard against theft of Company's currency, inventory, and property. However, The Company reserves the right to use surveillance in the investigation and deterrence of any unlawful behavior.

b. Employees should not expect privacy in work-related areas

Employee privacy in non-work areas will be respected to the extent possible. However, The Company reserves the right to use video surveillance in a non-work area where there is a reasonable suspicion of onsite drug use, physical abuse, theft, or similar circumstances. The Company will seek legal advice prior to installing video surveillance in a non-work area.

c. Management of Video Surveillance Systems

The Company's Security Consultant/Department is responsible for the management of all video surveillance systems used at The Company. No other department shall install video surveillance equipment without the knowledge and approval of the Security Consultant/Department. Company will seek legal advice prior to installing covert cameras or video surveillance cameras in non-work areas.

d. Video Surveillance Monitoring and Recording

The Company's video surveillance systems are capable of being monitored by the Security Consultant/Department and Management. Video surveillance is generally reviewed on a periodic basis or in response to a specific incident.

The Company's video surveillance systems are capable of being recorded. Recorded video is used exclusively for the investigation of security and safety incidents and not for other purposes.

e. Access to Video Recordings

The Company will not make recorded video available to employees or to the general public, even upon request. If it is determined that a security incident occurred in an area where video surveillance is available, Management and/or the Security Consultant/Department will review the recorded video to determine whether it is relevant to the incident. If it is determined that the video is relevant, the video will be used to investigate and resolve the incident.

The Company will seek legal advice prior to responding to a request by a law enforcement agency or other legal entity to view or use The Company's video recordings. Any release of The Company's video recordings will be in compliance with state and federal law.

f. Storage of Video Recordings

Recorded video is generally stored for a period of thirty (30) days unless instructed otherwise by The Company's lawyers, a law enforcement agency, or a court of law. Video recordings which could become evidence in a civil or criminal proceeding are kept indefinitely until directed otherwise by The Company's lawyers, a law enforcement agency, or a court of law.

Policy Number: PP 2.4

Policy Title: Identity Theft

Policy Statement/Purpose: The Company has policies and procedures in place to safeguard the confidentiality of resident Protected Health Information (PHI) to comply with laws, rules, regulations, and standards of practice.

Policy Interpretation and Implementation: Identity theft protection is a component of The Company Compliance and Ethics program.

A. IDENTITY THEFT PREVENTION PLAN

1). *Overview:* The Company recognizes that it has a duty to safeguard the confidentiality of resident Protected Health Information (PHI); therefore, whether the red flag rules are mandated for The Company or not, The Company chooses to comply.

2). *Definition:*

a. Identity theft is fraud committed or attempted by using identifying information of another person (individual or entity) without authority.
b. Medical identity theft is a growing problem with potentially fatal results.
c. Data taken by identity thieves can include social security numbers (SSN), account numbers, and other personal information.
d. Consumers are victimized by identity thieves because they must spend time and incur out of pocket expenses to correct their personal information and repair their credit.
e. Businesses are victimized by identity thieves because they cannot collect amounts owed for their goods and services.

3). *Identity Theft Prevention Program:*

Step One: Identify Covered Accounts: The Red Flag Rules require each creditor (who is subject to FTC enforcement) to determine periodically whether it offers or maintains covered accounts under the Red Flag Rules. A healthcare provider may consider the following as possible covered accounts under the Red Flag Rules: patient/resident accounts and billing records that include patient/resident identifying information.

Step Two: Identify Relevant Red Flags: See PP 2.4-D- Red Flags for Identity Theft. In the following circumstances, staff should be alert for the possibility of identity theft:

a. The resident submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
b. The photograph on the driver's license or other photo ID submitted by the resident does not resemble the resident.
c. The physical description on the driver's license or other photo ID submitted by the resident does not match the resident's appearance.
d. The resident's signature on the driver's license or other document does not match the resident's signature; or the resident's signature does not match the signature on file in The Company's records.

e. Information on one form of identification submitted by the resident is inconsistent with information on another form of identification, or with information already in The Company's records.
f. The Social Security Number (SSN) furnished by the resident has not been issued, is listed on the Social Security Administration's Death Master File, or is otherwise invalid. The following numbers are always invalid:
    1. The first three digits are in the 800, 900, or 000 range, are in the 700 range above 772, or are 666
    2. The fourth and fifth digits are 00
    3. The last four digits are 0000
g. The address given by the resident does not exist, is a post office box, or does not match existing records.
h. The phone number given by the resident is invalid or is associated with a pager or an answering service.
i. The resident fails to provide, or refuses to give, identifying information or documents.
j. Personal identifying information given by the resident is not consistent with personal identifying information in The Company's records.
k. The SSN or other identifying information furnished by the patient is the same as identifying information in The Company's records furnished by other individuals.
l. Suspicious activity includes:
    1. Requests for new/additional/replacement accounts shortly following change of address
    2. Mail repeatedly returned as undeliverable
    3. Notification that mail is not being received by intended recipient
    4. Notice of unauthorized charges

USE OF CREDIT REPORTS

If the Company uses a credit report:

a. When the Company requests a consumer report, and the address provided in the request differs from the address the consumer reporting agency has on file for the consumer, the agency is required to send The Company a notice of address discrepancy.
b. If the Company receives a notice of address discrepancy, The Company should notify the consumer reporting agency of the address reported by the individual.
c. The Company will compare information from the consumer reporting agency with information in The Company files or obtained from the resident.

Step Three: Detect Red Flags: See PP 2.4-C - Verifying Personal Identity.

Step Four: Respond to Red Flags: Responding to Red Flags requires preventing and mitigating identity theft through appropriate responses such as:

a. Monitoring covered accounts for evidence of identity theft.
b. Contacting the resident, if necessary.
c. Changing passwords and security codes.
d. Reopening, as appropriate, a covered account with a new account number, declining to open a new account, or closing an existing account.
e. Not attempting to collect on an account or selling it to a debt collector.
f. Notifying law enforcement.

g. A possible appropriate response may include, all things considered, no action is necessary.

To respond appropriately, it is necessary to assess whether the Red Flag that was detected evidences a risk of identity theft. It may be appropriate in some cases to deny services or tell a resident that he or she cannot be treated until more documentation is provided.

If an individual claims to be a victim of identity theft, The Company will investigate the claim. The following guidelines apply:

a. The individual must have filed a police report for identity theft.
b. The individual must complete one of the following documents:
    1. The ID Theft Affidavit developed by the FTC, including supporting documentation
    2. An ID theft affidavit recognized under state law
    3. A statement including the following information:
        - A statement that the individual is a victim of identity theft
        - A copy of the individual's driver's license or identification card
        - Any other identification document that supports the statement of identity theft
        - Specific facts supporting the claim of identity theft, if available
        - Any other explanation that the individual did not incur the debt
        - Any available correspondence disputing the debt
        - Documents of the residence of the individual at the date of service, including copies of utility bills, tax statements, or other statements from businesses sent to the individual at his or her residence
        - A telephone number for contacting the individual
        - Any information that the individual may have concerning the person who registered in his or her name
        - A statement that the individual did not authorize the use of his or her name or personal information for obtaining services
        - A statement certifying that the representations are true, correct, and contain no material omissions of fact to the best knowledge and belief of the person submitting the certification
c. The individual must cooperate with comparing his or her personal information with information in The Company's records.
d. If following investigation, it appears that the individual has been a victim of identity theft, The Company will take the following actions:
    1. The Company will cease collection on open accounts that resulted from identity theft. If the accounts had been referred to collection agencies or attorneys, the collection agencies/attorneys will be instructed to cease collection activity
    2. The Company will cooperate with any law enforcement investigation relating to the identity theft
    3. If an insurance company, government program, or other payor has made payment on the account, the provider will notify the payor and refund the amount paid
    4. If an adverse report had been made to a consumer reporting agency, The Company will notify the agency that the account was not the responsibility of the individual
    5. If following investigation, it does not appear that the individual has been a victim of identity theft, The Company or the collection agency will give written notice to the individual

that he or she is responsible for payment of the bill. The notice will state the basis for determining that the person claiming to be a victim of identity theft was in fact the resident

6. If it is confirmed that a resident record was created as the result of identity theft, a notation concerning the identity theft will be placed in the record. All demographic information will be removed from the record
7. Medical records staff will determine whether any other records are linked to the record found to be created through identity theft
8. In some cases, identity theft may involve an identity thief receiving care under the name of another person, who has been a resident. In such a case, other files relating to the resident will be reviewed and any information relating to the identity theft will be removed and segregated

If a resident makes a claim of identity theft, see PP 2.4 E *Investigation of Suspected Identity Theft*.

If identity theft has been confirmed, see PP 2.4 F *Disposition of Medical Record when Identity Theft is Confirmed*.

Step Five: Oversee the Program: The Privacy Officer with oversight by the Compliance and Ethics Committee will oversee, develop, implement, and administer the Identity Theft Prevention Program.

Step Six: Train Employees: Appropriate workforce training must occur on an annual basis. General training will be given to all employees to sensitize them to the issues surrounding identity theft. Staff involved with resident registration and with resident accounts will be trained on the requirements of the Identity Theft Prevention Program.

Step Seven: Oversee Service Provider Arrangements: For any third party granted access to the covered accounts in providing services, The Company will ensure that the activity is carried out in compliance with its Identity Theft Prevention Program. This is accomplished through a business associate agreement – see the following documents:

VC 2.1- *Business Associates*

VC Appendix 2.1 B - *Business Associate Agreement*

Step Eight: Approve the Identity Theft Prevention Program: The Red Flag Rules require that the Identity Theft Prevention Program be approved by the Governing Body, an appropriate committee of the Governing Body, or highest executive authority (e.g., the president, owner). See PP 2.4-B *Identity Theft Prevention Program Governing Body Resolution*.

Step Nine: Provide Reports and Periodic Updates to the Identity Theft Prevention Program: The Privacy Officer will review the program periodically and make appropriate changes based on The Company's experience in encountering identity theft.

At least on an annual basis, the Privacy Officer should provide a written report to the Governing Body and Compliance and Ethics Committee. This report should address material matters concerning the Identity Theft Prevention Program, such as:

a. Effectiveness of policies and procedures in addressing the risk of identity theft in opening new accounts.

b. Service provider arrangements.
c. Significant incidents involving identity theft and management's response.
d. Recommendations for material changes to the Identity Theft Prevention Program.

B. IDENTITY THEFT PREVENTION PROGRAM GOVERNING BODY RESOLUTION

C. VERIFYING PERSONAL IDENTITY

1). *Overview:* The Company has a policy and procedure for verifying or checking a resident's identity including the resident's residence address and insurance coverage to comply with The Company's Identity Theft Prevention Program. Verifying personal identities and authenticating a personal identifier are the same thing. It is important to ensure unauthorized persons cannot have access to protected health information and that several residents' health information could not be consolidated under only one person which could lead to The Company's healthcare workers to make decisions on incomplete or wrong information.

2). *Procedure:* To ensure healthcare workers verify and authenticate the identity of a person or personal representative at intake and admission, all resident identification will be verified. The resident should provide the following:

a. Photo Identification – Driver's license, passport, student ID, or employment ID.
    1. View the photo and confirm identity
    2. Review the physical description
    3. Verify the name and note any middle initial
    4. Verify the residence address. If not shown, see Proof of Residence Address below
b. Proof of Residence Address – If the photo ID does not show the resident's current address, utility bills or other correspondence mailed to the resident may be used to show current residence
c. Current Insurance Card

If the resident is a minor, the resident's representative (parent or guardian) should provide the information listed above.

The requirement to provide resident identification may be waived for residents who have been treated within the last six (6) months. If the resident has not completed the registration form within the last six (6) months, a new registration form must be completed and verified. In all cases the method of verification is to be noted in the record.

3). *Personal Representative:* The Company is to treat a personal representative, with respect to disclosing protected health information, the same as a resident. The procedure for verifying the identity of a representative is the same as for a resident; however, the authority of the representative must be verified with the resident as follows:

a. When an adult claims to represent an adult resident, it must be confirmed with the resident before protected health information can be disclosed. The representative identity can be confirmed by asking the resident in person, by phone, fax, email, or by letter.
b. When an adult claims to represent or assumes the role of representing an unemancipated minor resident, the fact that a parent or guardian is with the child is usually sufficient evidence that

the parent or guardian has the authority, but it is important to verify the relationship of the adult to the minor to rule out potential trafficking or abduction. (Note: be mindful of human trafficking, abduction, etc. Don't assume; it is best to verify their identity/relationship to the child).

In all cases, the name of the representative and the method of verification of the representative are to be noted in the record.

When The Company is informed of an abusive situation, this information should be communicated to the people handling requests for access, i.e., intake or admissions. Intake or admissions should note it in the record for representatives. In abuse, neglect, or endangerment situations, The Company can exercise professional judgment and may decide that it is not in the best interest of the resident to treat the person as the resident's personal representative. This, too, should be noted in the record. State authorities are to be contacted immediately.

D. Red Flags for Identity Theft

1). *Overview:* The Company's staff will be alert for discrepancies in documents and resident information that suggest risk of identity theft or fraud. The Company established a policy and procedure for detecting identity theft or fraud.

2). *Procedure:* In the following circumstances, staff should be alert for the possibility of identity theft:

a. The resident submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
b. The photograph on the driver's license or other photo ID submitted by the resident does not resemble the resident.
c. The physical description on the driver's license or other photo ID submitted by the resident does not match the resident's appearance.
d. The resident's signature on the driver's license or other document does not match the resident's signature; or the resident's signature does not match the signature on file in The Company's records.
e. Information on one form of identification submitted by the resident is inconsistent with information on another form of identification, or with information already in The Company's records.
f. The Social Security Number (SSN) furnished by the resident has not been issued, is listed on the Social Security Administration's Death Master File or is otherwise invalid. The following numbers are always invalid:
    1. The first three digits are in the 800, 900, or 000 range, are in the 700 range above 772, or are 666
    2. The fourth and fifth digits are 00
    3. The last four digits are 0000
g. The address given by the resident does not exist, is a post office box, or does not match existing records.
h. The phone number given by the resident is invalid or is associated with a pager or an answering service.
i. The resident fails to provide or refuses to give identifying information or documents.
j. Personal identifying information given by the resident is not consistent with personal identifying information in The Company's records.

k. The SSN or other identifying information furnished by the resident is the same as identifying information in The Company's records furnished by other individuals.
l. Suspicious activity includes:
    1. Requests for new/additional/replacement accounts shortly following change of address
    2. Mail repeatedly returned as undeliverable
    3. Notification that mail is not being received by intended recipient
    4. Notice of unauthorized charges

3). *Use of Credit Reports:* If The Company uses a credit report:
a. When The Company requests a consumer report, and the address provided in the request differs from the address the consumer reporting agency has on file for the consumer, the agency is required to send The Company a notice of address discrepancy.
b. If The Company receives a notice of address discrepancy, The Company should notify the consumer reporting agency of the address reported by the individual.
c. The Company will compare information from the consumer reporting agency with information in The Company files or obtained from the resident.

E. Investigation of Suspected Identity Theft

1). *Overview:* The Company will investigate situations in which an individual claims to be a victim of identity theft. Sometimes an individual may claim identity theft to avoid payment of the bill. The Company establishes a policy and procedure for investigating potential identity theft or fraud.

2). *Procedure:* If an individual claims to be a victim of identity theft, The Company will investigate the claim. The following guidelines apply:
a. The individual must have filed a police report for identity theft.
b. The individual must complete one of the following documents:
    1. The ID Theft Affidavit developed by the Federal Trade Commission (FTC), including supporting documentation
    2. An ID theft affidavit recognized under state law
    3. A statement including the following information:
        - A statement that the individual is a victim of identity theft
        - A copy of the individual's driver's license or identification card
        - Any other identification document that supports the statement of identity theft
        - Specific facts supporting the claim of identity theft, if available
        - Any other explanation that the individual did not incur the debt
        - Any available correspondence disputing the debt
        - Documents of the residence of the individual at the date of service, including copies of utility bills, tax statements, or other statements from businesses sent to the individual at his or her residence
        - A telephone number for contacting the individual
        - Any information that the individual may have concerning the person who registered in his or her name
        - A statement that the individual did not authorize the use of his or her name or personal information for obtaining services

- A statement certifying that the representations are true, correct, and contain no material omissions of fact to the best knowledge and belief of the person submitting the certification

c. The individual must cooperate with comparing his or her personal information with information in The Company's records.

If following investigation, it appears that the individual has been a victim of identity theft, The Company will take the following actions:

a. The Company will cease collection on open accounts that resulted from identity theft. If the accounts had been referred to collection agencies or attorneys, the collection agencies/attorneys will be instructed to cease collection activity.
b. The Company will cooperate with any law enforcement investigation relating to the identity theft.
c. If an insurance company, government program, or other payor has made payment on the account, the provider will notify the payor and refund the amount paid.
d. If an adverse report had been made to a consumer reporting agency, The Company will notify the agency that the account was not the responsibility of the individual.

If following investigation, it does not appear that the individual has been a victim of identity theft, The Company or the collection agency will give written notice to the individual that he or she is responsible for payment of the bill. The notice will state the basis for determining that the person claiming to be a victim of identity theft was in fact the patient.

F. Disposition of Medical Records When Identity Theft is Confirmed

1). *Overview:* Inaccuracies in medical records resulting from identity theft will be isolated and corrected. The Company has established a policy and procedure for correcting errors in medical records resulting from identity theft.

2). Procedure:

a. If it is confirmed that a resident record was created as the result of identity theft, a notation concerning the identity theft will be placed in the record. All demographic information will be removed from the record.
b. Medical records staff will determine whether any other records are linked to the record found to be created through identity theft.
c. In some cases, identity theft may involve an identity thief receiving care under the name of another person, who has been a resident. In such a case, other files relating to the resident will be reviewed and any information relating to the identity theft will be removed and segregated.

6. DATA INTEGRITY (DI)

6. DATA INTEGRITY (DI)

Policy Number	Policy
DI 1.0	INFORMATION SECURITY MANAGEMENT PLAN
	A. INFORMATION SECURITY MANAGEMENT B. APPOINTMENT OF AN INFORMATION SECURITY MANAGER C. CREATING IDENTIFIERS D. SECURITY CONFIGURATION DOCUMENTATION E. HARDWARE AND SOFTWARE INSTALLATION F. INTERNAL SECURITY AUDITING G. RANSOMWARE
DI 2.0	ACCESS CONTROLS
	A. PHYSICAL ACCESS CONTROLS B. EMERGENCY ACCESS C. REMOTE ACCESS
DI 2.1	MEDIA CONTROLS
	A. RECORD PROCESSING AND MEDIA CONTROLS B. LOG IN MONITORING C. ORAL DISCLOSURES
DI 2.2	DATA DISPOSITION
	A. RELEASE OF PROTECTED HEALTH INFORMATION B. DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION C. ACCEPTABLE METHODS TO RENDER UNSECURED PROTECTED HEALTH INFORMATION UNUSABLE, UNREADABLE, OR INDECIPHERABLE TO UNAUTHORIZED INDIVIDUALS D. ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION
DI 2.3	WORKFORCE DATA MANAGEMENT
	A. ACCEPTABLE USE B. PASSWORD STANDARDS C. WORKSTATION USE D. WORKSTATION SECURITY E. SERVER SECURITY
DI 2.4	WIRELESS COMMUNICATION

	A. VIRTUAL PRIVATE NETWORK (VPN)
DI 3.0	PRIVACY AND INFORMATION SECURITY COMPLIANCE EVALUATION

Policy Number: DI 1.0

Policy Title: Information Security Management Plan

Policy Statement/Purpose: The Company has a systematic information security management plan to ensure compliance with laws, regulations, and standards.

Policy Interpretation and Implementation: The information security plan consists of a data security (information) manager, unique identifiers, security configuration, and hardware/software installation that are consistent with The Company Compliance and Ethics program.

A. INFORMATION SECURITY MANAGEMENT

1). *Overview:* Security is the means by which information is protected. Security focuses on accessibility and integrity of data through such mechanisms as firewalls, access controls, and encrypting data when the information is transmitted or stored. Security is about denying access to protected health information (PHI) according to The Company's established privacy policies and procedures.

Security Management has to do with creation, administration, and oversight of policies to ensure the prevention, detection, containment, and correction of security breaches involving risk analysis and risk management.

It is the responsibility of the Information Security Manager to develop, implement, and monitor the security system for The Company. The Information Security Manager will monitor breaches and quality of the security system.

The Information Security Manager will develop and implement policies and procedures and keep them current.

2). *Annual Review:* A risk assessment will be conducted at least yearly. Specific implementations will be technology specific. A risk assessment is an examination of a network from both the outside and inside to identify where security measures are lacking. This should be performed prior to designing a secure network/security infrastructure and at any time to ensure that an organization is not vulnerable to the latest network, operation system, or application exploits.

B. APPOINTMENT OF AN INFORMATION SECURITY MANAGER

1). *Overview:* The Health Insurance Portability and Accountability Act of 1996 and rules promulgated under the Act (HIPAA) require an Information Security Manager. In addition, there are other federal and state laws and applicable regulatory and accreditation standards that have an impact on data (information) security.

The Company is committed to ensuring the privacy and security of protected health information. To manage the facilitation and implementation of activities related to the privacy and security of

protected health information, The Company will appoint and maintain an internal Information Security Manager who is accountable through a Governing Body appointed officer position.

2). *Responsibilities:* The Information Security Manager will serve as the focal point for information security compliance-related activities and responsibilities. The final responsibility for the implementation and maintenance of the Information Security Program must rest with one individual. In general, the Information Security Manager is charged with developing, maintaining, and implementing organizational policies and procedures, conducting educational programs, reviewing conduct of those assigned security responsibilities, and administering reviews relating to The Company's Information Security Program.

All workforce members will be made aware of the Information Security Manager's role and responsibilities. Any Information Security Manager changes will be promptly communicated.

The Information Security Manager will:

a. Lead in the development and enforcement of information security policies and procedures, measures, and mechanisms to ensure the prevention, detection, containment, and correction of security incidents. Ensure that security standards comply with statutory and regulatory requirements regarding health information.
b. Maintain security policies that include:
    1. **Administrative Security** – Formal mechanisms for risk analysis and management, information access controls, and appropriate sanctions for failure to comply
    2. **Personnel Security** – Formal mechanisms for ensuring personnel only have access to sensitive information for which they have the appropriate authority and clearance
    3. **Physical Safeguards** – Ensure assigned security responsibilities, control access to media (e.g., diskettes, tapes, CDs, backups, disposal, or data), protect against hazards and unauthorized access to computer systems, and secure workstation locations and use
    4. **Technical Security** – Establish access controls, emergency procedures, authorization controls, and data/entity access and authentication
    5. **Transmission Security** – Access controls, system alarms, audit trails, encryption, event reporting, and integrity controls
c. Maintain security procedures that include:
    1. Evaluation of compliance with security measures
    2. Contingency plans for emergencies and disaster recovery
    3. Security incident response process and protocols
    4. Testing of security procedures, measures, mechanisms, and continuous improvement
    5. Security incident reporting mechanisms and sanction policy
d. Maintain appropriate security measures and mechanisms to guard against unauthorized access to electronically stored and/or transmitted patient data and protect against reasonably anticipated threats and hazards; for example:
    1. Integrity controls
    2. Authentication controls
    3. Access controls
    4. Encryption
    5. Abnormal condition alarms, audit trails, entity authentication, and event reporting
e. Oversee and/or perform ongoing security monitoring of organization information systems.

1. Perform periodic information security risk assessments
2. Conduct functionality and gap analyses to determine the extent to which key business areas and infrastructure comply with statutory and regulatory requirements
3. Evaluate and recommend new information security technologies and counter-measures against threats to information or privacy

f. Ensure compliance through adequate training programs and periodic security audits.
g. The Information Security Manager serves as a resource regarding matters of informational security, and on a periodic basis, reports the status of information security activities to the Compliance and Ethics Committee.

3). *Information Security Manager Eligibility:* The Information Security Manager must demonstrate familiarity with the legal requirements relating to privacy and healthcare operations, as well as the ability to communicate effectively with and coordinate the efforts of technology and non-technology personnel. Information security covers legal issues, hardware and software security, as well as physical information security.

It is desirable that the Information Security Manager have a background to include the following:

a. Bachelor's degree or higher from an accredited university in Management Information Systems, Computer Science, Business Administration, or similar discipline
b. Security certification (e.g., Certified Information Systems Security Professional (CISSP))
c. Minimum of three years in information security experience

C. CREATING IDENTIFIERS

1). *Overview:* An individual may have multiple personal identifiers including social security number, universal identification number, driver's license number, passport number, member ID, picture, credit card, smart card, and employee number. The Company assigns a unique personal identifier to each person who may need to access protected health information.

2). *Implementation:* All residents will be assigned one unique identifier. Creating a resident identifier should follow the procedure below:

a. Attempt to verify at the time of creating the identifier who this person is. Check the picture on the driver's license. Perhaps capture the driver's license number.
b. Assign a temporary unique personal identifier.
c. Ask if the person has ever registered under a different name or ID.
d. Mail the personal identifier to the person's address much like a credit company does. This will also indicate that the billing address is valid.

After performing these checks, The Company makes the temporary personal identifier his or her permanent unique personal identifier.

For residents who already have one or more identifiers assigned, attempt to weed out multiple personal identifiers by performing the above checks and selecting one as the primary personal identifier.

Personal identifiers should not be significant (i.e., none of the characters that comprise the identifier should mean something by itself).

D. Security Configuration Documentation

1). *Overview:* There needs to be assurance that routine changes to system hardware and/or software do not contribute to or create security weaknesses. This requirement applies to documentation of hardware and software installation, maintenance and testing, inventory procedures, and virus checking.

All application and infrastructure security features will be documented in advance of testing. Operating system and communications software security features may need to be tested and documented.

2). *Implementation:* Software quality assurance will test all security features that correspond to the documented security features before the software is approved for production. The software is not to be released for production if there are any faults/bugs/incidents present.

When software configurations related to security are changed on mainframes, workstations, or servers, all changes must be logged for that device.

E. Hardware and Software Installation

1). *Overview:* The Company provides formal, documented procedures for connecting and loading new equipment and programs on its production network.

The Information Security Manager must approve and oversee the installation of all new hardware and software.

2). *Implementation:* When new hardware is installed, the Information Security Manager will ensure that the new system has the appropriate security patches and configuration. If the new system is not secure, it will compromise the network.

The Information Security Manager will check with various organizations that track known vulnerabilities to various versions of hardware and software. These databases will be searched for known exploits and known fixes prior to installation of new hardware or software.

F. Internal Security Auditing

1). *Overview:* The Company ensures that it has the technical capabilities to record and examine systems that contain or use electronic protected health information (PHI). The Company has the ability to assess and access the damage should there be a break-in or in the event of accidental access to PHI data.

The Company implements and utilizes the necessary hardware, systems, applications, and procedural measures to record and examine system activity, including access and transaction activity,

in all systems that receive, store, transmit, or otherwise access electronic protected health information. The Company examines and reviews the recorded activity on a periodic basis and maintains and stores such recorded activity for a reasonable period of time.

It is the responsibility of the Information Security Manager to analyze the logs to determine unauthorized access.

2). *Implementation:*

a. The Information Technology Department will provide an audit trail for applications and networks.
b. The Information Security Manager will:
    1. Be educated about the audit control features and functionality of the systems, applications, and devices that receive, store, transmit, or otherwise access electronic protected health information that are in use by The Company
    2. Educate the appropriate workforce members in charge of systems, applications, or devices that receive, store, transmit, or otherwise access electronic protected health information about the audit control features and functionality of their systems
    3. Ensure that the appropriate audit control features are turned "on" and utilized in all systems, applications, and devices that receive, store, transmit, or otherwise access electronic protected health information
        - If systems, applications, or devices that receive, store, transmit, or otherwise access electronic protected health information do not have adequate audit control features and functionality, the Information Security Manager will contact the vendors of those products to request such features be upgraded, and to determine when the features will be available and shall document the vendor's response. Such systems shall be thoroughly considered in the risk assessment
    4. Consider audit control features and functionality in purchase decisions for systems, applications, and devices that receive, store, transmit, or otherwise access electronic protected health information
    5. Ensure that adequate systems storage is available for the storage of audit control information
    6. Determine:
        - What information needs to be captured by audit control features and functionality within each system, application, and device
        - Which audit control reports must be generated from each system, application, and device
        - How often audit control reports should be generated and in what manner
        - Who will receive and review the audit control information
        - Procedures for documenting and reporting audit control discrepancies
        - The length of time and manner in which to store the generated audit control information

G. RANSOMWARE

1) *Overview*: Company policy is to implement and maintain as tight a level of security as possible and maintain backups. Ransomware is a virus that shuts down an IT system until a Bit-coin or other non-traceable financial method of ransom is paid. Once the ransom is paid, the IT system is

unlocked and normal operations can resume. Company leadership will dictate whether to pay a ransom, which is determined on a case-by-case basis. Typically, it is not recommended to pay the ransom.

2) *Importance of Security Management:* The possibility of an attack emphasizes the importance of overall security management by the Privacy Manager, Security Information Manager, and Information Technology Department, including installation and monitoring of antivirus or cybersecurity software for detection of suspicious files or activity. Appropriate safeguards, including encryption and access controls, may mitigate or even prevent unauthorized access to or loss of protected information.

3) *Security Measures:* The HIPAA Security Rule requires security measures to prevent, detect, and respond to cyberattacks. These include, but are not limited to, the following:
   a. Conduct risk analyses to identify risks and vulnerabilities
   b. Implement a risk management process to mitigate identified risks and vulnerabilities
   c. Regularly review audit and system logs to identify abnormal or suspicious activity
   d. Implement procedures to identify and respond to security incidents
   e. Establish and periodically test contingency plans, including data backup and disaster recovery plans to ensure data is backed up and recoverable
   f. Implement access controls to limit access to ePHI, and encrypt as appropriate
   g. Implement a security awareness training program, including periodic security reminders, education, and awareness of implemented procedures concerning malicious software protection for all staff

Ransomware Advisory

The U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) issued an advisory to highlight the sanctions risks associated with making ransomware payments related to malicious cyber-enabled activities. OFAC may impose civil penalties for sanctions violations based on strict liability, meaning that a person subject to U.S. jurisdiction may be held civilly liable even if it did not know or have reason to know it was engaging in a transaction with a person that is prohibited under sanctions laws and regulations administered by OFAC. For this reason, facilities receiving ransomware notices and payment demands may be violating the law if they choose to pay the ransom.

Reporting of Ransomware Attacks

OFAC encourages victims and those involved with addressing ransomware attacks to contact OFAC immediately if they believe a request for a ransomware payment may involve a sanctions nexus. Victims should also contact the U.S. Department of the Treasury's Office of Cybersecurity and Critical Infrastructure Protection if an attack involves a U.S. financial institution or may cause significant disruption to a firm's ability to perform critical financial services.

- U.S. Department of the Treasury's Office of Foreign Assets Control
  - Sanctions Compliance and Evaluation Division: ofac_feedback@treasury.gov – (202) 622-2490 / (800) 540-6322
  - Licensing Division: https://licensing.ofac.treas.gov/ - (202) 622-2480
- U.S. Department of the Treasury's Office of Cybersecurity and Critical Infrastructure Protection (OCCIP)
  - OCCIP-Coord@treasury.gov; (202) 622-3000

- Financial Crimes Enforcement Network (FinCEN)
  - FinCEN Regulatory Support Section: frc@fincen.gov

Contact Information for Other Relevant U.S. Government Agencies:
- Federal Bureau of Investigation Cyber Task Force
  - https://www.ic3.gov/default.aspx; http://www.fbi.gov/contact-us/field
- U.S. Secret Service Cyber Fraud Task Force
  - www.secretservice.gov/investigation/#field
- Cybersecurity and Infrastructure Security Agency
  - https://us-cert.cisa.gov/forms/report
- Homeland Security Investigations Field Office
  - https://www.ice.gov/contact/hsi

On July 15, 2021, the U.S. government announced new resources and initiatives to protect American businesses and communities from ransomware attacks. The new website establishes a one-stop hub for ransomware resources for individuals, businesses, and other organizations. It is a collaborative effort of the U.S. Department of Justice (DOJ) and the U.S. Department of Homeland Security (DHS) with federal partners to help private and public organizations mitigate their ransomware risks. The website can be accessed at: Stop Ransomware | CISA.

For questions about the scope of sanctions, please contact OFAC's Sanctions Compliance and Evaluation Division at (800) 540- 6322 or (202) 622-2490
(*Advisory on Potential Sanctions Risks for Facilitating Ransomware Payments*, October 1, 2020)

Policy Number: DI 2.0

Policy Title: Access Controls

Policy Statement/Purpose: The Company has systems in place to control access privileges to entities to ensure the establishment and protection of privacy in accordance with laws, regulations, and standards.

Policy Interpretation and Implementation: Physical, emergency, and remote access controls are components of The Company Compliance and Ethics policy.

A. PHYSICAL ACCESS CONTROLS

1). *Overview:* An important part of the overall Privacy Program is physical security. When routine, non-routine, or contingent events occur, physical security must be maintained. The Company values the establishment and protection of privacy. This means *restricting access* to *protected health information* for only those entities that have access privileges.

The Company often requires easy access to information, especially in urgent or emergent situations. At the same time, for other than treatment, only the minimum necessary information is to be used or disclosed. This policy and procedure *limits physical access* to The Company's *electronic information systems* while ensuring that properly authorized access is allowed.

This document establishes physical access policy and procedures to *address disaster recovery, an emergency mode operation,* equipment control, a company security plan, procedures for verifying access authorizations, maintenance records, need-to-know procedures for workforce members' access, procedures to sign in visitors and provide escorts, and testing and revision.

Physical access will be the responsibility of The Company's Information Technology Department. The Information Technology Department will maintain a current list of privileges for each workforce member.

Workforce members who see an unauthorized user in a restricted area (e.g., data center, peripheral equipment locations, and IT staff offices) must either ask the unauthorized user for identification or notify the Information Security Manager.

Equipment removal requires a property pass issued by IT Department or Information Security Manager prior to removing personal computers, software, backup media, or any other computer equipment from The Company.

a. Definitions
   1. **Authorized internal user** - Any member of the workforce who has been authorized to access, create, read, update, and delete information created or held by The Company
   2. **Authorized external user** - Organizational entities and third-party intermediaries distinct from The Company with contractual permissions for information exchange with The Company

b. Implementation

1. The Privacy Manager and Information Security Manager are responsible for establishing the policy and procedures for assigning access privileges to entities that need access to protected health information
2. The Information Technology Department will be responsible for assigning protected health information access privileges to entities, as well as be responsible for assigning physical access privileges to internal staff and authorized external users
3. Authorized external users are required to enforce the "chain-of-trust" provision of their contract. The chain-of-trust provision should implement the similar restrictions on access as authorized internal users
4. All internal staff and authorized external users will need to sign on to the network before signing on to specific applications or desktops. For each entity identifier, the Information Technology Department will maintain records as to which privileges are assigned to the entity identifier
5. Some users may need badges (or some other identification) with specific privileges to certain rooms
6. Emergency access relating to treatment, payment, or healthcare operations is to be provided. The Information Technology Department will provide the procedures
7. The Privacy Officer and Information Security Manager will establish the guidelines for access privileges. The guidelines will be used by the IT Department to assign privileges. The Privacy and Information Security Managers must approve all exceptions in writing
8. The Privacy Officer and Information Security Manager, with the aid of the Information Technology Department, will audit this policy and procedure once a year using, for example, sampling techniques or actual access logs for specific systems. The results of the audit are to be documented

B. EMERGENCY ACCESS

1). *Overview:* During an emergency, knowledge of an individual's health information may be critical to ensure the well-being of the resident. In these situations, access to PHI may be granted by the Information Security Manager.

Emergency Access is defined as access to PHI that may be granted to an individual when this information is critical to the well-being of the resident.

Access to this PHI must be limited to the individual resident who is affected by the emergency. Access that has been granted during the emergency to unauthorized personnel must be revoked immediately following the incident.

The Company will always have a workforce member available (on call or in person) who has access to all PHI and can grant the necessary access in an emergency.

2). *Implementation:*

a. When an event occurs, and a workforce member determines that the well-being of the resident depends on his/her knowledge of particular information, he/she is to contact the designated manager who will grant the necessary access in conjunction with the information security manager.
b. When the manager receives the request for PHI access, he/she will provide access to the appropriate PHI in one of several ways:
    1. Modify the requesting user's access rights to allow access to the necessary PHI
    2. Provide the requestor with a separate user ID that has the appropriate level of access
    3. Record access level modification in the Access Control Log
c. The manager must notify the Information Security Manager to inform him that the access list has been modified.
d. Once the emergency is over and access to the PHI is no longer necessary, the manager who granted the additional access is responsible for revoking these rights by:
    1. Modifying the requesting user's account to revoke the additional access rights
    2. Changing the authorization credentials for the account that was used to give the requesting user access to the appropriate PHI
e. The Information Security Manager is responsible for verifying that the additional rights have been revoked.

C. REMOTE ACCESS

1). *Overview:* The Company defines standards for connecting to The Company's network from any host. These standards are designed to minimize the potential exposure to The Company from damages which may result from unauthorized use of Company resources. Damages include the loss of sensitive or Company confidential data, intellectual property, damage to public image, and damage to critical Company internal systems.

2). *Implementation:*

a. It is the responsibility of The Company workforce members with remote access privileges to The Company's corporate network to ensure that their remote access connection is given the same consideration as the user's on-site connection to The Company.
b. General access to the internet for recreational use by immediate household members through the Company Network on personal computers is not permitted. Company workforce members are responsible to ensure the family member does not violate any Company policies, does not perform illegal activities, and does not use the access for outside business interests. Refer to *Requirements,* below. Company workforce members bear responsibility for the consequences should the access be misused.
c. Additional information regarding The Company's remote access connection options, including how to order or disconnect service, cost comparisons, troubleshooting, etc., can be obtained from the Information Security Manager.

3). *Requirements:*

a. Secure remote access must be strictly controlled.

b. At no time should any Company workforce member provide their login or email password to anyone, not even family members.
c. The Company workforce members and contractors with remote access privileges must ensure that their Company-owned or personal computer or workstation, which is remotely connected to The Company's corporate network, is not connected to any other network at the same time, with the exception of personal networks that are under the complete control of the user.
d. The Company workforce members with remote access privileges to The Company's corporate network must not use non-Company email accounts or other external resources to conduct Company business, thereby ensuring that official business is never confused with personal business.
e. Non-standard hardware configurations and security configurations for access to hardware must be approved by the Information Security Manager.
f. All hosts that are connected to Company internal networks via remote access technologies must use the most up-to-date anti-virus software (this includes personal computers).
g. Personal equipment that is used to connect to The Company's networks must meet the requirements of Company-owned equipment for remote access.
h. Workforce members who wish to implement non-standard Remote Access solutions to The Company production network must obtain prior approval from the Information Security Manager.

Policy Number: DI 2.1

Policy Title: Media Controls

Policy Statement/Purpose: The Company designates responsibility for securely backing up data related to protected health information, providing a backup copy off-site, acquiring all new media, and properly disposing of all previously used media in accordance with laws, rules, regulations, and standards.

The Information Technology Department or its designee is to account for all media that is acquired.

Policy Interpretation and Implementation: Media controls are considered formal, documented policies and procedures that govern the receipt and removal of hardware/software (such as diskettes, tapes, and CDs) into and out of The Company, including access control, accountability (the property that ensures that the actions of an entity can be traced uniquely to that entity), data backup (a retrievable, exact copy of information), data storage (the retention of healthcare information pertaining to an individual in an electronic format), and disposal (final disposition of electronic data, and/or the hardware on which electronic data is stored).

1. Backups are to be retained for a period of ten years.
2. Backups are to be under strict access control. This means that few people are to be given access to backups. It is expected that most people having access will be hardware/software administrators.

The Information Technology Department or its designee is to erase all protected health information before disposing of media and to account for all media that is disposed.

A. Record Processing and Media Controls

1). *Overview:* The Company establishes an administrative procedure that specifies how The Company will deal with PHI from its inception to its disposal and all points in between.

The Information Technology Department or its designee will be responsible for securely backing up data related to protected health information (PHI) and providing a copy off-site; as well as properly disposing of all previously used media.

The Company has a formal mechanism for processing records by documenting policies and procedures for the routine and non-routine receipt, manipulation, data storage (the retention of PHI pertaining to an individual in an electronic format), dissemination, transmission, and/or disposal (final disposition of electronic data, and/or the hardware on which electronic data is stored) of PHI.

2). *Implementation:*

a. Receipt - New PHI information will only be received and entered into the appropriate applications by workforce members with the necessary authorizations. The proper authorization will be enforced by The Company's access control system.
b. Manipulation - The Company's IT access control system will enforce who has authorization to manipulate PHI information stored with the IT systems.

c. Storage - All applications that store PHI will be protected by an appropriate access control solution which will only allow authorized workforce members to view or modify this information.
    1. All PHI archived to backup media must have a session password or another form of protection. Other forms of protection may include encryption or restore restrictions to/from a particular system
d. Dissemination - All workforce members must adhere to The Company's guidelines when disclosing any information to non-Company workforce members.
e. Transmission - Any PHI transmitted beyond The Company's private network must be encrypted.
f. Backups - Backups are to be retained for a period of ten years.
    1. Backups are to be under strict access control. This means that few people are to be given access to backups. It is expected that most workforce members having access will be hardware/software administrators
    2. All logs are to be retained by IT Department and/or the Information Security Manager for a period of ten (10) years
    3. The IT Department will create a retrievable exact copy of PHI when needed before movement of equipment
g. Disposal - All expired backup media will be disposed of by shredding. A log of disposal must be maintained for legal audit trails.
    1. The Information Technology Department or its designee is to erase all protected health information before disposing of media and to account for all media that is disposed
    2. Prior to disposal, all data on hard drives and/or any other storage media is to be erased and overwritten using an approved utility program to prevent access to any information. Furthermore, holes are to be drilled through the platters of hard drives to prevent the possibility of the use of any electronic means to retrieve the data
h. Media Reuse - The IT Department will implement and oversee procedures for removal of PHI from electronic media before the media are made available for re-use.
i. Accountability - The IT Department will maintain a record of the movements of hardware and electronic media and any person responsible for such media.

B. LOGIN MONITORING

1). *Overview:* The Company ensures that it complies with applicable laws and regulations regarding the security of electronic protected health information through login monitoring. The Company monitors log in attempts to detect and report log in discrepancies, such as unauthorized and/or failed log in attempts and dual log in attempts.

2). *Implementation:* The Information Security Manager will:
a. Monitor and review login activity.
b. Ensure that The Company's systems have login monitoring and reporting functionality properly configured based on the risk rating of the system, in accordance with the risk assessment.
c. Ensure that sufficient products and/or services are dedicated to the monitoring and reviewing of systems-generated login reports, based on the risk rating of the system, in accordance with the risk assessment.

d. Establish a review process whereby systems login logs, reports, or other mechanisms that document log in activity are reviewed by the Information Security Manager at intervals commensurate with their risk level, but not less than once per _____ [RECOMMENDATION: month].
e. Implement a process whereby system-generated login logs, reports, and other documentation are maintained and archived for no less than six (6) years.
f. Alerted by workforce members and The Company's systems to log in attempts deemed reasonably "suspect" by the workforce members or the system within a reasonable period of time.
g. Determine and set a reasonable time of inactivity that will terminate a workforce member's workstation by automatic logoff.
h. Consider a system's login monitoring and reporting functionality as a factor in The Company's systems purchase decisions for those systems that require it.
i. Contact the vendors of The Company's systems that lack the functionality to monitor and report logins to request that the functionality be added to the systems and shall document the vendor's response. Such system shall be thoroughly considered in the risk assessment.
j. Ensure that workforce members receive training and reminders about login monitoring and reporting of discrepancies.

C. ORAL DISCLOSURES

1). *Overview:* There are many circumstances when oral disclosures of health information are made, particularly to the resident. This policy and procedure is about precautions associated with such disclosures

2). *Procedure:*

When members of the workforce talk to residents or their representative in an open area, best efforts should be made so that only the resident or their representative hears the conversation. In practice, this means pulling curtains and/or shutting the door, talking in a low voice, and facing the person you are addressing.

Relative to phone conversations with residents, including appointments, phone conversations should be held in such a manner as to minimize being overheard by other residents.

Accidental disclosures may happen. It is the responsibility of the workforce to mitigate the impact of accidental disclosures.

Policy Number: DI 2.2

Policy Title: Data Disposition

Policy Statement/Purpose: The Company has policies and procedures for the release, disposition, and disposal of data that is compliant with requirements, laws, regulations, and standards of practice.

Policy Interpretation and Implementation: Data disposition is a component of The Company Compliance and Ethics Program.

A. Release of Protected Health Information

1). *Overview:* The Company receives many requests for PHI. There are letters from attorneys, court orders, requests from health plans, subpoenas, etc., that request a resident's protected health information. The Company has established a policy and procedure for releasing Protected Health Information (PHI).

2). *Implementation:* The release of PHI to anyone but the resident and the healthcare team (for the purpose of treatment, payment, and healthcare operations) will occur only after executing the following seven-step process:

Step 1 - *Verify that the person requesting PHI is the person who he/she claims to be.*
Step 2 - *Verify that the person has the authority to be requesting protected health information.* Refer to PP 2.4 C - *Verifying Personal Identity* for determining whether a personal representative has the authority.
Step 3 - *Verify that the person is requesting the minimum necessary information for the purpose described.*
Step 4 - *Did the resident sign* PP Appendix 2.0.2 H - *Request for Restriction of Use and Disclosure of Protected Health Information Form*? Refer to PP 2.0 E - *Securing Consent/Restrictions/Requests*.
Step 5 - *Is a consent, authorization, or opportunity to agree or object required for the release*? The following uses and disclosures may not require consent, authorization, or the opportunity to agree or object:

a. Uses and Disclosures Required by Law
b. Uses and Disclosures for Public Health Activities
c. Disclosures about victims of abuse, neglect, or domestic violence
d. Uses and Disclosures for health oversight activities
e. Disclosures for judicial and administrative proceedings
f. Disclosures for law enforcement purposes
g. Uses and Disclosures about decedents
h. Uses and Disclosures for cadaveric organ, eye, or tissue donation purposes
i. Uses and Disclosures for research purposes
j. Uses and Disclosures to avert serious imminent threat to health or safety
k. Uses and Disclosures for specialized government functions

The Company is not required to obtain an authorization when it uses or discloses protected health information to make a marketing communication to a resident that:

a. occurs in a face-to-face encounter with the resident;
b. concerns products or services of nominal value; or
c. concerns the health-related products and services of The Company or of a third party and the communication meets certain standards (see Privacy Officer).

If the marketing communication is written, an opt-out provision must be provided.

The Company may use or disclose to a business associate or to an institutionally related foundation, the following protected health information for the purpose of raising funds for its own benefit, without an authorization but must provide an opt-out provision:

a. Demographic information relating to a resident
b. Dates of healthcare provided to a resident

The Privacy Officer, or his or her designee, must sign the use or disclosure if it pertains to the above categories. In addition, The Company may disclose to a family member, other relative, close personal friend of the resident, or any other person identified by the resident, the protected health information directly relevant to such a person's involvement with the resident's care or payment related the resident's care. The Company may use or disclose protected information to notify, or assist in the notification of, a family member, personal representative of the resident, or another person responsible for the care of the resident or resident's location, general condition, or death.

PHI associated with HIV, pregnancy, sexually transmitted diseases, alcohol and drug abuse, and other chemical dependencies requires an authorization. Refer to PP Appendix 2.0.1 G - *Authorization*.

PHI for the purpose of treatment, payment, and healthcare operations does not require consent. Refer to PP 2.0 E- *Securing Consent/Restrictions/Requests*.

Step 6 - Verify that de-identification is not required.

Step 7 - Document all nonroutine disclosures, i.e., disclosures that are not related to business associates or requests from other covered entities for the purpose of treatment or for which residents have signed an authorization, with type of disclosure.

B. De-identification of Protected Health Information

1). *Overview:* The Company may use Protected Health Information (PHI) to create information that is not individually identifiable health information or disclose PHI only to a business associate for such purpose, whether or not the de-identified information is to be used by The Company. Use of de-identified information is generally encouraged. De-identified information can be used for marketing purposes, research, and public health studies. The Company has established requirements for de-identified information when PHI needs to be used for other than treatment, payment, or healthcare operation purposes. Uses and disclosure of de-identified information is permitted.

2). *Implementation:* Under the HIPAA Privacy Rule there are two acceptable methods of de-identifying information:

a. Safe-harbor method
b. Statistical method

Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information and, therefore, is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protections.

The only accepted method of de-identifying information is the safe-harbor method, unless the Privacy Officer approves an exception. Proposed exceptions must show how the specific statistical method will result in de-identified information that has a very small probability of being re-identified.

All disclosures of de-identified protected health information will be logged in the Disclosure Log.

3). *De-identification Procedure:* A covered entity may determine that health information is not individually identifiable health information by utilizing either of the following methods:

a. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable:
    1. Applying such principles and methods determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information
    2. Documenting the methods and results of the analysis that justify such determination
b. The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:
    1. Names
    2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes (note that the first three (3) digits may be used if it represents more than 20,000 people)
    3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
    4. Telephone numbers
    5. Fax numbers
    6. Electronic mail addresses
    7. Social security numbers
    8. Medical record numbers
    9. Health plan beneficiary numbers
    10. Account numbers
    11. Certificate/license numbers
    12. Vehicle identifiers and serial numbers, including license plate numbers
    13. Device identifiers and serial numbers
    14. Web Universal Resource Locators (URLs)
    15. Internet Protocol (IP) address numbers
    16. Biometric identifiers, including finger and voice prints
    17. Full face photographic images and any comparable images
    18. Any other unique identifying number, characteristic, or code

c. The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

4). *Re-identification Procedure:* The Company may assign a code or other means of record identification to allow information de-identified under this section to be re-identified, provided that:
   a. the code or other means of record identification is not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual; and
   b. The Company does not use or disclose the code or other means of record identification for any other purpose and does not disclose the mechanism for re-identification.

C. Acceptable Methods to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals

1). *Overview:* The Information Security Manager, in conjunction with the Information Technology Department, will determine lawful compliance acceptable methods to render protected health information unusable, unreadable, or indecipherable to unauthorized individuals. Such methods will involve either protected health information encryption, or destruction of the media on which the protected health information is stored or recorded.

2). Implementation: Protected health information (PHI) is rendered unusable, unreadable, or indecipherable to unauthorized individuals if one or more of the following applies:
   a. Electronic PHI has been encrypted as specified in the HIPAA Privacy Program by "the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key, and such confidential process or key that might enable decryption has not been breached." To avoid a breach of the confidential process or key, these decryption tools should be stored on a device or at a location separate from the data they are used to encrypt or decrypt. The encryption processes identified below have been tested by the National Institute of Standards and Technology (NIST) and judged to meet this standard.
      1. Valid encryption processes for data at rest are consistent with NIST Special Publication 800-111, Guide to Storage Encryption Technologies for End User Devices
      2. Valid encryption processes for data in motion are those which comply, as appropriate, with NIST Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS) 140-2 validated

   b. The media on which the PHI is stored or recorded has been destroyed in one of the following ways:
      1. Paper, firm, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction

2. Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI cannot be retrieved

D. Accounting of Disclosures of Protected Health Information

1). *Overview:* Residents have the right to receive an accounting of disclosures of their PHI made by The Company in the six (6) years prior to the date on which the accounting is requested. The Company has established a policy and procedure for tracking Protected Health Information (PHI) disclosures.

2). *Implementation:* The Company does not have to track and account for the following disclosures:

a. Disclosures to carry out treatment, payment, or healthcare operations
b. Disclosures to the resident about him/herself
c. Disclosures to the resident's personal representative
d. Disclosures to individuals involved in the resident's treatment or care
e. Disclosures made pursuant to a valid authorization
f. Use in The Company's directory
g. Disclosures for national security or intelligence purposes
h. Disclosures to correctional institutions or law enforcement
i. Use as part of a limited data set
j. Other incidental uses or disclosures permitted or required by applicable laws, rules, and regulations

Residents have the right to receive an accounting of disclosures of their PHI made by The Company in the six (6) years prior to the date on which the accounting is requested.

Policy Number: DI 2.3

Policy Title: Workforce Data Management

Policy Statement/Purpose: The Company adheres to rules, regulations, and standards to protect the employee and The Company from data exposure risks, virus attacks, compromise of network systems and services, and legal issues.

Policy Interpretation and Implementation: Workforce data management policies apply to employees, contractors, consultants, temporaries, and other workers at The Company, including all personnel affiliated with third parties. This policy applies to all equipment that is owned or leased by The Company.

A. ACCEPTABLE USE

1). *Overview:* The Company's intentions for publishing an Acceptable Use Policy are not to impose restrictions that are contrary to The Company's established culture of openness, trust, and integrity. The Company is committed to protecting its workforce members and The Company from illegal or damaging actions by individuals, either knowingly or unknowingly.

Internet/Intranet/Extranet-related systems, including but not limited to computer equipment, software, operating systems, storage media, network accounts providing electronic mail, and World Wide Web browsing are the property of The Company. These systems are to be used for business purposes in serving the interests of The Company and our residents during normal operations. Please review Human Resources policies for further details, including WM 2.5 *Employment Conduct and Behavior*.

Effective privacy and security is a team effort involving the participation and support of every workforce member who deals with information and/or information systems. It is the responsibility of every computer user to know these guidelines and to conduct their activities accordingly.

The purpose of this policy is to outline the acceptable use of computer equipment at The Company. These rules are in place to protect the workforce member, resident, and The Company. Inappropriate use exposes The Company to risks including virus attacks, compromise of network systems and services, and legal issues.

2). *Computer Security Training Procedures:* Everyone who plans, designs, and implements networks or applications is required to be trained in computer security procedures. For the existing members of the workforce, training must be conducted on an annual basis. For a new member of the workforce, training must be completed thirty (30) days after the person joins the workforce. For existing members of the workforce whose functions have changed, training must be completed within thirty (30) days of the function changes. Establishment of security training will be the responsibility of the Information Security Manager. Reference WM 2.4 *Orientation and Training* and WM 2.4 Section G, *Security Awareness Training*

3). *General Use and Ownership:* While The Company desires to provide a reasonable level of privacy, users should be aware that the data they create on the corporate systems remains the property of The Company.

4). *Security and Proprietary Information:* Encryption of information will be determined and directed by The Company.

B. Password Standards

1). *Overview:* The Company policy is to establish a standard for creation of strong passwords, the use and ownership of those passwords, the protection of those passwords, and the frequency that those passwords must be changed.

Passwords are an important component of computer security, and oftentimes they serve as the only way to authenticate a user. Lax password procedures can compromise The Company's entire information systems environment.

To the extent possible, The Company will only deploy systems, applications, devices, and equipment that store passwords in an encrypted format and support strong passwords.

It is important to remember that all passwords are the property of The Company and must be given to the Information Security Manager upon request.

2). *Key Points:*

a. Authorized Users are required to use strong passwords to reduce the likelihood of a password being cracked by hackers or unauthorized users. There will be consequences for violators of this policy.
b. KEEP ALL PASSWORDS CONFIDENTIAL. Authorized users are responsible for the security of their passwords and accounts.
c. DO NOT reveal your password to anyone. Shared accounts are NOT allowed or authorized. If anyone does not have an account, they are NOT AUTHORIZED to use The Company network or any of its resources.
d. DO change your password immediately should you suspect that your password security has been compromised and NOTIFY The Company's Information Security Manager IMMEDIATELY.
e. System level passwords should be changed in accordance with The Company's policy.

3). *Scope:* This policy applies to all workforce members who have or are responsible for a systems account (or any form of access that supports or requires a password) on any system, application, device, or other equipment that:

a. Resides at any company
b. Is hosted by an application service provider
c. Has access to The Company network
d. Stores any nonpublic Company information

4). *Implementation:* It is required to use strong passwords to reduce the likelihood that your password can be broken. There are several ways hackers can crack network passwords.
   a. Brute Force Attack: A brute force attack attempts to crack the passwords by trying every possible combination of characters against the password until a match is found.
   b. Dictionary Attack: Instead of trying every possible combination of characters, a dictionary attack uses entries in a dictionary or word list. This dramatically reduces the computing time required to crack a password. A dictionary attack can reduce the number of character combinations from trillions to thousands.
      1. An English dictionary contains approximately 200,000 words
      2. Publicly available word lists include 250,000 to 2.6 million words
      3. If your password resides on one of these lists, a dictionary attack can find a match within *seconds*
   c. Phishing: Phishing is an attempt to acquire sensitive information for malicious reasons. Millions of phishing emails are sent out every second, using a variety of lures to get recipients to open infected email. Examples include:
      a. Offers of financial bonuses
      b. Fake online receipts
      c. Job applications from prospective employees
      d. Job offers from prospective employers
      e. Patient records
   d. Social engineering: Social engineering is the process of tricking users into believing that the individual is a legitimate agent.
   e. Shoulder surfing: This occurs when hackers disguise themselves in order to gain access to company sites by looking over the shoulders of employees to gain access to passwords. Small companies are most at risk for this activity.

5). *Password Guidelines:* All system-level passwords (e.g., root, enable, admin, application administration accounts, etc.) must be changed _____ [RECOMMENDATION: monthly]. Whenever the system or the application supports it, this change must be prompted by the system or application itself, on an automated basis.
   a. All user-level passwords (e.g., email, web, desktop computer, etc.) must be changed _____ [RECOMMENDATION: quarterly].
   b. Re-use of passwords will not be allowed. Users must not use the same password for gaining access to informational Web sites as they do for gaining access to Company systems or applications.
   c. Passwords must not be inserted into email messages or other forms of electronic communication.
   d. All system-level and user-level passwords must conform to the guidelines described below.
   e. Default administration-level passwords that come with systems, applications, or devices must be changed immediately.
   f. Passwords must never be written down or stored online.
   g. Passwords must not be revealed to anyone, including family members and coworkers.
   h. DO create a password with a minimum length of 8 characters.
   i. DO use a password that contains alphanumeric characters and punctuation.
   j. Illegal punctuation characters include:
      1. Comma (,)

2. Colon (:)
3. Semi-colon (;)
4. Forward Slash (/)
5. Back Slash (\)
6. Question Mark (?)
7. Asterisk (*)
8. Tilde (~)

k. DO use a password that can be typed quickly, without having to look at the keyboard. This makes it harder for someone to steal your password by looking at your keyboard (also known as "shoulder surfing").
    1. Counting keystrokes as you type in your password can save a hacker a lot of time when running particular password cracking attacks
l. DO NOT use a network login ID in any form (reversed, capitalized, etc.) as a password.
m. DO NOT use your first, middle, or last name in any form. Do not use your initials or any nicknames you may have.
n. DO NOT use a word contained in English or foreign dictionaries, spelling lists, or other word lists.
1. Passwords contained in these lists can be cracked in several seconds, regardless of their length.
o. DO NOT use reverse words.
p. DO NOT use other information easily obtained about you. This includes pet names, friends' or relatives' names, license plate numbers, telephone numbers, identification numbers, the brand of your automobile, the name of the street you live on, employee information, dates, and so on. Such passwords are very easily guessed by someone who knows the user.
q. DO NOT use a password of all numbers, or a password composed of all alphabetic characters. DO mix numbers, letters, and punctuation.
    1. For example, choose two real words of five characters or more and tie them together (concatenate them) with a punctuation mark between the words, such as:
        - house#cherry
        - feeder&animal
        - jester%engine
        - comedy$penny
        - whistle?airport
r. Choose a line from a poem or song. Compose a password from the first letter of each word in the line.
    1. "I'm dreaming of a white Christmas" becomes "idoawc"
    2. "Raindrops keep falling on my head" becomes "rdkfomh"
s. Alternate between one consonant and one or two vowels, up to eight characters, to create nonsense words that are easily remembered because they are pronounceable, such as:
    1. booptaal
    2. vatguud
    3. meekrix
t. DO NOT write a password on sticky notes, desk blotters, calendars, or store it online where it can be accessed by others.
u. DO NOT reveal a password to anyone. A large percentage of network attacks originate from within the organization.

v. DO NOT use shared accounts. Accountability for group access is extremely difficult.
w. DO NOT use a keyboard pattern such as qwertyui or oeuidhtn (look at a Dvorak keyboard).
x. DO NOT repeat any character more than once in a row like zzzzzzzz.
y. Do not use all punctuation, all digit, or all alphabetic.
z. If someone demands access to a password, you must refer him or her to the Information Security Manager.

If you feel that an account or password has been compromised, report the incident to the Information Security Manager and change all passwords.

Workforce members' adherence to this policy will be monitored, and periodic random testing of passwords may be performed by the Information Security Manager or his or her delegates. If a password is guessed or cracked during one of these tests, the user will be required to change it and the disciplinary policy may apply.

6). *Application Development Standards:* With respect to applications developed for The Company, it must be assured that such applications and related programs contain the following security features:
a. Authenticates individual users, not groups
b. Stores passwords in an encrypted form
c. Supports role management, such that one user can take over the functions of another without having to know the other's password

Figure 1 Possible Passwords

Password Length	Letters Only (non-case sensitive) (26)	Letters and Numbers (36)	Letters, Numbers, & Punctuation** (60)
1	26	36	60
2	650	1,260	3,540
3	15,600	42,840	205,320
4	358,800	1,413,720	11,703,240
5	7,893,600	45,239,040	655,381,440
6	165,765,600	1,402,410,240	36,045,979,200
7	3,315,312,000	42,072,307,200	1,946,482,876,800
8	62,990,928,000	1,220,096,908,800	103,163,592,470,400
9	1,133,836,704,000	34,162,713,446,400	5,364,506,808,460,800
10	19,275,223,968,000	922,393,263,052,800	273,589,847,231,501,000
11	308,403,583,488,000	23,982,224,839,372,800	13,679,492,361,575,000,000
12	4,626,053,752,320,000	599,555,620,984,320,000	670,295,125,717,177,000,000

Figure 2 Time Required to Check All Possible Passwords*

Password Length	Letters Only (non-case sensitive) (26)	Letters and Numbers (36)	Letters, Numbers, & Punctuation** (60)
1	Under 1 second	Under 1 second	Under 1 second
2	Under 1 second	Under 1 second	Under 1 second
3	Under 1 second	Under 1 second	Under 1 second
4	Under 1 second	1 second	12 seconds
5	8 seconds	45 seconds	11 minutes
6	3 minutes	23 minutes	10 Hours
7	55 minutes	12 hours	23 days
8	17.5 hours	14 Days	3.25 years
9	13 days	395 days	170 years
10	214 days	29 years	8,675 years
11	10 years	760 years	433,733 years
12	147 years	19,000 years	21,250,000 years

*Assuming ~1,000,000 attempts per second (conservative estimate for a 1GHz PC). This table represents passwords which are not contained in a dictionary or word list (all possible passwords in a word list can be checked in under 2 seconds).

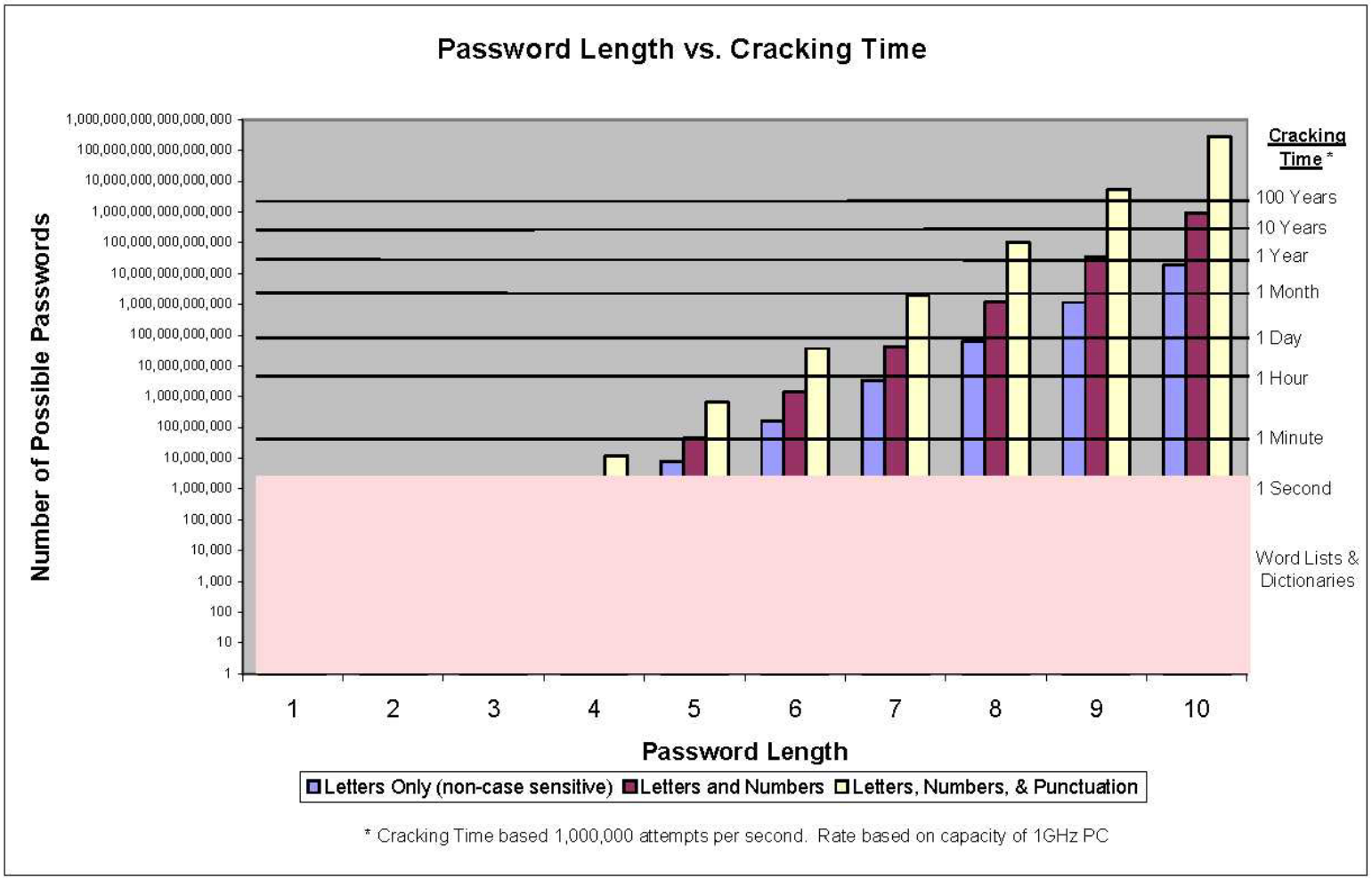
** Punctuation excludes characters listed under Password Guidelines #3. Total characters in this classification is 60.

Figure 3 Password Examples

Password	Time to Break P/W	Reason
Sally	Less than 1 second	This password is contained in word lists. Names are also easily guessed by someone who knows the person.
yatguud	About 1 hour	This is a 7-character password which is not contained in a word list.
booptaal	About 17 hours	This is an 8-character password which is not contained in a word list.
Telephone	Less than 1 second	This word is contained in a dictionary.
rdkfomyh	About 17 hours	This is an 8-character password which is not contained in a word list.
Gracias	Less than 1 second	This word is contained in a foreign language dictionary.
qwertyui	1 second	This common sequence is based on the keyboard layout and is contained in word lists. It is also easy to break by watching the user type.

house#cherry whistle$airport comedy$penny	Thousands of years	These are long passwords that contain punctuation. They are not included in word lists.
SaltLakeCity	1 second	This password is included in a word list.
elbat	1 second	Reverse words can be broken as quickly as regular words.

Figure 4 Password Length vs. Cracking Time



C. WORKSTATION USE

1). *Overview:* It is the policy of The Company to implement acceptable workstation use procedures that ensure the security of electronic protected health information. To ensure that The Company minimizes the risk of unauthorized access to or disclosure of electronic protected health information, and to prevent the compromise of The Company's desktop, workstation, and notebook computers that are used to create, store, access, receive, or transmit electronic protected health information.

Since most workstations have access to protected health information, there are policies and procedures that must be followed by all workstation users. For security purposes it is important that there be documented instructions on the proper use of the workstation.

The Information Security Manager will administer the Workstation Use Policy.

Workstations, in this context, include desktop, workstation, and notebook computers.

2). *Acceptable workstation use:*

a. Everyone using a workstation must be able to show evidence that they are a member of the workforce. Non-workforce members are not normally permitted to use The Company's workstations. There may be exceptions to this policy which will require approval by the Information Security Manager.
b. Under no circumstances should workstations be shared with nonemployees.
c. All workstations must be placed so that nonemployees cannot view the screen content.
d. All Authorized Users must log in with their own unique account identification, and it is prohibited to share account identification. Each Authorized User is responsible for the security of his/her account information.
e. Passwords must never be written down or stored online.
f. Prior authorization from The Company for moving workstations is needed to maintain physical security of the workstations.

3). *Notebook and Tablet Computer Security:*

a. DO NOT permanently store protected health information on a notebook or tablet computer's hard drive.
b. Limit the use of notebook and tablet computers to business uses.
c. DO NOT let any unauthorized person use the notebook or tablet computer.
d. DO NOT leave the notebook or tablet computer unattended unless secured.
e. Safeguard notebook and tablet computers at all times, especially while off-site.
f. DO NOT leave notebook or tablet computers in cars for extended periods of time.
g. DO NOT log into any service or website unless authorized to do so.
h. DO NOT download any unauthorized software onto notebook or tablet computers.
i. Employees using handheld notebook or tablet computers should return the computers at the end of their shift.
j. Immediately report all security breaches to the Information Security Manager.

4). *Unacceptable workstation use:* The following activities are, in general, prohibited. Employees may be exempted from these restrictions during the course of their legitimate job responsibilities (e.g., The Company staff may have a need to disable the network access of a host if that host is disrupting production services). The lists below are not exhaustive but attempt to provide a framework for activities which fall into the category of unacceptable use.

a. System and Network Activities - The following activities are strictly prohibited, with no exceptions:
    1. Violations of the rights of any person or company protected by copyright, trade secret, patent or other intellectual property, or similar laws or regulations, including, but not limited to, the installation or distribution of "pirated" or other software products that are not appropriately licensed for use by The Company
    2. Unauthorized copying of copyrighted material including, but not limited to, digitization and distribution of photographs from magazines, books or other copyrighted sources, copyrighted music, and the installation of any copyrighted software for which The Company or the end user does not have an active license is strictly prohibited
    3. Exporting software, technical information, encryption software, or technology, in violation of international or regional export control laws is illegal. The appropriate management should be consulted prior to export of any material that is in question
    4. Introduction of malicious programs into the network or server (e.g., viruses, worms, Trojan horses, email bombs, etc.)
    5. Revealing your account password to others or allowing use of your account by others, including family and other household members when work is done at home
    6. Using a Company computing asset to actively engage in procuring or transmitting material that is in violation of sexual harassment or hostile workplace laws
    7. Making fraudulent offers of products, items, or services originating from any Company account
    8. Making statements about warranty, expressly or implied, unless it is a part of normal job duties
    9. Executing any form of network monitoring which will intercept data not intended for the employee's host, unless this activity is a part of the employee's normal job/duty
    10. Circumventing user authentication or security of any host, network, or account
    11. Providing information about, or lists of, The Company workforce members to parties outside The Company

b. Email and Communications Activities
    1. Sending unsolicited email messages, including the sending of "junk mail" or other advertising material to individuals who did not specifically request such material (email spam)
    2. Any form of harassment via email, telephone, or paging, whether through language, frequency, or size of messages
    3. Unauthorized use, or forging, of email header information
    4. Solicitation of email for any other email address, other than that of the poster's account, with the intent to harass or to collect replies
    5. Creating or forwarding "chain letters", "Ponzi", or other "pyramid" schemes of any type
    6. Use of unsolicited email originating from within The Company's networks of other Internet/Intranet/Extranet service providers on behalf of, or to advertise, any service hosted by The Company or connected via The Company's network

In addition, workforce members must use extreme caution and proper judgment when opening email attachments received from unknown senders, which may contain viruses, email bombs, ransomware, Trojan horse code, or other malware.

5). *System precautions:*

a. All users will be automatically logged off the system if they leave the system for ___ minutes. The Information Security Manager will determine what time frame is reasonable for each system based upon a risk assessment and will notify workforce members.
b. Users must not load unauthorized software onto any of The Company's desktop, workstation, or notebook computers without express permission of the Information Security Manager.
c. Users will not store electronic protected health information on a local hard drive without the express permission of the Information Security Manager.
d. Users will store electronic protected health information on a network drive whenever one is available, or as directed by the Information Security Manager.
e. In the event the Information Security Manager permits electronic protected health information on a local hard drive, users will back up all electronic protected health information stored on their local hard drive in accordance with The Company's Data Backup Policy.
f. Users will use Company desktops, workstation, or notebook computers for business only to perform the user's job function.
g. Users will not use The Company's desktop, workstation, or notebook computers for personal gain.
h. Users will not use The Company's desktop, workstation, or notebook computers to access electronic protected health information for which they are not authorized.

6). *Workstation Use Awareness Training:* Acceptable and unacceptable workstation use will be a key element in the awareness and training program for all new and existing users. Reference policy WM 2.4 *Orientation and Training*.

7). *Enforcement:* Any workforce member found to have violated this policy may be subject to disciplinary action, up to and including termination of employment or workforce relationship. Reference WM 2.9 *Disciplinary Standards*

D. Workstation Security

1). *Overview:* The Company ensures the minimization of risk of unauthorized access to or disclosure of electronic protected health information, and to prevent the compromise in any way of The Company's desktop, workstation, and notebook computers that are used to create, store, access, receive, or transmit electronic protected health information.

The Company implements procedures that ensure the security of electronic protected health information by controlling access to desktop, workstation, and notebook computers; ensuring that desktop, workstation, and notebook operating systems allow for secure log-in; and allowing for a secure unattended mode (automatic log off or secure screensaver). The Company ensures that desktop, workstation, and notebook computers are protected from threats (e.g., malware, flood damage, fire, power surges), are patched appropriately, and are configured to minimize the unauthorized disclosure of electronic protected health information and the installation of unauthorized software.

This policy applies regardless of the location of the desktop, workstation, and notebook computers (e.g.; on or off-site).

2). *The Information Security Manager will:*

a. Administer the Workstation Security policy in accordance with The Company's risk assessment.
b. Maintain an inventory that documents the location, status, responsible user, configuration, and other security attributes of each desktop, workstation, and notebook computer, including all changes made to bring the unit into compliance with this Policy.
c. Assess the physical placement of all desktop, workstation, and notebook computers to ensure that:
    1. They are placed such that damage from flood, fire, and other hazards is minimized
    2. They are physically secured if they store electronic protected health information on their hard drives
    3. They are situated such that casual observance of electronic protected health information on their screens/monitors is minimized
    4. They are connected to an uninterruptible power supply (UPS)
d. Assess the desktop, workstation, and notebook computers to ensure that they are running an operating system that allows for:
    1. Secure login
    2. Automatic log off or secure screensaver
    3. Encryption where required by the risk assessment
    4. They have had all non-essential devices removed or disabled
    5. They have had all necessary operating system patches, updates, and service packs applied
    6. They are running appropriate anti-virus and anti-spyware software
    7. They are free from all forms of malware
    8. No unauthorized software is installed on them
    9. No electronic protected health information is stored on them if a network drive is available and the Information Security Manager has issues and exceptions
    10. Any electronic protected health information that is stored on them is backed up in accordance with The Company's Backup Policy
    11. Any electronic protected health information that is stored on them is encrypted in accordance with The Company's Encryption Policy
    12. Other measures as determined by the risk assessment
e. Review desktop, workstation, and notebook computer system's activity logs and audit trails to ensure compliance with the Workstation Security Policy.

3). *Implementation:*

a. In situations where electronic protected health information resides on local hard drives, those drives must be backed up in accordance with The Company's Backup Policy.
b. Desktops, workstations, and notebooks that are not owned by The Company will not be used to create access, receive, store, or transmit electronic protected health information, and will not be placed on The Company's network for any purpose.
c. Everyone using a computer workstation must be able to show evidence that they are a member of the workforce. No others are normally permitted to use The Company's workstations. There

may be exceptions to this policy which will require approval by the Information Security Manager.

d. Except for intake or admissions, workstations are not to be shared with residents.
e. Except for intake and admissions where workstations may be shared with residents, workstations must be placed so that residents cannot view the screen.
f. All workstation software must be configured so that all users will be required to log onto and off of the network, desktops, and applications.
g. All users must log in with their own unique account identification, and it is prohibited to share account identification.
h. Only users with special privileges will be allowed to write information to a disk that can then be taken from the workstation. This does not include writing to fixed disks that cannot be easily taken from the workstation.
i. Members of the workforce are not to make any configuration changes to the workstation. This is the responsibility of the Information Technology Department. Exceptions to this policy require the approval of the Information Security Manager.
j. Disposal of the workstation is to be performed by the Information Technology Department.
k. An automatic logout will occur after no activity is detected coming from the station for a period of _____ minutes. Everyone is encouraged to logout instead of having the timeout log them off the system.
l. Notes recording passwords are not to be posted on the workstation or visible anywhere around the workstation.
m. Antivirus software will be used to minimize, if not eliminate, the likelihood of viruses infecting the workstation.
1. Workstations, in this context, include PCs, terminals, image terminals, and what are usually considered workstations.
n. The Information Technology Department will provide a documented method for performing log in/log off procedures in a secure manner.
o. Prior authorization from IT Department for moving workstations is needed in order to maintain physical security of the workstations.

4) *Awareness training*- Proper workstation security will be a topic in the awareness and training program including, but not limited to:

a. Limiting the use of notebook computers to business uses.
b. Not letting any unauthorized person use the notebook computer.
c. Not leaving a notebook computer unattended unless secured.
d. Safeguarding notebook computers at all times, especially while off-site.
e. Not leaving notebook computers in cars for extended periods of time.
f. Not logging into any service or website unless authorized to do so.
g. Not downloading any unauthorized software onto notebook computers.
h. Returning handheld notebook computers at the end of a workforce member's shift.
i. Immediately reporting all security breaches to the Information Security Manager.

E. SERVER SECURITY

1). *Overview:* The Company establishes standards for the base configuration of internal server equipment that is owned and/or operated by The Company to minimize unauthorized access to proprietary information and technology.

This policy applies to server equipment owned and/or operated by The Company, and to servers registered under any Company-owned internal network domain.

This policy is specifically for equipment on the internal Company network. For secure configuration of equipment external to The Company network (DMZ or perimeter network) refer to the Information Security Manager.

The IT Department is responsible for all IT system administration. Approved server configuration guides must be established and maintained based on business needs and approved by the Information Security Manager. The IT Department should monitor configuration compliance and implement an exception policy, as well as establish a process for changing the configuration guides, which includes review and approval by the Information Security Manager.

2). *Implementation:*

a. Servers must be registered and kept up to date within the IT Department. At a minimum, the following information is required to positively identify the point of contact:
    1. Server contact(s) and location, and a backup contact
    2. Hardware and Operating System/Version
    3. Main functions and applications, if applicable
b. Configuration changes for production servers must follow appropriate change procedures.
c. All security-related events on critical or sensitive systems must be logged and audit trails saved as follows:
    1. Security-related events will be reported to the Information Security Manager, who will review logs and report incidents to the Information Technology Department. Corrective measures will be prescribed as needed
    2. Audits will be performed on a regular basis by, or under the direction of, the IT Department and Information Security Manager.

Policy Number: DI 2.4

Policy Title: Wireless Communication

Policy Statement/Purpose: The Company prohibits access to Company networks via unsecured wireless communication mechanisms. Only wireless systems that meet the criteria of the Wireless Communication policy or have been granted an exclusive waiver by the Information Security Manager, are approved for connectivity to The Company's networks.

Policy Interpretation and Implementation: This policy covers all wireless data communication devices (e.g., personal computers, cellular phones, PDAs, smart technology, etc.) connected to any of The Company's internal networks. This includes any form of wireless communication device capable of transmitting packet data. Wireless devices and/or networks without any connectivity to The Company's networks do not fall under the purview of this policy.

To comply with this policy, wireless implementations must be approved by Information Security Manager and Information Technology Department.

A. VIRTUAL PRIVATE NETWORK (VPN)

1). *Overview:* The Company provides guidelines for Remote Access IPSec or L2TP Virtual Private Network (VPN) connections to The Company's corporate network.

2). *Scope:* This policy applies to all Company employees, contractors, consultants, temporaries, and other workers, including all personnel affiliated with third parties utilizing VPNs to access The Company's network. This policy applies to implementations of VPN that are directed through an IPSec Concentrator.

3). *Implementation:*

a. Approved Company employees and authorized third parties (customers, vendors, etc.) may utilize the benefits of VPNs, which are a "user managed" service. This means that the user is responsible for selecting an Internet Service Provider (ISP), coordinating installation, installing any required software, and paying associated fees.
b. It is the responsibility of employees with VPN privileges to ensure that unauthorized users are not allowed access to Company internal networks.
c. VPN use is to be controlled using either a one-time password authentication such as a token device, or a public/private key system with a strong passphrase.
d. When actively connected to the corporate network, VPNs will force all traffic to and from the PC over the VPN tunnel: all other traffic will be dropped.
e. Dual (split) tunneling is NOT permitted; only one network connection is allowed.
f. VPN gateways will be set up and managed by The Company network operational groups.
g. All computers connected to The Company's internal networks via VPN or any other technology must use the most up-to-date anti-virus software that is the corporate standard; this includes personal computers.

h. VPN users will be automatically disconnected from The Company's network after thirty minutes of inactivity. The user must then logon again to reconnect to the network. Pings or other artificial network processes are not to be used to keep the connection open.
i. The VPN concentrator is limited to an absolute connection time of 24 hours.
j. Users of computers that are not Company-owned equipment must configure the equipment to comply with The Company's VPN and Network policies.
k. Only Information Security Manager-approved VPN clients may be used.
l. By using VPN technology with personal equipment, users must understand that their machines are a de facto extension of The Company's network, and as such are subject to the same rules and regulations that apply to Company-owned equipment, i.e., their machines must be configured to comply with The Company's Security Policies.

4). *Enforcement:* Any employee found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

Policy Number: DI 3.0

Policy Title: Privacy and Information Security Compliance Evaluation

Policy Statement/Purpose: To ensure that The Company complies with applicable laws regarding compliance evaluation.

Policy Interpretation and Implementation: The Company will review all Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) policies and procedures for technical and non-technical viability, effectiveness, and compliance on an annual basis, or more frequently as per the Privacy and Security Managers. Additionally, The Company will evaluate its overall compliance plan on an annual basis.

Procedure:

1. The Privacy and Security Managers will schedule periodic reviews of The Company's policies and procedures based upon:
   a. Changes in the Privacy and Security regulations
   b. New federal, state, or local laws and regulations affecting privacy and security
   c. Changes in The Company's information technology environment
   d. Changes in The Company's business processes with respect to information technology
   e. A significant security incident occurs
2. Perform a formal audit on an annual basis.
3. Perform comprehensive reviews by interviewing, among others, workforce members to obtain feedback, comments, and other input regarding the policies and procedures.
4. Perform reviews taking into consideration the following:
   a. The number of security incidents that have occurred at The Company
   b. The number of workforce member sanctions applied
   c. The number of security incidents that have occurred at business associates
   d. The results of the annual audit
5. Develop and recommend changes to policies and procedures. The following steps must be followed as part of this process:
   a. All recommended policy and procedure changes will be communicated to the facility Administrator for final approval.
   b. Upon approval, all changes will be communicated to the workforce members via privacy and security reminders.
6. Requests for amendments - Upon approval, all changes will be reflected in the policies and procedures.

7. RESIDENT RIGHTS (RR)

7. RESIDENT RIGHTS AND FREEDOM FROM ABUSE, NEGLECT AND EXPLOITATION (RR)

Policy Number	POLICY
RR 1.0	RESIDENTS' RIGHTS
RR.1.1	FREEDOM FROM ABUSE NEGLECT AND EXPLOITATION

Policy Number: RR 1.0

Policy Title: Resident Rights

Policy Statement/Purpose: It is the policy of The Company that all residents have the right to a dignified existence, self-determination, and communication with and access to people and services both inside and outside The Company consistent with applicable law, regulation (§483.10), policy, and procedure. All Company employees shall treat each resident with kindness, respect, and dignity. The policy is applicable to all Company employees, any and all directors, officers, medical staff, independent contractors, consultants, and others working for The Company.

Policy Interpretation and Implementation:

1). *Procedure:*

a. A copy of The Company's statement of residents' rights shall be given to each new employee when they are hired.
b. Copies of the statement of residents' rights shall be posted within each Facility. (§483.10)
c. Company personnel shall make every effort to assist residents in exercising their rights.
d. All organizational policies and procedures concerning resident rights must be consistent with Law and Regulation. These policies and procedure shall be reviewed, at least, annually and updated as required by Law and Regulation.
e. All residents and staff will be oriented to resident rights according to the Requirements of Participation (§483.10).
f. All staff will be trained annually on organizational policies and procedures related to resident rights
g. An auditing and monitoring program will be designed, and results reported to the QAA/QAPI committee for action and follow up.

2). Residents' Rights per (§483.10):

Tag #	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings
F550	X	Resident Rights/Exercise of Rights	483.10(a)(1)(2)(b)(1)(2)	483.10 Resident Rights
F551		Rights Exercised by Representative	483.10(b)(3)-(7)(i)-(iii)	483.10 Resident Rights
F552		Right to be Informed/Make Treatment Decisions	483.10(c)(1)(4)(5)	483.10 Resident Rights
F553		Right to Participate in Planning Care	483.10(c)(2)(3)	483.10 Resident Rights
F554		Resident Self-Admin Meds-Clinically Appropriate	483.10(c)(7)	483.10 Resident Rights
F555		Right to Choose/Be Informed of Attending Physician	483.10(d)(1)-(5)	483.10 Resident Rights
F557		Respect, Dignity/Right to have Personal Property	483.10(e)(2)	483.10 Resident Rights

Tag #	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings
F558	X	Reasonable Accommodations of Needs/Preferences	483.10(e)(3)	483.10 Resident Rights
F559	X	Choose/Be Notified of Room/Roommate Change	483.10(e)(4)-(6)	483.10 Resident Rights
F560		Right to Refuse Certain Transfers	483.10(e)(7)(i)-(iii)(8)	483.10 Resident Rights
F561	X	Self Determination	483.10(f)(1)-(3)(8)	483.10 Resident Rights
F562		Immediate Access to Resident	483.10(f)(4)(i)(A)-(G)	483.10 Resident Rights
F563		Right to Receive/Deny Visitors	483.10(f)(4)(ii)-(v)	483.10 Resident Rights
F564		Inform of Visitation Rights/Equal Visitation Privileges	483.10(f)(4)(vi)(A)-(D)	483.10 Resident Rights
F565	X	Resident/Family Group and Response	483.10(f)(5)(i)-(iv)(6)(7)	483.10 Resident Rights
F566		Right to Perform Facility Services or Refuse	483.10(f)(9)(i)-(iv)	483.10 Resident Rights
F567		Protection/Management of Personal Funds	483.10(f)(10)(i)(ii)	483.10 Resident Rights
F568		Accounting and Records of Personal Funds	483.10(f)(10)(iii)	483.10 Resident Rights
F569		Notice and Conveyance of Personal Funds	483.10(f)(10)(iv)(v)	483.10 Resident Rights
F570		Surety Bond - Security of Personal Funds	483.10(f)(10)(vi)	483.10 Resident Rights
F571		Limitations on Charges to Personal Funds	483.10(f)(11)(i)-(iii)	483.10 Resident Rights
F572		Notice of Rights and Rules	483.10(g)(1)(16)	483.10 Resident Rights
F573		Right to Access/Purchase Copies of Records	483.10(g)(2)(i)(ii)(3)	483.10 Resident Rights
F574		Required Notices and Contact Information	483.10(g)(4)(i)-(vi)	483.10 Resident Rights
F575		Required Postings	483.10(g)(5)(i)(ii)	483.10 Resident Rights
F576		Right to Forms of Communication with Privacy	483.10(g)(6)-(9)	483.10 Resident Rights
F577		Right to Survey Results/Advocate Agency Info	483.10(g)(10)(11)	483.10 Resident Rights
F578		Request/Refuse/Discontinue Treatment; Formulate Advanced Directives	483.10(c)(6)(8)(g)(12)(i)-(v)	483.10 Resident Rights
F579		Posting/Notice of Medicare/Medicaid on Admission	483.10(g)(13)	483.10 Resident Rights

Tag #	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings
F580		Notify of Changes (Injury/Decline/Room, Etc.)	483.10(g)(14)(i)-(iv)	483.10 Resident Rights
F582		Medicaid/Medicare Coverage/Liability Notice	483.10(g)(17)(18)(i)-(v)	483.10 Resident Rights
F583		Personal Privacy/Confidentiality of Records	483.10(h)(1)-(3)(i)(ii)	483.10 Resident Rights
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)	483.10 Resident Rights
F585		Grievances	483.10(j)(1)-(4)	483.10 Resident Rights
F586		Resident Contact with External Entities	483.10(k)	483.10 Resident Rights

3) The following section summarizes the Centers for Medicare & Medicaid Services (CMS) State Operations Manual Appendix PP content for Resident Rights, F550 through F586:

a. F550 Resident Rights/Exercise of Rights
   1. Right to a dignified existence, self-determination, and communication with others inside and outside the facility
   2. Right to be treated with respect, dignity, and care to enhance quality of life and individuality
   3. Right to have equal access to quality care regardless of diagnosis, severity of condition, or payment source
   4. Exercise rights without interference, coercion, discrimination, or reprisal

b. F551 Rights Exercised by Representative
   1. Right to designate a representative/surrogate, according to state law, who may exercise the resident's rights to the extent provided by state law
   2. The resident may retain the right to exercise any rights not delegated to a representative, including the right to revoke a delegation of rights
   3. When a resident is determined to be incompetent by a court, the rights of the resident are exercised by the representative appointed under state law to act on the resident's behalf
   4. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrate

c. F552 Planning and Implementing Care
   1. Right to be informed in a language he/she can understand, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care
   2. Informed of risks and benefits of proposed care, of treatment and treatment alternatives or options, and to choose the alternative or option he or she prefers

d. F553 Right to Participate in Planning Care – Person Centered Care
   1. Identify individuals to include in the planning process, request meetings and revisions
   2. Participate in establishing goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care
   3. Informed, in advance, of changes to the plan of care
   4. Receive the services and/or items included in the plan of care, see it, and sign it

5. Incorporate personal and cultural preferences in developing goals of care

e. F554 Resident Self-Administration of Medications-Clinically Appropriate
   1. Interdisciplinary team determines if the medications are appropriate and if self-administration is clinically appropriate by determining the following:
      - What is the resident's physical capacity to swallow without difficulty and to open medication bottles?
      - What is the resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for?
      - What is the resident's capability to follow directions and tell time to know when medications need to be taken?
      - Can the resident comprehend instructions for the medications they are taking, including dose, timing, signs of side effects, and when to report to staff?
      - Does the resident understand what refusal of medication is, and appropriate steps staff must take to provide education when this occurs?
      - Can the resident ensure that medication is stored safely and securely?

f. F555 Right to Choose/Be Informed of Attending Physician –
   1. The physician must be licensed to practice and willing/approved to serve in the facility

g. F557 Respect, Dignity/Right to have Personal Property –
   1. Right to use personal possessions, including furnishings and clothing, as space permits, unless this would infringe upon the rights or health and safety of other residents.
   2. Examples of noncompliance may include, but are not limited to:
      - Residents, their representatives, or family members have been discouraged from bringing personal items to the facility.
      - A decision to refuse to allow a resident to retain any personal belongings was not based on space limitations or on a determination that the rights, health or safety of other residents would be infringed.
      - Facility staff searching a resident's body or personal possessions without the resident's or, if applicable, the resident's representative's consent.

h. F558 Reasonable Accommodations of Needs/Preferences –
   1. Right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents
      - Accommodation of resident needs and preferences is essential to creating an individualized, home-like environment

i. F559 Choose/Be Notified of Room/Roommate Change –
   1. Right to share a room with his/her spouse when married residents live in the facility and consent to live together
   2. Right to share a room with roommate of choice
   3. Right to receive written notice, with reason for a change, before room or roommate is changed

j. F560 Right to Refuse Certain Transfers –
   1. To another room in the facility to relocate a resident of a SNF from the SNF distinct part to a part that is not a SNF, or relocate a resident of a NF from the distinct part that is a NF to a distinct part that is a SNF, or solely for the convenience of staff
      - Right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits

k. F561 Self Determination –
    1. Right to choose activities, schedules (including sleeping and waking times), healthcare and providers consistent with his/her interests, assessments, and plan of care
    2. Right to make choices about aspects of his/her life in the facility that are significant to him/her
    3. Right to interact with members of the community and participate in community activities both inside and outside the facility
    4. Right to participate in social, religious, and community activities that do not interfere with the rights of others
    5. If a facility changes its policy to prohibit smoking (including electronic cigarettes), it should allow current residents who smoke to continue smoking in an area that maintains quality of life for these residents and takes into account non-smoking residents. The smoking area may be an outside area provided that residents remain safe. Residents admitted after the facility changes its policy must be informed of this policy at admission.

l. F562 Immediate Access to Resident –
    1. Right to immediate access to any resident by:
        - Any representative of HHS, the state, or Ombudsman
        - Resident's individual physician
        - Representative of the protection and advocacy systems
        - Agency responsible for the protection and advocacy system for individuals with mental disorder
        - The resident's representative

m. F563 Right to Receive/Deny Visitors –
    1. Right to receive visitors of his/her choosing at the time of his/her choosing, deny visitation, and visit in a manner that does not impose on the rights of another resident, subject to reasonable clinical and safety restrictions
    2. Reasonable clinical and safety restrictions include:
        - Restrictions to prevent community-associated infection or communicable disease;
        - Visitors with signs and symptoms of a transmissible infection should defer visitation until no longer potentially infectious according to CDC guidelines and/or local health department recommendations.
        - Keeping the facility locked or secured at night yet allowing visitors approved by the resident;
        - Denying access or providing limited, supervised access to an individual if suspected of abusing, exploiting, or coercing a resident until an investigation has been completed and/or substantiated;
        - Denying access to individuals found to have committed criminal acts such as theft;
        - Denying access to individuals who are inebriated or disruptive; or
        - Denying access or providing supervised visitation to individuals with a history of bringing illegal substances into the facility;
        - During an infectious disease outbreak, while not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors.

n. F564 Inform of Visitation Rights/ Visitation Privileges

1. Right to be informed of visitation rights and related policy/procedures, including clinical or safety restriction/limitation on such rights, reasons for the restriction/limitation, and to whom the restrictions apply

o. F565 Resident/Family Group and Response
   1. Right to organize and participate in resident/family groups in the facility
p. F566 Right to Perform Facility Services or Refuse
   1. Right to perform services for the facility, if he/ she chooses, when:
      - staff document the resident's need or desire for work in the plan of care, which specifies the nature of services performed and whether they are voluntary or paid;
      - compensation for paid services is at or above prevailing rates; and
      - resident agrees to the work arrangement described in the plan of care.
q. F567 Protection/Management of Personal Funds
   1. Right to manage his/her financial affairs, including the right to know, in advance, what charges a facility may impose against a resident's personal funds
r. F568 Accounting and Records of Personal Funds –
   1. Right to receive a full, complete, separate accounting, according to generally accepted accounting principles, of personal funds entrusted to the facility with no commingling of resident funds with facility funds or funds of any other person
   2. Right to receive an individual financial record through quarterly statements and upon request
s. F569 Notice and Conveyance of Personal Funds –
   1. If receiving Medicaid benefits, right to be notified when the resident's account reaches $200 less than the SSI resource limit for one person, and that if the amount in the account, in addition to the value of other nonexempt resources, reaches the SSI resource limit for one person, he/she may lose eligibility for Medicaid or SSI
   2. At discharge, eviction, or death, a resident with a personal fund deposited with the facility: the facility must convey the funds within thirty (30) days, and a final accounting of the funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate
t. F570 Surety Bond - Security of Personal Funds –
   1. Right to have personal funds that are deposited with the facility protected by a Surety Bond
u. F571 Limitations on Charges to Personal Funds –
   1. Not have charges imposed against his/her personal funds for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts)
v. F572 Information and Communication –
   1. Be informed of his/her rights and all rules/regulations governing resident conduct and responsibilities, and state-developed notice of Medicaid rights/obligations, if any
w. F573 Right to Access/Purchase Copies of Records –
   1. Right to access personal and medical records pertaining to him/herself upon an oral or written request, in the form and format requested, and with two (2) working days advance notice. The facility may impose a reasonable, cost-based fee
x. F574 Required Notices and Contact Information –
   1. Receive notices orally and in writing (including Braille) in a format and language he/she understands, including:
      - a written description of legal rights for protecting personal funds

- names, addresses (mail and email), and telephone numbers of all pertinent state regulatory and informational agencies
- right to file a complaint with the State Survey Agency
- information regarding Medicare and Medicaid eligibility and coverage
- contact information for the Medicaid Fraud Control Unit
- information and contact information for filing grievances or complaints

y. F575 Required Postings –
   1. The facility must post, in a form and manner accessible and understandable to residents, resident representatives names, addresses (mailing and email), and telephone numbers of all pertinent state agencies/advocacy groups:
      - State Survey Agency
      - State licensure office
      - Adult protective services where there is jurisdiction in facilities
      - State Long-Term Care Ombudsman program
      - Protection and advocacy network
      - Home and community based service programs
      - Medicaid Fraud Control Unit
   2. The facility must post a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to:
      - Resident abuse, neglect, exploitation, or misappropriation of resident property in the facility
      - Noncompliance with Advanced Directives requirements
      - Requests for information on returning to the community

z. F576 Right to Forms of Communication with Privacy –
   1. Reasonable access to use of a telephone, including TTY (teletypewriter) and TDD (telecommunications device for the deaf) services, and a place where calls can be made without being overheard
   2. Retain and use a cellular phone at the resident's own expense
   3. Internet access, to the extent available to the facility
   4. Stationery, postage, writing implements, and the ability to send mail
   5. Send and receive mail, and receive letters, packages, and other materials delivered to the facility through a means other than a postal service; privacy of such communications; and access to stationery, postage, and writing implements at the resident's own expense

aa. F577 Right to Survey Results/Advocate Agency Info –
   1. Right to examine results of the most recent survey conducted by federal or state surveyors and any plan of correction in effect with respect to the facility
   2. Right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies

bb. F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives –
   1. Right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an Advance Directive

cc. F579 Posting/Notice of Medicare/Medicaid on Admission –

1. The facility must display written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits

dd. F580 Notify of Changes (Injury/Decline/Room, etc.) –

1. A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is—
   - An accident involving the resident resulting in injury with potential for requiring physician intervention
   - A significant change in the resident's physical, mental, or psychosocial status (a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)
   - A need to alter treatment significantly, discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment
   - A decision to transfer or discharge the resident from the facility
   - A change in room or roommate

ee. F582 Medicaid/Medicare Coverage/Liability Notice –

1. The facility must inform each Medicaid-eligible resident, in writing, at the time of admission and when the resident becomes eligible for Medicaid of—
   - Items/services included in provided services for which the resident may not be charged
   - Other items/services the facility offers for which the resident may be charged, and the amount of those charges
   - Inform each Medicaid-eligible resident when changes are made to items and services
2. Beneficiary Notices:
   - Notice of Medicare Non-Coverage (NOMNC) The NOMNC, Form CMS-10123, is given to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending.
   - Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. The facility must inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.

ff. F583 Personal Privacy/Confidentiality of Records –

1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups
2. Personal privacy includes the right to privacy in oral, written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility for the resident
3. The resident has the right to refuse the release of personal and medical records; however, the Ombudsman may examine a resident's medical, social, and administrative records in accordance with state law

gg. F584 Safe/Clean/Comfortable/Homelike Environment –

1. Right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely
2. Housekeeping and maintenance services that maintain a sanitary, orderly, and comfortable interior
3. Clean bed and bath linens that are in good condition

4. Private closet space in each resident room
5. Adequate and comfortable lighting levels in all areas, comfortable and safe temperatures levels (71-81°F), and maintenance of comfortable sound levels

hh. F585 Grievances –

1. Voice grievances to the facility or other agency/entity that hears grievances without discrimination or reprisal, including those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff, and of other residents, and other concerns regarding their LTC facility stay
2. Facility must make prompt efforts to resolve grievances
3. Facility must provide information on how to file a grievance or complaint

ii. F586 Resident Contact with External Entities –

1. A facility must not prohibit or discourage a resident from communicating with federal, state, or local officials including, but not limited to, federal and state surveyors, other health department employees, representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorders

Policy Number: RR 1.1

Policy Title: Freedom from Abuse Neglect and Exploitation

Policy Statement/Purpose: It is the policy of The Company that all residents have the right to be free from abuse, neglect, and exploitation. It is Company policy to comply with the Centers for Medicare & Medicaid Services (CMS) requirements as presented in the State Operations Manual, Appendix PP, in §483.12 Freedom from Abuse, Neglect, and Exploitation. Abuse Sections §§1819 and 1919 of the Social Security Act provide that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility must provide a safe resident environment and protect residents from abuse, and not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The Company is committed to detecting and preventing the abuse, neglect, and exploitation of our residents, and ensuring that each resident is free from abuse, neglect, and corporal punishment of any type by anyone.

Policy Interpretation and Implementation:

1). *Procedure*:

a. Training on the Company's policy and procedure for Freedom from Abuse, Neglect, and Exploitation shall be given to each new employee when they are hired.
b. Company personnel shall make every effort to prevent residents from experiencing any type of abuse, neglect, or exploitation.
c. All organizational policies and procedures concerning abuse, neglect, and exploitation must be consistent with Law and Regulation. These policies and procedure shall be reviewed, at least, annually and updated as required by Law and Regulation.
d. The Company is charged with responsibility for current policies and procedures that comply with CMS requirements when developing, reviewing, and teaching about residents' freedom from abuse, neglect, or exploitation.
e. All residents and staff will be oriented to policies and procedures addressing abuse, neglect, and exploitation Requirements of Participation (§483.12).
f. All staff will be trained annually on organizational policies and procedures related to resident freedom from abuse, neglect, or exploitation.
g. An auditing and monitoring program will be designed, and results reported to the QAA/QAPI Committee for action and follow up.

2). Residents' Rights per (§483.12)

Tag #	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings
F600	X	Free from Abuse and Neglect	483.12(a)(1)	483.12 Freedom from Abuse, Neglect, and Exploitation
F602	X	Free from Misappropriation/Exploitation	483.12	483.12 Freedom from Abuse, Neglect, and Exploitation
F603	X	Free from Involuntary Seclusion	483.12(a)(1)	483.12 Freedom from Abuse, Neglect, and Exploitation
F604	X	Right to be Free from Physical Restraints	483.10(e)(1) 483.12(a)(2)	483.10 Resident Rights 483.12 Freedom from Abuse, Neglect, and Exploitation

F605	X	Right to be Free from Chemical Restraints	483.10(e)(1) 483.12(a)(2)	483.10 Resident Rights 483.12 Freedom from Abuse, Neglect, and Exploitation
F606	X	Not Employ/Engage Staff with Adverse Actions	483.12(a)(3)(4)	483.12 Freedom from Abuse, Neglect, and Exploitation
F607	X	Develop/Implement Abuse/Neglect, etc. Policies	483.12(b)(1)-(4)	483.12 Freedom from Abuse, Neglect, and Exploitation
F609	X	Reporting of Crimes	483.12(c)(1)(4)	483.12 Freedom from Abuse, Neglect, and Exploitation
F610	X	Investigate/Prevent/Correct Alleged Violation	483.12(c)(2)-(4)	483.12 Freedom from Abuse, Neglect, and Exploitation

3). Freedom from Abuse, Neglect, or Exploitation (§483.12) – The following section summarizes the Centers for Medicare & Medicaid Services (CMS) State Operations Manual Appendix PP content for Abuse, Neglect, and Exploitation F600 through F610. To obtain the full detail for each Abuse F-Tag, access Appendix PP at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

A. F600 Freedom from Abuse, Neglect, and Exploitation –

1. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.
2. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.
3. When a facility has identified abuse, it must take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately, thus reducing the risk of further harm continuing or occurring to other residents and potentially preventing the scope and severity of the deficiency from increasing. Failure to take steps could result in findings of current noncompliance and increased enforcement action.
4. Use the Psychosocial Outcome Severity Guide to apply the reasonable person concept. The survey team will determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in the resident's similar situation to suffer as a result of the noncompliance). Psychosocial Severity Guide (cms.gov)
5. Definitions:
   - **Abuse** is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish, including abuse facilitated or enabled through the use of technology.
   - **Neglect** means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress

- **Sexual abuse** is defined as nonconsensual sexual contact of any type with a resident. Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must ensure the resident is evaluated for capacity to consent. Residents without the capacity to consent to sexual activity may not engage in sexual activity.
- **Willful** as used in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
- **Physical Abuse** includes, but is not limited to, hitting, slapping, punching, biting, and kicking.
- **Mental Abuse** is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.
- **Verbal Abuse** includes the use of oral, written, or gestured communication or sounds to residents within hearing distance, regardless of age, ability to comprehend, or disability.
- **Staff** includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs.

B. F602 Free from Misappropriation of Property and Exploitation –
   1. Each resident has the right to be free from misappropriation of property and exploitation.
   2. Definitions:
      - **Exploitation** means taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.
      - **Misappropriation of resident property** is the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.
        i. Residents' property includes all residents' possessions, regardless of their apparent value to others. This includes jewelry, clothing, furniture, money, and electronic devices, the resident's personal information such as name and identifying information, credit cards, bank accounts, driver's licenses, and social security cards
        ii. Examples of misappropriation of resident property include:
            - Identity theft
            - Theft of money from bank accounts
            - Unauthorized or coerced purchases on a resident's credit card
            - Unauthorized or coerced purchases from resident's funds
            - A resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion
            - A resident who provides monetary assistance to staff, after staff had made the resident believe that the staff member was in a financial crisis
            - Diversion of a resident's medication, including controlled substances, for staff use or personal gain

C. F603 Free from Involuntary Seclusion –
   1. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.

2. Involuntary seclusion is defined as separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident representative.

D. F604 Respect and Dignity: Free from Physical Restraints –
   1. The resident has a right to be treated with respect and dignity, including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.
   2. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
   3. A bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently
   4. Definitions:
      - **Convenience** is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care, and is not in the resident's best interest.
      - **Discipline** is defined as any action taken by the facility for the purpose of punishing or penalizing residents.
      - **Freedom of movement** means any change in place or position for the body or any part of the body that the person is physically able to control.
      - **Manual method** means to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint.
      - **Medical symptom** is defined as an indication or characteristic of a physical or psychological condition.
      - **Position change alarms** are alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in certain ways.
      - **Physical restraint** is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:
        i. is attached or adjacent to the resident's body;
        ii. cannot be removed easily by the resident; and
        iii. restricts the resident's freedom of movement or normal access to his/her body.

E. F605 Respect and Dignity: Free from Chemical Restraints –
   1. The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
   2. Definitions:
      - **Chemical restraint** is defined as any drug that is used for discipline or staff convenience and not required to treat medical symptoms.
      - **Convenience** is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest.
      - **Discipline** is defined as any action taken by facility staff for the purpose of punishing or penalizing residents.

- **Indication for use** is defined as the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.
- **Medical symptom** is defined as an indication or characteristic of a medical, physical, or psychological condition.

3. Determination of Medical Symptoms - The clinical record must reflect whether the staff and practitioner have identified, to the extent possible, and addressed the underlying cause(s) of distressed behavior, either before or while treating a medical symptom. Potential underlying causes for expressions and/or indications of distress may include, but are not limited to:
   - Delirium
   - Pain
   - The presence of an adverse consequence associated with the resident's current medication regimen
   - Environmental factors, such as staffing levels, over stimulating noise or activities, under stimulating activities, lighting, hunger/thirst, alteration in the resident's customary location or daily routine, physical aggression leading to altercations, temperature of the environment, and crowding
4. Determination of Indication for Medication Use - The clinical record must reflect the following:
   - Whether there is an adequate indication for use for the medication (e.g., a psychotropic medication is not administered unless the medication is used to treat a specific condition)
   - Whether an excessive dose and/or duration of the medication was administered to the resident
   - Whether there is adequate monitoring for the effectiveness of the medication in treating the specific condition and for any adverse consequences resulting from the medication
   - Whether a resident who uses a psychotropic drug(s) is receiving gradual dose reduction and behavioral interventions, unless clinically contraindicated
   - Whether a resident who receives a psychotropic drug(s) pursuant to a PRN (pro re nata, or as needed) order is not administered the medication unless the medication is necessary to treat a diagnosed specific symptom, as documented in the clinical record

F. F606 Not Employ/Engage Staff with Adverse Actions –
   1. The facility must not employ or otherwise engage individuals who
      - have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
      - have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
      - have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.
   2. The facility must report to the state nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

3. Definitions
   - **Found guilty…by a court of law** applies to situations where the defendant pleads guilty, is found guilty, or pleads no contest to charges of abuse, neglect, exploitation, misappropriation of property, or mistreatment.
   - **Finding** is defined as a determination made by the state that validates allegations of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property.
   - **Mistreatment** means inappropriate treatment or exploitation of a resident.

G. F607 Develop/Implement Abuse/Neglect/Exploitation/Misappropriation Policies –
1. The facility must develop and implement written policies and procedures that:
   - Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property;
   - Establish policies and procedures to investigate any such allegations; and
   - Include training as required at paragraph §483.95;
   - Establish coordination with the QAPI program.
2. Definitions
   - **Covered individual is a**nyone who is an owner, operator, employee, manager, agent, or contractor of the facility.
   - **Crime** is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.
   - **Law enforcement** is the full range of potential responders to elder abuse, neglect, and exploitation including police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners.
   - **Serious bodily injury** means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse.
   - **Criminal sexual abuse** is defined as serious bodily injury/harm considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.
3. The facility must develop and implement policies and procedures that include the following seven components:
   - **Screening**: The facility must have written procedures for screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property in order to prohibit abuse, neglect, and exploitation of resident property. This includes attempting to obtain information from previous and/or current employers, and checking with appropriate licensing boards and registries.

- **Training**: The facility must have written policies and procedures that include training new and existing nursing home staff, and in-service training for nurse aides in the following topics:
  i. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation;
  ii. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property;
  iii. Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators;
  iv. Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge without fear of reprisal; and
  v. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond, including:
    - Aggressive and/or catastrophic reactions of residents;
    - Wandering or elopement-type behaviors;
    - Resistance to care;
    - Outbursts or yelling out; and
    - Difficulty in adjusting to new routines or staff.

4. **Prevention**: The facility must have and implement written policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves (but is not limited to):
   - Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development/presence of an ongoing sexually intimate relationship;
   - Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. This includes implementation of policies that address the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and ensure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any;
   - Ensuring that residents are free from neglect by having structures and processes to provide needed care and services to all residents, including provision of a facility assessment to determine what resources are necessary to care for its residents competently;
   - Identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as:
     i. Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;
     ii. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;
     iii. Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;

iv. Taking, touching, or rummaging through other's property;
v. Wandering into other's rooms/space;
vi. Residents with a history of self-injurious behaviors;
vii. Residents with communication disorders or who speak a different language; and
viii. Residents that require extensive nursing care and/or are totally dependent on staff for the provision of care.
- Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions;
- Providing residents and representatives, information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed.

5. **Identification**: The facility must have written procedures to assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. This would include identifying the different types of abuse- mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services.
   - Because some cases of abuse are not directly observed, understanding resident outcomes of abuse could assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include, but are not limited to:
     i. An injury that is suspicious because the source of the injury is not observed or the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time; and
     ii. Sudden or unexplained changes in the following behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame.
6. **Investigation:** The facility must have written procedures for investigating abuse, neglect, misappropriation, and exploitation that include:
   - Investigating different types of alleged violations;
   - Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;
   - Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and
   - Providing complete and thorough documentation of the investigation.
7. **Protection**: The facility must have written procedures that ensure that all residents are protected from physical and psychosocial harm during and after the investigation, including:
   - Responding immediately to protect the alleged victim and integrity of the investigation;
   - Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;
   - Increased supervision of the alleged victim and residents;
   - Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;
   - Protection from retaliation; and
   - Providing emotional support and counseling to the resident during and after the investigation, as needed.
8. **Reporting/Response**: The facility must have written procedures that must include:

- Immediately reporting all alleged violations to the Administrator, State agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes;
- Ensuring that reporters are free from retaliation or reprisal: Facilities must post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint, in an area that is visible to employees, such as the same area where the facility posts other employee signs, such as labor management posters. Size and type requirements for the sign should be no less than the minimum required for any other required employment-related signs.;
- Reporting to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service;
- Taking all necessary actions as a result of the investigation, including the following:
  i. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences;
  ii. Defining how care provision will be changed and/or improved to protect residents receiving services;
  iii. Training of staff on changes made and demonstration of staff competency after training is implemented;
  iv. Identification of staff responsible for implementation of corrective actions;
  v. The expected date for implementation; and
  vi. Identification of staff responsible for monitoring the implementation of the plan.
- **Coordination with QAPI**: The facility must develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program under §483.75. Cases of physical or sexual abuse, for example by facility staff or other residents, always require corrective action and tracking by the QAA Committee, at §483.75(g)(2).
- **Retaliation** – In order to encourage reporting of the suspicion of a crime, facilities should develop and implement policies and procedures that promote a culture of safety and open communication in the work environment, prohibiting retaliation against an employee who reports a suspicion of a crime. Actions that constitute retaliation against staff include:
  i. When a facility discharges, demotes, suspends, threatens, harasses, or denies a promotion or other employment-related benefit to an employee, or in any other manner discriminates against an employee in the terms and conditions of employment because of lawful acts done by the employee.
  ii. When a facility files a complaint or a report against a nurse or other employee with the state professional licensing agency because of lawful acts done by the nurse or employee for reporting a reasonable suspicion of a crime to law enforcement.

H. F609 Reporting of Abuse/Neglect

1. The facility must develop and implement written policies and procedures that:
   - Ensure reporting of crimes occurring in federally-funded long-term care facilities.
   - The policies and procedures must include but are not limited to the following elements.
     i. Annually notifying covered individuals of their obligation to comply with the following reporting requirements:

- Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision (e.g., city, county, township, village) in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or receiving care from, the facility.
- Each covered individual shall report immediately, but **not later than 2 hours** after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or **not later than 24 hours** if the events that cause the suspicion do not result in serious bodily injury.

2. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
   - Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures:
     i. immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury,
     ii. or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.
   - Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
   - **Abuse** is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology.
   - **Alleged violation** is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another healthcare provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.
   - **Covered individual** is anyone who is an owner, operator, employee, manager, agent or contractor of the facility (see section 1150B(a)(3) of the Act).
   - **Crime**: Section 1150B(b)(1) of the Act provides that a "crime" is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.
   - **Exploitation** means taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.
   - **Injuries of unknown source** occur when both of the following criteria are met:
     i. The source of the injury was not observed by any person, or
     ii. The source of the injury could not be explained by the resident, and

iii. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

- Law enforcement is the full range of potential responders to elder abuse, neglect, and exploitation including: police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners.
- **Misappropriation of resident property** means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.
- **Mistreatment** is inappropriate treatment or exploitation of a resident.
- **Neglect** means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
- **Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, protracted loss or impairment of the function of a bodily member, organ, or mental faculty, or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation. Serious bodily injury is considered to have occurred when an injury results from criminal sexual abuse (see section 2011(19)(B) of the Act).
- **Criminal sexual abuse** is defined as serious bodily injury/harm if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.
- **Sexual abuse** is non-consensual sexual contact of any type with a resident.
- Willful is defined at §483.5 in the definition of "abuse," and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

3. A facility's policies and procedures for reporting under 42 CFR 483.12(b)(5) should specify the following components, which include, but are not limited to:
   - Identification of who in the facility is considered a covered individual;
   - Identification of crimes that must be reported; NOTE: Each State and local jurisdiction may vary in what is considered to be a crime and may have different definitions for each type of crime. Facilities should consult with local law enforcement to determine what is considered a crime.
   - Identification of what constitutes "serious bodily injury;"
   - The timeframe for which the reports must be made; and
   - Which entities must be contacted, for example, the State Survey Agency and local law enforcement.
4. Follow-up Investigation Report- Within 5 working days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.

I. F610 Investigate/Prevent/Correct Alleged Violation

1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
   - Have evidence that all alleged violations are thoroughly investigated.
   - Put measures in place to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
   - Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
2. The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, or mistreatment:
   - Thoroughly investigate the alleged violation;
   - Prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress; and
   - Take appropriate corrective action, as a result of investigation findings.

8. WORKFORCE MANAGEMENT (WM)

Med-Net's mission focuses on Corporate Compliance and Ethics with supporting policies in fraud, waste, abuse, privacy, quality, data integrity, and workforce management. As such, Human Resources policies and procedures are referred to a third party that specializes in the production of human resources policies, such as the *Society for Human Resource Management* (*SHRM*) (Note, Med-Net does not have a relationship with SHRM).

8. WORKFORCE MANAGEMENT (WM)

Policy Number	POLICY
WM 2.0	BACKGROUND SCREENING, EVAUATION, AND INVESTIGATION A. INITIAL EMPLOYEE SCREENING AND BACKGROUND INVESTIGATION B. FOREIGN NATIONALS C. APPLICANT DRUG TESTING
WM 2.0.1	NEPOTISM
WM 2.1	EMPLOYMENT IMMIGRATION LAW REQUIREMENTS (I-9)
WM 2.2	STAFF LICENSING AND CERTIFICATION A. VERIFICATION OF LICENSES AND CERTIFICATES B. CNA BACKGROUND VERIFICATION
WM 2.3	CREDENTIALING OF LICENSED INDEPENDENT PRACTITIONERS
WM 2.4	ORIENTATION AND TRAINING A. GENERAL AND ROLE SPECIFIC ORIENTATION B. ON-THE-JOB TRAINING C. COMPLIANCE AND ETHICS PROGRAM D. COMPLIANCE AND ETHICS PROGRAM TRAINING AND EDUCATION REQUIREMENTS E. CODE OF CONDUCT F. CONFLICTS OF INTEREST G. SECURITY AWARENESS TRAINING H. ACTIVE SHOOTER
WM 2.5	EMPLOYMENT CONDUCT AND BEHAVIOR A. USE OF HANDHELD DEVICES, CELL PHONES, AND BEEPERS B. DRUGS AND ALCOHOL

WM 2.6	FAMILY AND MEDICAL LEAVE ACT (FMLA)
WM 2.7	NONDISCRIMINATION A. DIVERSITY POLICY B. INFORMATION COMMUNICATION C. COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY D. AUXILIARY AIDS AND COMMUNICATION WITH PERSONS WITH SENSORY IMPAIRMENTS E. AGE RESTRICTION/REQUIREMENT F. SECTION 504 NOTICE OF PROGRAM ACCESSIBILITY G. SECTION 504 GRIEVANCE
WM 2.8	WORKPLACE VIOLENCE A. WORKPLACE VIOLENCE PREVENTION PLAN B. POLICY AGAINST HARASSMENT
WM 2.9	DISCIPLINARY STANDARDS A. DISCIPLINE B. DISCIPLINARY GUIDELINES C. NON-RETALIATION AND NON-RETRIBUTION
WM 2.10	CONTROLLED SUBSTANCES AND ABUSE
WM 2.11	TERMINATION

Policy Number: WM 2.0

Policy Title: Background Screening, Evaluation, and Investigation

Policy Statement/Purpose: To ensure that The Company maintains a background screening, evaluation, and investigation policy for new and current staff in accordance with state and federal laws.

Policy Interpretation and Implementation: Background screening, evaluation, and investigation are components of The Company's Compliance and Ethics Program.

The Company will perform background investigations on new hires and reassigned and promoted employees and Associates to prevent the employment of any individual who has been convicted of a criminal offense related to healthcare or who has been debarred, excluded, or held to be otherwise ineligible for participation in federal or state programs.

In addition, verification must be obtained that background records checks have been completed on all agency or contract staff. Background investigations of present staff may be made on a regular basis or at the time of transfer, promotion, reclassification, or changes in job duties.

Results of the required background check activities promptly shared with the compliance officer and appropriate compliance personnel.

Many states and localities prohibit criminal background checks until after a conditional offer of employment has been made. It is general policy that no criminal background inquiry be made of ANY *prospective* employee. Candidates must receive a provisional offer of employment prior to signing an authorization providing written consent for a criminal background check to be performed. (Reference state specific criminal background check requirements).

It is the ongoing and continuous obligation of all Company staff to alert the Human Resources Department of any conviction or finding that may disqualify them from providing services.

Accuracy of information - The Company relies on the accuracy of information contained in the employment application, as well as the accuracy of other data presented throughout the hiring process and employment. Any misrepresentations, falsifications, or material omissions of this information or data may result in The Company's exclusion of an employee or staff person from further consideration for employment or, if the person has been hired, termination of employment.

Definitions:

a. **Background check/Initial screening**- Includes an initial screening/review and documentation of requisite eligibility to work requirements such as verification of professional licenses, certifications as required, driver's license if indicated, reference checks, eligibility to work in the US (I-9), etc. conducted prior to an offer of employment being made.
b. **Criminal background check**- Includes state mandated inquiries into the background of a Conditional employee to ensure Company compliance to regulations and protections of staff and clients. Inquiries are documented and retained.

c. **Staff**- Staff includes employees, Medical Director, consultants, contractors, volunteers, caregivers who provide care on behalf of The Company, and students or interns.

A. Initial Employee Screening and Background Investigation

1). *Overview:* The Company will conduct screening and background investigations in accordance with state and federal law and standards of practice as part of the pre-employment screening procedures for prospective employees. This policy and procedure applies to any and all directors, officers, staff who provide care on behalf of The Company, employees, independent contractors, Medical Director, consultants, contractors, volunteers, students or interns, and others working for The Company ("Associates").

Federal, and some state, laws impose obligations on healthcare providers to investigate the background of potential employees and, in some cases, preclude providers from hiring individuals found to have committed certain offenses. It is Company policy to perform background checks of all employees to the fullest extent required and/or permitted by applicable state law and to retain on file applicable records of current employees regarding such investigations. In addition, verification must be obtained that background records checks have been completed on all agency or contract staff.

Background investigations of present staff may be made on a regular basis or at the time of transfer, promotion, reclassification, or changes in job duties.

2). *Procedure:*

a. Positions Subject to Screening Requirements - The Compliance and Ethics Officer, in consultation with Counsel, may identify other employment positions that may require pre-employment background checks, positions that may require pre-employment and/or periodic drug screening, and medical testing conditions. Employment contracts for such positions, if used, will set forth expressly the applicant's acknowledgment and acceptance of these requirements. (Refer to Policy WM 2.0 Section A: *Initial Employment Screening and Background Investigation).* At a minimum, The Company will:
   1. Check with all State Nurse Assistant Registries The Company has reason to believe contain information on an individual prior to using the individual as a nurse assistant
   2. Check with all applicable State licensing and certification authorities to ensure that employees hold the requisite license and/or certification status to perform their job functions
   3. Require that all potential employees certify as part of the employment application process that they:
      - have not been convicted of an offense or otherwise been found under applicable local, state, or federal law to have committed an offense that would preclude employment in a nursing facility; and
      - have not been excluded from participation in any state or federal healthcare program, including Medicaid and Medicare.
   4. Check available public sources, including the OIG's LEIB and the System for Award Management (SAM), for potential employees whose activities would be recorded there and whose activities may preclude them from employment in The Company

b. All prospective employees/staff must fill out a pre-employment application and respond to all applicable questions presented in accordance with applicable state and federal law, including whether they have:
    1. Been listed by the government as debarred, excluded, or otherwise ineligible for federal program (i.e., Medicare and Medicaid) participation
    2. Had any exclusive action taken against them and any criminal convictions, in accordance with state and federal laws

    The Company will not employ any individual who has been convicted of a criminal offense related to healthcare or who is debarred, excluded, or otherwise determined ineligible for participation in federal healthcare programs. The Company will not hire any such individual without documentation that the prospective employee has been officially reinstated into the federal healthcare programs.

    It is the ongoing and continuous obligation of all employees of The Company to alert the Human Resources Department of any conviction, exclusion from participation in a federal or state healthcare program, or other finding that would disqualify them from providing services.

    Results of the required exclusion activities are promptly shared with the compliance officer and appropriate compliance personnel.

c. Personal Interview – The Company conducts a personal interview to determine the applicant's qualifications for the position for which they have applied, and to inform the applicant of the position's responsibilities.
d. Working Papers – For all applicants who are under the age of 18 years, The Company must obtain appropriate working papers or permits before they can start work. A copy of these papers will be kept in the employee's employment file.
e. Licensure Verification – All personnel who are required to be licensed or certified to provide resident care shall show the Director of Human Resources their License or Certification before they can start work. This license will be verified/documented with the issuing state's on-line verification system.
f. The Company will refrain from making any verbal or written inquiries into a prospective employee's past criminal background or history during the initial employment application process.
g. The Company will perform background screening and investigations on new staff. In addition, verification is obtained that background records checks have been completed on all agency or contract staff.
h. Offers of Employment - Candidates must receive a Conditional Offer of Employment prior to signing an authorization providing written consent for a criminal background check to be performed.
i. All offers of employment and volunteer/intern positions are contingent upon the results of background checks to be performed by the Human Resources Department designee.
j. Notice and Disclosures - The Human Resources designee must comply with notice and disclosure requirements under the Fair Credit Reporting Act (FCRA) prior to conducting any background checks.

1. After receiving a Conditional Offer of Employment, the applicant must sign an Authorization providing written consent for a criminal background check to be performed
2. Once the authorization form is signed, the Human Resources designee will provide the conditional employee with a copy of the *Summary of Your Rights* under the FCRA, to be supplied by the credit reporting agency, and any corresponding state law
3. If The Company decides to take an adverse employment action based on the criminal background report, based on the overall background of the conditional employee, including the seriousness of the offense, the length of time since the offense was committed, work history and quality of the conditional employee's references, and not solely on a positive criminal background check result unless such result creates a danger/potential risk to a vulnerable population, The Company will:
    - Provide the conditional employee with a copy of the criminal background check result in addition to another copy of the *Summary of Your Rights* prior to taking any adverse employment action
    - Provide the conditional employee with the contact information of the agency that prepared the report to contest the accuracy of the information contained in the report
    - Provide the conditional employee with five (5) days to respond to or contest the accuracy of the report and obtain a corrected report
    - After the five (5) days, The Company will notify the conditional employee with a final notice of Adverse Employment action if it intends to discontinue the hiring process based on the results of the criminal background report

k. Prior convictions will not necessarily disqualify an applicant from employment. Serious consideration shall be given to the position sought, the seriousness of the offense, the length of time since the offense was committed, work history, and quality of the conditional employee's references.

l. Retention of Applications - If the applicant is hired, the completed application shall be kept as part of the employment file. If the applicant is not hired, the completed application shall be kept on file for one (1) year.

m. Confidentiality - All background investigation results will remain confidential.

B. Foreign Nationals

1). *Overview:* The Company has procedures in place to document Foreign Nationals consistent with law and regulation.

2). *Procedure:*

a. Verification of Status:
    1. If the Foreign National has worked in the United States for one (1) year or longer, a criminal history check covering time in the United States will be completed
    2. If the Foreign National's visa and/or authorization to work in the United States was issued before implementation of the Patriot Act on October 24, 2001, a criminal history check will be completed in the individual's prior countries of residence
    3. If the Foreign National's visa and/or authorization to work in the United States was issued or renewed under the provisions of the Patriot Act, no criminal history check will be required

b. The Human Resources Department must perform the following background investigations:

1. Criminal background checks to determine the following:
   - Prior conviction of a criminal offense unrelated to healthcare
   - Prior conviction of a criminal offense related to healthcare; specifically:
     - Criminal offense related to the delivery of an item or service under Medicare or Medicaid
     - Criminal offense related to the neglect or abuse of residents in connection with the delivery of a healthcare item or service
     - Felony related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a healthcare item or service, if the conviction or guilty plea occurred after August 21, 1996
     - Felony related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, if the conviction or guilty plea occurred after August 21, 1996
2. Verification that any prospective employees (regular and/or temporary), contractors, or subcontractors who directly or indirectly will be furnishing, ordering, directing, managing, or prescribing items or services in whole or in part are not excluded, unlicensed, or uncertified by searching the following databases:
   - Federal Exclusions Database:
     - http://oig.hhs.gov/fraud/exclusions.asp
   - The General Services Administration's System for Award Management (available at http://www.sam.gov)
   - State Medicaid Exclusion List
     Information on those who have been debarred is available at State specific websites
3. Because the Affordable Care Act has proclaimed an individual excluded in one state as excluded in all states, The Company shall also verify that no current or prospective employees (regular and/or temporary), contractors, or subcontractors who directly or indirectly will be furnishing, ordering, directing, managing, or prescribing items or services in whole or in part are excluded, unlicensed, or uncertified by searching currently maintained state databases

c. The Human Resources Department may perform at its discretion the following background investigations:
   1. Credit History Check (Federal law prohibits discrimination against an applicant or employee because of bankruptcy.)
   2. Sex and Violent Offender Registry Check
   3. U.S. Department of Justice, Office of Diversion Control – http://www.deadiversion.usdoj.gov/index.html
   4. State specific databases and registries as noted in Chapter 13 of this manual.

d. Results of the background check/sanction activities are promptly shared with the compliance officer and appropriate compliance personnel.

C. APPLICANT DRUG TESTING

1). *Overview:* It is Company policy that all Company applicants pass a drug test. Applicants will be informed of drug test requirement during their interview.

2). *Procedure:*

a. A former employee returning to The Company is not required to take a drug test so long as they have passed a drug test administered by The Company in the past six months.
b. Only qualified applicants who are provided with a Conditional Offer of Employment are to be drug tested.
c. If an applicant refuses a drug test, their Conditional Offer of Employment will be revoked.
d. Applicants are to complete Appendix WM 1 Item F, *Applicant Consent to Drug Testing* and provide a urine sample in a multi-drug screen cup on Company premises.
e. A positive result or the tampering of any sample will result in the withdrawal of employment offer.
f. The Company will inform applicant of their test results.
g. If positive test results are disputed by the applicant within five (5) days of receipt, The Company will send applicant to be retested by a certified laboratory and pay for the cost or retesting. The Company will inform applicant of their results upon receipt.
h. If positive test results from a laboratory are disputed by the applicant within five (5) days of receipt by The Company, applicant may arrange for a second retest at a certified laboratory. The Company will reimburse the applicant only if test results are negative.
i. Drug test results and all related documentation are to be filed in a locked cabinet separate from personnel file.

Policy Number: WM 2.0.1

Policy Title: Nepotism and Relationships at Work

Policy Statement/Purpose: This policy is intended to minimize the potential for actual or perceived conflicts of interest which may arise when a [FACILITY] employee and another [FACILITY] employee, manager, or officer who are in positions of inherently unequal authority also have a familial relationship, consensual romantic or personal intimate relationship, and/or live together.

The Facility permits the hiring of a current employee's family member or a related person when such person is the most qualified candidate for a position. However, in an effort to eliminate any actual or perceived conflicts of interest from arising in the workplace, FACILITY does not permit a current employee to be in a position of unequal authority over a family member or related person. As a result, FACILITY shall not hire, transfer, or promote any person if doing so will result in a current employee in a position of unequal authority to another.

When there is a change in circumstance during the course of employment that creates a conflict with this policy (e.g., colleagues become related as a result of marriage, dating, living together, or an employee is transferred resulting in an employee being in a position of unequal authority to another family member or related person), the employee with seniority must report the potential conflict of interest to his or her immediate manager or Human Relations. Both affected family members or related persons must take steps to eliminate the potential or actual conflict, within a reasonable time period determined by FACILITY. The employees may work with their manager and/or Human Relations to consider possible resolutions. If the employees are not able to eliminate the potential or actual conflict of interest in a manner acceptable to FACILITY, FACILITY has sole discretion to determine the appropriate resolution, including transfer or separation of one or both of the involved employees. At all times, the employee with senior authority to the other member must take responsibility for disclosing the relationship to his or her current direct supervisor.

Requests for exceptions to this policy, including situations in which one employee currently is in a position of unequal authority over a family member or related person must be made in writing to the managing employee's next immediate manager or the Director of Human Relations to review the request. Such request should identify how potential conflicts of interest are mitigated. The employees' respective manager shall approve the request. Due to constantly changing circumstances, Facility may withdraw any exception at any time.

Policy Interpretation and Implementation: This policy applies to the following persons at Facility, unless a person is covered by a separate agreement: Physicians, Healthcare Providers, Non-Provider Staff, Temporary Staff, Per Diem/PRN Staff, Volunteers, and Students.

Definitions

- Family Member: spouse, partner, parent, in-law parent, grandparent, sibling, child, cousin, aunt, uncle, niece, nephew, or any other person related by blood, marriage, or operation of law to a Facility employee, manager, or officer. Family members shall include step relations and in-laws.
- Related Persons: Facility employees, managers, and officers (hereinafter "employee") who live together in the same household, regardless of whether the relationship is platonic or otherwise,

and/or Facility employees, managers, or officers who have a romantic, intimate, or sexual relationship with each other, regardless of whether they live in the same household.

- Persons of Inherently Unequal Positions of Authority: Persons are considered to be in positions of inherent unequal authority when one individual has the indirect or direct ability to influence the performance appraisal, benefits, schedule, assignment, salary, and/or career progress of the family member or related person; or whose employment relationship to the family member or related person creates an actual or perceived conflict of interest as determined at Facility's sole discretion.

Examples of such relationships include, but are not limited to, relationships between supervisors and their staff, between senior and junior staff in the same department, between physicians and staff, staff within the same department, attending physicians and staff, and so forth. This list is provided only by way of example and shall not be considered to be exhaustive.

Policy Number: WM 2.1

Policy Title: Employment Immigration Law Requirements (I-9)

Policy Statement/Purpose: To ensure proper completion of Form I-9 for everyone hired for employment in the United States. This includes citizens and noncitizens.

Policy Interpretation and Implementation: All U.S. employers must ensure proper completion of Form I-9 for each individual they hire for employment in the United States. This includes citizens and noncitizens. Both employees and employers (or authorized representatives of the employer) must complete the form. On the form, an employee must attest to his or her employment authorization. The employee must also present his or her employer with acceptable documents evidencing identity and employment authorization. The employer must examine the employment eligibility and identity document(s) an employee presents to determine whether the document(s) reasonably appear to be genuine and to relate to the employee and record the document information on the Form I-9. Employers must retain Form I-9 for a designated period and make it available for inspection by authorized government officers.

1). *Procedure:*

a. For all new employees, The Company will visit www.uscis.gov/files/form/i-9.pdf to view and download the latest I-9 form and Instructions for Form I-9.
b. Company is responsible for complying with the time frames and instructions set forth on the latest I-9 form, as discussed in letter a. above.
c. Newly hired employees must complete and sign Section 1 of Form I-9 **no later than the first day of employment but not before the employee has accepted a job offer.**
d. The employee completes section 1 of the form, attesting that he or she is a citizen or national of the United States, a lawful permanent resident alien, or an alien with work authorization. Only people in these three categories can lawfully work in the Unites States.
e. To obtain the list, employees may present from the List of Acceptable Documents, found on the last page of Form I-9, to establish identity and employment authorization. Employers must present one selection from List A OR a combination of one selection from List B and one selection from List C.
f. Employer must indicate on Form I-9 which documents have been examined. It is employer's responsibility to decide whether the employee's documents appear valid. The USCIS advises that employers must accept documents that reasonably appear to be genuine and to relate to the person presenting them. To do otherwise could be an unfair immigration-related employment practice and therefore illegal.
g. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they should be made for ALL new hires or reverifications. Photocopies must be retained and presented with Form I-9 in case of an inspection by DHS or other federal government agency. Employers must always complete Section 2, even if they photocopy an employee's document(s). Making photocopies of an employee's document(s) cannot take the place of completing Form I-9. Employers are still responsible for completing and retaining Form I-9.
h. Employers must retain Form I-9 for either three (3) years after the date of hire or one (1) year after the date employment ended, whichever is later.

Policy Number: WM 2.2

Policy Title: Staff Licensing and Certification

Policy Statement/Purpose: The Company has policies in place to ensure employee licensing and certification is consistent with applicable legal requirements and standards of practice.

Policy Interpretation and Implementation: Practicing professionals and paraprofessionals are regulated by state licensing boards and must meet Company employment standards as identified in the current job description. Employees are responsible for maintaining their current licensure and for providing appropriate proof to The Company. Employees who become aware of potential licensing and certification violations must immediately report those violations to their supervisor, Administrator, Compliance and Ethics Officer, or through the Compliance Hotline. In instances where the violation could place any resident in substantial jeopardy, the employee must immediately report directly to his/her director supervisor, Administrator, or Compliance and Ethics Officer.

A. VERIFICATION OF LICENSES AND CERTIFICATES

1). *Overview:* The Company will verify the license or certificate prior to hire of any employee required to hold such a license or certificate, and again periodically as determined by the license renewal cycle or as directed by the Administrator and/or Human Resources Director.

2). *Procedure:*

a. Prior to hire, and periodically prior to license renewal, the Human Resources designee will verify that a license or certificate is current by conducting primary source on-line verification and documenting the date of that verification. Before an applicant begins work with The Company or continues work over time, a license or certificate must be verified with the appropriate state or national agency prior to hire and prior to license expiration. For example:
   1. Administrator - State Licensure Board
   2. RNs and LPNs - State Board of Nursing
   3. CNAs and NAs - State Abuse Registry
   4. Rehabilitation Professionals - State Licensing Boards
   5. Social Workers - State Licensing Board, as applicable
   6. Activity Directors - National Association of Certified Activity Professionals
   7. Dietitians - State Licensing Board and/or Commission on Dietetic Registration
   8. Food Service Directors - State requirements for food service managers or dietary managers
   9. Others as applicable

b. To ensure that Company's employees are licensed and certified to properly care for Company residents, the following elements are incorporated into the Compliance and Ethics Program policies:
   1. Proof of Licensure/Certification - The hiring supervisor is responsible to verify that each newly hired employee possesses a valid license in good standing applicable to his or her position. The hiring supervisor is responsible to *check with the State Board Licensing database* to review the potential employee's licensing status prior to job placement in the licensing category and for continued licensure prior to license expiration.

2. The Human Resource Department is responsible for verifying that each newly hired employee has not been suspended or excluded by any government agency or court from participating in the Medicare, Medicaid, or any Federal or State healthcare program and verifying the National Practitioner Data bank (NPDB) for licensed individuals https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwj3zOysyqHdAhVMu1MKHU jICAEQFjAAegQICBAB&url=https%3A%2F%2Fwww.npdb.hrsa.gov%2Fresources%2FaboutLegsAndRegs.jsp&usg=AOvVaw2l676JDue7CrlY6-0kEUDd

3. The Human Resource Department is responsible for a periodic review of the Office of Inspector General (GIG) Exclusion Database and the Government Services Agency (GSA) databases

c. Expired Credentials
   1. Employees who do not provide proof of renewal by the expiration date of their credentials, as evidenced by verification of the state board on-line data base, will be subject to immediate job reclassification, and their pay may be adjusted accordingly
   2. Employees who fail to provide proof of renewed credentials within ten (10) days of expiration will be terminated

d. Loss of Licensure
   1. Employees must inform their supervisors immediately if they lose their licensure or are placed on probation for any reason
   2. Employees who lose their license will be subject to immediate job reclassification, with appropriate pay change, or termination

e. Failed Licensure Exam
   1. Employees must notify their supervisor immediately of licensure test results (pass/fail)
   2. Employees who do not pass their licensure exam are subject to immediate job reclassification, with appropriate pay change, or termination
   3. Employees who fail either a National and/or State credentialing examination, as specified in the job description, two consecutive times (regardless of whether both failures occur under employ) will be terminated

g. Distinguish licensure from optional certifications such as those from professional societies such as certified DON, or AANAC unless it is required by job description (Company policy)

B. CNA Background Verification

1). *Overview:* The Company will verify the status of a Certified Nursing Assistant (CNA) by checking the State Nurse Aide Registry.

2). *Procedure:*

a. The Human Resources Designee will verify the CNA's certification status on the state's CNA registry. Alternatively, the HR Designee will contact the Department of Health & Senior Services to determine any adverse background of any CNA prior to hire.
b. Any history of abuse or neglect towards the elderly will be grounds for denial of employment.
c. The CNA verification process will be repeated periodically as determined by the Human Resources Director and/or the Administrator, or as needed.

Policy Number: WM 2.3

Policy Title: Credentialing of Licensed Independent Practitioners

Policy Statement/Purpose: The Company has a defined process to credential individuals permitted by law and authorized by The Company to practice independently.

Policy Interpretation and Implementation: The credentialing process is a component of The Company Compliance and Ethics program.

The Company has applied credentialing criteria to licensed independent practitioners (e.g., Attending Physicians, on-call Physicians, Dentists, Podiatrists, Nurse Practitioners, Psychiatrists, Physiatrists, Radiologists, and Cardiologists) applying to provide resident care or treatment under The Company's auspices. If a consultant writes orders and provides treatment, the credentialing process will be initiated. If a cardiologist, radiologist, and pathologist only provide impressions to The Company and attending physician, the attending physician is ultimately responsible to make a final diagnosis based on his individual clinical assessment.

Procedure:
The credentialing criteria specify the requirements for authorizing an independent licensed practitioner to practice in The Company. This credentialing process establishes an applicant's background and current competence which ensures that Company residents receive safe, quality of care and that The Company is compliant with prevailing laws and regulations. The credentialing requirements include:

1. Credentialing Application
2. Current license
3. DEA Number
4. State Narcotic Certificate
5. Professional liability and malpractice insurance certificate
6. Written Resume of relevant education, training, and experience
7. Scope of Service letter - A statement that the individual is able to perform the services he/she is applying to provide (mentally and physically competent and sets privileges within the scope of The Company's Provider status).
8. Two current competencies verified in writing by individuals personally acquainted with the applicant's professional and clinical performance. These letters are to contain informed opinions on the individual's scope and level of performance.
9. National Practitioner Data Bank verification

This information may be obtained through the following resources:

1. The Company will perform primary source verification either by letter, documented phone call, or on-line licensure verification from the primary source licensing agency or State Board.
2. Alternatively, contract with a Credentialing Verification Organization (CVO) after assessing the services provided by the CVO.
3. Rely on the decision from a Joint Commission Accredited Hospital to perform the primary source verification and then provide evidence of that verification to The Company (copy of appointment letter, current staff list, practitioner's status).
4. Rely on the applicant Physician to provide an original copy of a recent appointment letter to its

medical staff of a Joint Commission Accredited Hospital, with verification from the hospital.
5. For physicians not practicing at a Joint Commission accredited hospital, The Company must conduct the primary source verification and The Company medical director evaluates the candidate's credentials for privileging at the Company.
6. References and/or interview with Administrator and Medical Director.

Once all the above documentation is obtained, it will be reviewed, verified, and signed by the Medical Director and approved by the Credentialing Committee (if applicable) or The Company Administrator. (Reference WM Appendix 2.0, Section B. *Medical Staff Credentialing and Appointment Checklist)*

The decision of the Governing Body or Administrator will be documented, and the independent practitioner will be notified in writing of the credentialing decision (and scope of practice) on an ongoing basis on re-licensing credentialing and thereafter.

All Physicians and Clinical Staff will be informed of the credentialed practitioner authorized scope of practice (privileges) to practice by official, retrievable memo.

All independent practitioners will be reviewed bi-annually for re-appointment (i.e., by verifying the licensed independent practitioner's current license).

Policy Number: WM 2.4

Policy Title: Orientation and Training

Policy Statement/Purpose: All new employees, and those re-hired after an absence of six (6) months or more, are required to complete The Company's orientation program.

Policy Interpretation and Implementation: Orientation and training are components of The Company Compliance and Ethics program.

A. General and Role Specific Orientation

1). *Overview:* General and Role specific training will be provided to new employees, as necessary.

2). *Procedure:*

a. All new employees and those re-hired after an absence of six (6) months or more are required to participate in Company's orientation program on their first day of work.
b. The orientation program will cover all topics listed on WM Appendix 3.0, section A *General Orientation Checklist*.
c. New employees are also required to complete State Mandated Orientation and In-Service topics relevant to their job position and/or department.
d. New employees will also participate in a Department Specific orientation, in which Department Heads will introduce employees to department specific policies and procedures.
e. New employees are required to initial next to each completed task on the *General Orientation Checklist*. New employees are also required to sign the General Orientation Checklist where indicated following the completion of orientation.

B. On-The-Job Training

1). *Overview:* On-the-job training will be provided to new employees, as necessary.

2). *Procedure:*

a. In order to provide new employees with the knowledge required to competently perform job duties, on-the-job training will be provided, as necessary.
b. On-the-job training will run from the first day of employment until the Department Head is confident that the new employee can perform their job duties without supervision.
c. Department Heads are responsible for creating an on-the-job training program for their department to ensure consistency among all new employees to a position. On-the Job training topics include fire, safety, infection control, and other operational practices unique to the department that support role-specific orientation.
d. General COVID education. Information changes frequently, sometimes daily or more often for COVID-19, so check frequently for updated information. OSHA Education for home health workers is available at This an extremely useful resource for home health care workers.

C. COMPLIANCE AND ETHICS PROGRAM

1). *Overview:* The Company ensures that all affected individuals, including employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors/contractors and subcontractors, agents, Chief Executive, and other senior administrators, managers, executives, Governing Body Members, corporate officers, 1099 employees, service contractors and all other persons associated with The Company are effectively trained about the Compliance and Ethics Program, specific regulatory compliance issues, and their responsibilities. The Company presents compliance and ethics requirements in a way that is understood by individuals who do not speak English as their primary language, those who have sensory challenges or accommodated disabilities, and those with varying reading levels. **All compliance training is mandatory.**

2). *Procedure:* The Company compliance and ethics training and education program is designed to communicate Company Program's standards and procedures to staff members in a meaningful and effective manner and to ensure consistent application of the Program's policies. The training program:

a. Is geared to the level of responsibility and job function.
b. Utilizes classroom, lecture, recorded instruction, and/or other means of communication, as appropriate to accommodate the skills, experience, and knowledge of the trainees.
c. Employs other forms of education, such as the use of posters, bulletin boards, paycheck stuffers, etc., to inform employees of new compliance issues or to reinforce various aspects of past training.
d. All training, regardless of information sharing method, must be thoroughly documented, including the date, attendees, and agenda.
e. During new hire orientation, all new hires, regardless of position and seniority, are trained on the Compliance and Ethics Program and specific requirements and expectations under the Program.
f. It is the Compliance and Ethics Officer's responsibility to coordinate training activities and maintain a library of compliance-related information and training materials.

3). *The ongoing Compliance Training Program includes the following*:

a. The *Compliance and Ethics Plan* including the *Code of Conduct.* (Reference CP 1.0 and CP 2.1)
b. New Hire Orientation, including Compliance Expectations (Reference Workforce Orientation)
c. Regular Compliance Training

4). *Managers and Supervisors*:

a. Must provide appropriate instruction to ensure that employees perform their duties as required and must exercise care to detect instances of noncompliance.
b. Are accountable for meeting this responsibility and may be subject to disciplinary action if they fail to do so.
c. Are in the best position to identify areas in which employees require additional training and are expected to advise the Compliance and Ethics Officer regarding any such training needs.
d. May be expected to assist in compliance training relating to their respective areas of operation.

5). Employee Acknowledgment: Each employee will acknowledge in writing that he or she:

a. Completed training (verified by appropriate training personnel).
b. Has read those sections of the *Compliance and Ethics Program Manual* that are relevant to his or her duties.
c. Pledges to adhere to the Compliance and Ethics Program.
d. Understands that promotion of and adherence to the Compliance and Ethics Program is a condition of employment and a factor in The Company's evaluation of the employee's performance, and that failure to comply with the Compliance and Ethics Program may lead to disciplinary actions, up to and including immediate discharge. (Reference WM Appendix 3 Section B *Annual Compliance and Conflicts of Interest Disclosure Statement*)

An employee's refusal to make such an acknowledgment will be noted on the employee's acknowledgment form and reported to the Compliance and Ethics Officer.

D. COMPLIANCE AND ETHICS PROGRAM TRAINING AND EDUCATION REQUIREMENTS

(Reference CP Section 2.0 L *Compliance and Ethics Training and Education*)

Overview: The Company maintains an ongoing compliance education program which includes the following minimum requirements:

1. Trainees: Education and training on compliance issues is provided to all affected individuals including but not limited to:
   a. All Company employees
   b. Admitting physicians and licensed independent practitioners
   c. Company corporate officers and Governing Body members
   d. Agents performing services on behalf of The Company
   e. Volunteers, students, interns

2. Training Materials: All affected individuals are given:
   a. Employee Handbook, if applicable
   b. A copy of Our Compliance Plan including, Code of Conduct, DRA Policy, and Policy Against Harassment
   c. Sections of the compliance standards and policies relevant to their duties

3. Training Methods: Training sessions will utilize classroom, lecture, and/or video instruction, and/or other means of communication, as appropriate to accommodate the skills, experience, and knowledge of the trainees. A series of introductory compliance training sessions will be provided at times when employees on all shifts can attend. These training sessions will be mandatory. Other forms of education will be employed, such as the use of posters, bulletin boards, paycheck stuffers, etc., to inform employees of new compliance issues or to reinforce various aspects of past training.

4. General Training: All training sessions will communicate:
   a. The purpose, scope, and importance of adherence to the Compliance and Ethics Program
   b. The disciplinary consequences of failing to adhere to Program requirements
   c. The standards and procedures relevant to the trainees' duties
   d. Relevant fraud and abuse laws

e. Everyone's duty to report misconduct and to adhere to the Compliance and Ethics Program

5. Targeted Training: After the initial training is completed, there is a series of focused training sessions that targets employees in their departments. This training will further explain the compliance issues that most directly affect employees in each department.

   Anyone whose activities may affect the accuracy of claims for reimbursement (e.g., individuals involved in billing, cost reporting, and marketing, or individuals who furnish medical services to The Company's residents) will receive targeted training regarding:
   a. Government and private payor reimbursement principles
   b. Claim development and submission processes
   c. Appropriate marketing practices, including the laws prohibiting attempts to influence referrals through free or discounted goods or services
   d. Additional topics relating to operations that could put The Company at risk of noncompliance with governmental healthcare program requirements

   Additional compliance training sessions may be scheduled when new laws or regulations are enacted that change the Code of Conduct, or when an employee's conduct indicates the need for additional training in an area.

6. Training Requirements for Employees: No employee is authorized to act on The Company's behalf without first completing the employee screening and compliance training process, unless written authorization is given by the Compliance and Ethics Officer.

7. Record of Training: A record of compliance training will be maintained in each employee's personnel file and/or retrievable Learning Management System. The record should contain the date of the training, the content of the training, and the person(s) who provided the training. (Reference Training Log, below)

42 CFR 483.95 – Mandatory Training Requirements

A company must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A company must determine the amount and types of training necessary based on a company assessment as specified at § 483.70 (e). Training topics must include but are not limited to:

(a) Communication. A company must include effective communications as mandatory training for direct care staff.

(b) Residents' rights and company responsibilities. A company must ensure that staff members are educated on the rights of the resident and the responsibilities of a company to properly care for its residents as set forth at §483.10.

(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements found at §483.12. Facilities must also provide training to their staff that at a minimum educates staff on:

(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property
(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property
(3) Dementia management and resident abuse prevention

(d) Quality assurance and performance improvement. A company must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of The Company's QAPI program as set forth at §483.75 and §483.95.

(e) Infection control. A company must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80 (a)(2).

(f) Compliance and ethics. The operating organization for each company must include as part of its compliance and ethics program as found at, §483.85.
(1) An effective way to communicate that program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program
(2) Annual training if the operating organization operates five or more facilities

(g) Required in-service training for nursing assistants. In-service training must:
(1) Be sufficient to ensure the continuing competence of nursing assistants but must be no less than 12 hours per year
(2) Include dementia management training and resident abuse prevention training
(3) Address areas of weakness as determined in nursing assistants' performance reviews and company assessment at §483.70(e) and may address the special needs of residents as determined by The Company staff
(4) For nursing assistants providing services to individuals with cognitive impairments, address the care of the cognitively impaired

(h) Required training of feeding assistants. A company must not use any individual working in The Company as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160.

(i) Behavioral health. A company must provide behavioral health training consistent with the requirements at § 483.40 and as determined by The Company assessment at §483.70(e). 82 FR 68870, October 4, 2016

Guidelines:
A. Our company will extend the same training given to certified nursing assistants to all staff but expanded to make it meaningful for all.
B. CMS encourages The Company to consider the use of free training materials such as the CMS “Hand in Hand” curriculum.

C. The regulations do not specify that a member of The Company has to conduct the training activities. The Company will consider working with training partners to meet the CMS mandated training requirement. Our company has the flexibility to work with outside entities to provide the training (e.g., Med-Net Compliance, LLC).
D. The Company strives to leverage any resources available to assist with developing and implementing our training program.
E. Staff providing direct care to residents are to be re-trained in dementia management at least annually. By direct care staff, CMS is referring to those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing.

E. Code of Conduct

(Reference CP 2.1 Code of Conduct)

F. Conflict of Interest

(Reference CP 2.2 Conflict of Interest)

G. Security Awareness Training

1). *Overview:* To successfully implement a security program requires security training for those that plan and design network and applications. General security awareness training is also necessary for all employees.

The establishment of security training courses will be the responsibility of the Information Security Manager.

Human Resources will administer the training program.

2). *Procedure:*

a. All workforce members who plan, design, and implement networks or applications are required to be trained in The Company's security policies and procedures.
b. For the existing members of the workforce, training must be conducted on an annual basis. For existing members of the workforce whose functions have changed, training must be completed within thirty (30) days of the function changes.
c. For a new member of the workforce, training must be completed thirty (30) days after the person joins the workforce.
d. The Company will implement a security awareness and training program for all workforce members including but not limited to:
    1. Security reminders - Periodic security updates
    2. Protection from malicious software - Procedures for guarding against, detecting, and reporting malicious software
    3. Log-in monitoring - Procedures for monitoring log-in attempts and reporting discrepancies
4. Password management - Procedures for creating, changing, and safeguarding passwords
5. Encryption for protected documents sent per email or text
6. Protecting proprietary documents

H. ACTIVE SHOOTER

1). *Overview*: Emergency planning responsibilities are significant for healthcare facilities as they are faced with planning for emergencies of all kinds. Because many emergencies occur with little or no warning, it is critical to plan in advance and to practice response through drills. For that reason, our facility is committed to training that enables our staff to be knowledgeable about this type of disaster. Early intervention can prevent the situation from escalating by identifying, assessing, and managing a threat. Recognizing pre-attack warning signs and indicators could prevent a potential tragic active shooter event.

2) Definition:

An active shooter is an individual who is actively engaged in killing or attempting to kill people in a confined and populated area. The individual is armed with at least one gun, and intends to kill people, not commit some other crime.

3) Procedure:

a. Each employee carries a three-fold responsibility regarding the potential for an active shooter event:
   - **First**: Learn the signs of a potentially volatile situation and ways to prevent an incident
   - **Second**: Learn steps to increase survival of self and others in an active shooter incident
   - **Third**: Be prepared to work with law enforcement during the response

b. Recommended Areas of Preparation: Our facility follows recommendations of the National Preparedness Planning Initiative by addressing five areas of active shooter preparedness:

   1. Prevention – action taken to keep a threatened or actual incident from occurring
   - Employees, medical staff, volunteers, and contractors must display an authorized identification badge properly at all times
   - All staff will be trained to practice a culture of vigilance and safety and report unusual, dangerous, or suspicious workplace violence activity immediately
   - Leadership will take all reports seriously and act upon them–lives depend on this
   - All levels of staff will work together to ensure locked doors remain closed and locked
   - Codes on doors with keypad access will be changed at specified intervals and sharing of codes is not to occur, with the exception of staff who need to know
   - Staff will ask individuals who seem lost or unfamiliar with the surroundings if they need assistance and report any concerns

   2. Protection – action focused on protecting residents/residents, staff, visitors, and property from a threat or hazard
   - Training will include what to expect and how to react.
   - Drills will be planned and conducted with first responders
   - A walk through with law enforcement will give them familiarity with the building
     - They can help identify shelter areas and alternate escape routes for staff to use in an emergency
   - Involve staff in all aspects of the practice and drills

3. **Mitigation** – reducing the likelihood that threats and hazards will happen

   Staff will be trained to watch others for the following warning signs and to report negative observations immediately:
   - Pre-Attack Behaviors: Paranoid ideas, delusional statements, changes in personality or performance, disciplinary problems on-site, depressed mood, suicidal ideation, non-specific threats of violence, increased isolation, odd or bizarre behavior, interest in or acquisition of weapons
   - Behavioral warning signs of a potential active shooter that should be brought to the attention of law enforcement and facility stakeholders include:
     - Development of a personal grievance
     - Contextually inappropriate and recent acquisition of multiple weapons, escalation in target practice and weapons training, or interest in explosives
     - Intense interest in or fascination with previous shootings or mass attacks
     - Experience of a significant real or perceived personal loss in the prior weeks and/or months, such as a death, breakup, divorce, or loss of a job

   A **Threat Assessment Team,** or TAT, consisting of administration, human resources, current employees, medical and mental health professionals, and law enforcement representatives will meet routinely to identify individuals who show risk factors for becoming active shooters if left unaddressed. TAT members will:
   - review reports of troubling behavior of current or former residents/residents and family members, visitors, staff, and others who are brought to their attention by staff or others associated with the facility;
   - consider the potentially threatening person's life–family, work, residential, social;
   - identify any potential targets or victims; and
   - determine whether law enforcement intervention, counseling, or other actions are needed.

4. **Response** – stabilizing an emergency once it has happened; restoring a safe and secure environment; saving lives and preventing destruction

   Announce the Active Shooter:
   - Staff will be trained to loudly state the following to alert all to the imminent danger if an incident occurs: ***"There is an active shooter on-site, location," ongoing status*****, followed by all clear when the event ends**
   - Plain language is best–staff will be trained not to use coded language that not everyone will understand
   - Staff will notify local emergency responders immediately. Everyone who can call 911 should do so–what if in the moment of panic, no one called?

   Follow the **Run, Hide, Fight Model**:

   Run – if you can do so safely
   - ✓ Leave personal belongings behind
   - ✓ Visualize possible escape routes, including for patients/residents, visitors, the disabled

- ✓ Avoid elevators
- ✓ Take others with you, but do not stay behind because they will not go

Hide – it may be the only option

- ✓ Barricade areas where residents, visitors, or staff are located
- ✓ Lock doors if locks are present
- ✓ Barricade doors with heavy furniture or a wedge
- ✓ Close and lock windows, close blinds, turn off lights
- ✓ Silence electronic devices and remain silent
- ✓ Look for ways to escape
- ✓ Identify things to use as weapons if the shooter enters the area
- ✓ Remain in place until the all clear is given

Fight – an option of last resort

- ✓ When confronted directly by a shooter, staff should consider trying to disrupt or incapacitate the shooter by using aggressive force and items in the environment, such as fire extinguishers, chairs, etc. They can spray the individual with the discharge from a fire extinguisher or use the extinguisher itself or a chair to hit the person forcefully over the head
- ✓ Confronting an active shooter will **never** be a requirement, but if faced with no other option, it may save lives

Staff will be educated on the following Active Shooter Incident response actions:

- When faced with the situation, forcefully communicate the danger and necessary action (Gun! Get out! Run!)
- Those closest to the public-address system or other communications system should announce the danger and necessary action
- Call 911 as soon as it can safely be done with information that is clear and accurate (it is acceptable to use a resident's phone in an emergency!)
- While personal safety is the primary consideration, helping others to safety increases survivability for all
- An individual might first need to hide and then run when it is safe to do so, so Run, Hide, Fight may occur in a different sequence
- If the active shooter discards a weapon or is incapacitated and drops a weapon, DO NOT PICK IT UP
    - The weapon can be secured in a trash can or bag, but should never be carried in the hand of the person finding it–this could make the individual appear to be the shooter in the eyes of the responding officers
- During the event, the police may yell instructions and perform aggressively as they work within the situation–staff must follow their commands promptly, recognizing how serious the situation is

5. **Recovery** – restoring the treatment environment as soon as possible after the active shooter event. Administration will:
    - Designate a facility spokesperson
    - Ensure an accounting for all individuals, including residents, visitors, and staff
    - Coordinate actions with first responders
    - Determine the best method for notifying families in coordination with law enforcement

- Assess the behavioral health of those at the scene and provide mental health resources for all
- Plan and activate an employee family unification plan in a safe place away from the press
- Determine when to resume full services
- Provide information to the community and plan on how the negative information will be delivered.
    - How, when, and by whom will families of residents and staff be notified of any injuries and deaths
    - Typically, law enforcement notifies family members of casualties that result from a crime
    - Facility response will be integrated with the procedures of law enforcement and the medical examiner

Administration will ensure the following Key Points for an Effective Plan are in place:

- Proactive steps, including training, will help employees identify individuals who may be on track to commit a violent act
- A preferred method for reporting active shooter incidents will be taught to all staff, including informing everyone in the facility or who maybe subsequently entering the building while an event is occurring in clear language that everyone will understand
    - Remember to make provision for the deaf, hard of hearing, and those for whom English is not the first language
- Establish a written evacuation policy and procedure that includes:
    - Emergency escape procedures and route assignments (floor plans that show exit routes and safe areas as part of the "Run, Hide, Fight" plan)
    - Lockdown procedures individualized for the facility's individual units, offices, buildings
- Integrate communication with the facility's internal incident commander with the external incident commander
- Post a list of local area emergency response agencies and hospitals (name of agency, phone number, contacts) in numerous locations, such as nurses' stations, all department manager offices, at every facility telephone, and provide a copy of the list to the facility's external resources for incident commanders at the facility to use

Resource:
Incorporating Active Shooter Incident Planning into Healthcare Facility Emergency Operations Plans https://www.phe.gov/Preparedness/planning/Documents/active-shooter-planning-eop2014.pdf

Policy Number: WM 2.5

Policy Title: Employment Conduct and Behavior

Policy Statement/Purpose: All Company employees shall accept certain responsibilities, adhere to acceptable practices in matters of conduct and behavior, and always exhibit a high degree of personal integrity. The Company's mission and expectations of achievement on behalf of its residents requires an exceptional level of consistent professional behavior on the part of all employees.

Policy Interpretation and Implementation: Employment conduct and behavior are components of The Company Compliance and Ethics program.

INAPPROPRIATE/UNACCEPTABLE CONDUCT AND BEHAVIOR

The following examples of inappropriate or unacceptable conduct and behavior reinforce the importance of performing responsibilities in a professional, honest, and sensitive manner when working with one another, residents, and their families.

Important Note: *The following list is illustrative only and not all inclusive.*

Examples of inappropriate or unacceptable conduct and behavior:

1. Resident abuse
2. Violating a resident's rights
3. Disobeying work directives or insubordinate behavior toward supervisors, department heads, or administrators
4. Stealing; willfully destroying or damaging Company, resident, or employee property
5. Disorderly or discourteous conduct
6. Discussing personal problems with residents, a resident's family, or visitors
7. Reports to work apparently under the influence of alcohol, illegal drugs or narcotics, or in a physical condition making it unsafe or unsatisfactory to continue employment (includes using substances while on duty)
8. "Logging in" for another employee's time, or asking someone to "log in" on one's own time card
9. Logging in or out at times other than those authorized, or leaving duties during working hours without permission
10. Borrowing money or other possessions from residents
11. Disclosing anything of a personal nature concerning a resident, either inside or outside of The Company ***Exception:*** *Unless the employee's duties require giving of or exchanging information as defined in the employee's job description*
12. Sexual or other form of coworker harassment
13. Failure to exercise proper responsibility of office or center keys assigned to the employee's care
14. Unauthorized possession of firearms or other weapons on Company property
15. Refusal to comply with safety and fire regulations or sanitation rules and regulations
16. Excessive or unjustified absences or tardiness. If unable to work, failure to notify the supervisor or department head
17. Smoking in unauthorized areas
18. Violating solicitation, distribution, and access policies and procedures

19. Performing personal work on Company time without permission of the supervisor or department head
20. Using Company telephones/communication systems for personal matters except in emergencies
21. Taking more time than allowed for meals and rest breaks
22. Inefficiency and/or negligence in the performance of assigned duties
23. Altering, falsifying, or making a willful misstatement of fact on a resident record or chart, job or work record, employment application, or other record or report
24. Misrepresenting reason(s) for a leave of absence or other time off from work
25. Failure to report back to work from authorized leave or vacation
26. Failure to use personal safety equipment, such as a back-support belt, when required
27. Failure to report to and begin work on time
28. Failure to treat all residents, visitors, and coworkers with kindness, respect, and dignity
29. Bringing firearms, alcoholic beverages, and/or other drugs and narcotics on the premises
30. Gambling on Company property

CONFLICTS BETWEEN EMPLOYEES

Conflicts between Company employees shall not be discussed in front or with residents or visitors. Supervisors, department heads, and/or center administrators shall assume responsibility in assisting employees to resolve conflicts. When conflicts cannot be settled, a grievance may be filed in accordance with policies and procedures.

DISCIPLINARY ACTION

Should an employee's work performance, habits, or attitudes become unsatisfactory based on one or more of the above cited examples or other similar behavior, appropriate disciplinary action shall be taken. (Reference WM 2.9 *Disciplinary Standards*)

A. USE OF HANDHELD DEVICES, CELL PHONES, AND BEEPERS

(Reference Privacy Practices PP 2.2 and 2.3)

1). *Overview:* Company employees shall exercise thoughtfulness and courtesy in responding to, and using, personal communications such as cell phones, beepers, and other handheld devices, and any social media applications (apps) to which images and/or audio of residents, family, and staff could be uploaded.

The Company has a ZERO TOLERANCE policy regarding employee personal cell phones and other personal communication devices being present in resident areas. The Company is dedicated to the care of the elderly and disabled and to the protection of their privacy. The care of these residents cannot be adequately accomplished when the employees are interrupted by outside personal phone calls. Residents' right to privacy and confidentiality for all aspects of care and services cannot be ensured if personal communication devices are present in resident care areas. The policy is to protect both the residents and employees from inappropriate, unlawful communications, including, but not limited to, recording and text communications using a personal cell phone/transmission device.

2). *Procedure:*

a. Employees shall not use Company's telephones for personal use unless it is an emergency. If personal calls are received, a message shall be taken by the receptionist and forwarded to the employee.
b. Employees are encouraged to inform friends, relatives, etc. not to call them while on duty.
c. Employees shall not be paged to a telephone unless it is a bona-fide emergency.
d. No Company employee shall possess or use a *personal* cellular telephone or beeper while at work, unless approved to do so by The Company Administrator. Guidelines for the use of cell phones include:
    1. Cell phones may be used for personal calls and text messaging ONLY when the employee is on authorized meal and break periods and in designated cell phone use areas
    2. Employees are expected to place their cell phones in their lockers or leave them in their vehicles when on The Company grounds
    3. Cell phones MAY be used while employees are in the break area or in their vehicles in the parking lot
    4. Cell phones MAY NOT be used on the grounds or parking lot other than in an employee's vehicle
    5. In the event there is an emergency situation that must be immediately tended to, inform the supervisor so communication arrangements can be approved in advance. Failure to comply with cell phone policies may result in disciplinary action
    6. Employees who have their personal cell phone in their possession in resident areas may be subject to disciplinary action, up to and including termination
    7. Exceptions to this policy may include physicians, physician extenders, and individuals who must carry a cell phone into resident areas due to the need to be reached immediately for patient/resident-related issues. This must be authorized in advance
    8. Texting or other transmission of resident protected health information (PHI) using employee personal cell phones is prohibited

B. DRUGS AND ALCOHOL

1). *Overview:* The Company has a significant interest in ensuring the health and safety of its residents and employees. In furtherance of this interest, The Company has established a policy prohibiting the use, possession, purchase, sale, transfer, or distribution of non-medically prescribed controlled substances or alcohol while on The Company's premises or elsewhere, while on Company business. The Company encourages an enlightened viewpoint toward alcoholism and drug dependencies as behavioral-medical problems, which, within reason, can be treated. The Company encourages employees or members of their families to seek assistance if alcohol or drug abuse is a problem. For these reasons, The Company has established the following substance abuse policy.

a. On the job Use, Possession, Sale, Transfer, or Distribution:
    1. The use, possession, sale, transfer, or distribution of non-medically prescribed controlled substances or of alcohol on The Company's premises or at any of The Company's work sites is prohibited. Any employee found in violation of the above-stated policy is subject to disciplinary action up to and including dismissal on the first offense. The term "work site" includes Company vehicles on and off The Company's premises; or anywhere in The Company's buildings or property

2. Depending on the circumstances, other action, including notification of appropriate law enforcement agencies, will be taken with respect to an employee violating this policy
3. Employees are prohibited from possessing paraphernalia used in connection with non-medically prescribed controlled substances

b. Employee Impairment and Drug Use:
   1. Employees are prohibited from reporting to and being at work while under the influence of alcohol, illegal drugs, or any controlled substance. Any employee violating this policy may be subject to disciplinary action up to and including dismissal on the first offense
   2. An employee taking a drug or other medication, whether or not prescribed by a physician for a medical condition, which is known or publicized as possibly impairing judgment, coordination, or other senses important to the safe and productive performance of work, must notify his or her supervisor prior to starting work. This supervisor will decide whether the employee can continue to work or will impose any necessary work restrictions

c. Employee Drug/Alcohol Testing:
   1. When The Company has reasonable suspicion to believe that an employee's behavior and/or performance is influenced by controlled substances and/or alcohol, The Company may require the employee to submit blood or urine samples for testing. Factors establishing reasonable cause include, but are not limited to:
      - Stumbling or difficulty walking
      - Slurred or incoherent speech
      - Apparent confusion and disorientation
      - Odor of alcohol and/or residual odor peculiar to some chemical or controlled substance
      - Dilated pupils/pinpoint pupils
      - Red eyes
      - Discovery or presence of illegal substances or alcohol in an employee's possession or near the employee's workplace
      - Nodding; appears more sleepy than awake (not regular tiredness/more sleepy than awake)

d. The above factors and observations can be further substantiated by the following documentation or observations:
   1. Excessive absenteeism or excessive tardiness
   2. Declining productivity or performance
   3. Violation of Company safety policies
   4. Involvement in any accident or near accident
   5. Conviction for violation of a criminal drug statute

e. If a supervisor makes such observations, the supervisor will contact the Executive Director or HR delegate. The Executive Director or HR delegate will then request a reasonable explanation from the employee as soon as possible. If no acceptable explanation is forthcoming, the Executive Director or his or her designee may request that the employee be scheduled for a drug test immediately.
   1. If the employee refuses to cooperate with the administration of the drug test, the employee will be advised that the failure to cooperate with the drug test will be considered as a positive result
   2. The employee will be removed from The Company and suspended without pay pending receipt of the test results

f. If an employee is involved in an accident while furthering Company business that involves serious injury, which includes significant property damage and/or an injury for which medical treatment beyond simple first aid is required, the employee may be requested to submit to a drug test based on the factors and observations set forth in a.1 and a.2 above. Generally speaking, only employees whose acts could have caused or contributed to the accident will be tested.
g. Any employee will be given the opportunity to have a positive test result verified at any qualified laboratory the employee chooses. The employee will pay for the cost of the independent testing. The verification will be conducted using a portion of the original sample to be provided by the custody procedure providing the same protection as the procedure described above. The employee will have five (5) business days from the date of notice by the original lab to have the second test conducted and must provide written verification of the test result to the Executive Director or the Executive Director's designee within one (1) week from the date of the test. Failure to provide this notice will be treated as a confirmation of the original lab result. The result of the verification test must be provided directly by the laboratory to the Executive Director or HR delegate for evaluation.
h. Employees having a positive test result are subject to appropriate disciplinary action up to and including dismissal subject to The Company's policy against employment discrimination on the basis of off-duty medicinal use of marijuana in compliance with state law.
i. Notification of Test Results: Test results will be treated in a confidential manner, and the employee's confidentiality shall be respected to the greatest possible extent. Test results shall not be disclosed to any individuals, inside or outside The Company, except those designated by the Executive Director or HR delegate as having a legitimate "need to know" to make decisions and enforce The Company's policies.

Corrective Action: As stated herein, any employee found in violation of this substance abuse policy may be subject to disciplinary action up to and including dismissal on the first offense.

Before The Company requests a test from an employee and terminates an employee's employment for violations of the substance abuse policy, the employee will be given one (1) opportunity to enter a treatment or counseling program in order to continue his or her employment. The employee must provide adequate proof to the Executive Director or HR delegate that he or she is involved in a treatment or counseling program and verify that he or she is abstaining from the use of controlled substances. This treatment or counseling program shall be at the sole cost of the employee, unless the cost of the program is covered by insurance.

Policy Number: WM 2.6

Policy Title: Family and Medical Leave Act (FMLA)

Policy Statement/Purpose: To ensure Family and Medical Leave is provided to eligible employees in accordance with state and federal law.

Policy Interpretation and Implementation: Employees may be eligible for family and medical leave under the Federal Family and Medical Leave Act (FMLA) and/or state family leave laws. Although the federal and state laws sometimes have different names, Company refers to these types of leaves collectively as "FMLA Leave." Employees will be eligible for the most generous benefits available under applicable law.

Procedure:

I. FMLA Leave

Eligible employees are entitled to up to twelve (12) work weeks of unpaid, job-protected leave a year, and requires group health benefits to be maintained during the leave as if employee continued to work instead of taking leave. Eligible employees are entitled to up to twenty-six (26) work weeks of unpaid, job-protected leave a year and maintenance of his/her group health benefits in order to care for a covered service member who is the spouse, child, parent, or next of kin of employee.

Company shall post a Notice to Employees of Rights under FMLA on the Employee Bulletin Board. The Notice can be found at the following website:
https://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf

II. Eligibility

To be eligible for FMLA Leave benefits, employee must: 1) have worked for The Company for a total of at least twelve (12) months; 2) have worked at least 1,250 hours over the previous twelve (12) months as of the start of the leave; and 3) work at a location where at least 50 employees are employed by The Company within 75 miles, as of the date the leave is requested.

Once Company becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.
See FMLA Notice of Eligibility and Rights & Responsibility form at the following website:
https://www.dol.gov/whd/forms/WH-381.pdf

III. Definitions

Serious Health Condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a healthcare pro-

vider for a condition that either prevents the employee from performing the functions of the employee's job or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two visits to a healthcare provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Child, *for purposes of Bonding Leave and Family Care Leave*, means a biological, adopted or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that Family and Medical Leave is to commence.

Child, *for purposes of Military Emergency Leave and Military Caregiver Leave*, means a biological, adopted or foster child, stepchild, legal ward, or a child for whom the person stood in loco parentis, and who is of any age.

Parent, for purposes of this policy, means a biological, adoptive, step or foster father or mother, or any other individual who stood in loco parentis to the person. This term does not include parents "in law." For Military Emergency leave taken to provide care to a parent of a military member*, the parent must be incapable of self-care, as defined by the FMLA.*

Covered Active Duty means 1) in the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country; and 2) in the case of a member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty (or notification of an impending call or order to active duty) in support of a contingency operation as defined by applicable law.

Covered Service Member means 1) a member of the Armed Forces, including a member of a reserve component of the Armed Forces, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness incurred or aggravated in the line of duty while on active duty that may render the individual medically unfit to perform his or her military duties, or 2) a person who, during the five (5) years prior to the treatment necessitating the leave, served in the active military, Naval, or Air Service, and who was discharged or released therefrom under conditions other than dishonorable (a "veteran" as defined by the Department of Veteran Affairs), and who has a qualifying injury or illness incurred or aggravated in the line of duty while on active duty that manifested itself before or after the member became a veteran. For purposes of determining the five-year period for covered veteran status, the period between October 28, 2009 and March 8, 2013 is excluded.

Qualifying exigency includes:

1. Issues arising from a covered military member's short notice deployment (i.e., deployment on seven (7) or fewer days of notice) for a period of seven (7) days from the date of notification
2. Military events and related activities, such as official ceremonies, programs, or events sponsored by the military or family support or assistance programs and informational briefings sponsored

or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member
3. Certain childcare and related activities arising from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on a non-routine, urgent, immediate need basis, enrolling or transferring a child in a new school or day care facility, and attending certain meetings at a school or a day care facility if they are necessary due to circumstances arising from the active duty or call to active duty of the covered military member
4. Making or updating financial and legal arrangements to address a covered military member's absence
5. Attending counseling provided by someone other than a healthcare provider for oneself, the covered military member, or the child of the covered military member, the need for which arises from the active military member who is on short-term duty or call to active duty status of the covered military member
6. Taking up to five (5) days of leave to spend time with a covered temporary, rest and recuperation leave during deployment
7. Attending to certain post-deployment activities, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of ninety (90) days following the termination of the covered military member's active duty status, and addressing issues arising from the death of a covered military member
8. Any other event that the employee and employer agree is a qualifying exigency

IV. Reasons for Leave

State and federal laws allow FMLA Leave for various reasons. Because an employee's rights and obligations may vary depending upon the reason for the FMLA Leave, it is important to identify the purpose or reason for the leave. FMLA Leave may be used for one of the following reasons, in addition to any reason covered by an applicable state family/medical leave law:

1. The birth, adoption, or foster care of an employee's child within twelve (12) months following birth or placement of the child ("Bonding Leave")
2. To care for an immediate family member (spouse, child, or parent with a serious health condition ("Family Care Leave")
3. An employee's inability to work because of a serious health condition ("Serious Health Condition Leave")
4. A "qualifying exigency," as defined under the FMLA, arising from a spouse's, child's, or parent's "covered active duty" (as defined above) as a member of the military reserves, National Guard or Armed Forces ("Military Emergency Leave")
5. To care for a spouse, child, parent or next of kin (nearest blood relative) who is a "Covered Service Member," as defined above ("Military Caregiver Leave")

V. Length of Leave

The maximum amount of FMLA Leave will be twelve (12) workweeks in any 12-month period when the leave is taken for: 1) Bonding Leave; 2) Family Care Leave; 3) Serious Health Condition Leave; and/or 4) Military Emergency Leave. However, if both spouses work for The Company and are eligible for leave under this policy, the spouses will be limited to a total of twelve (12) workweeks off between

the two of them when the leave is for Bonding Leave or to care for a parent using Family Care Leave. A 12-month period begins on the date of your first use of FMLA Leave. Successive 12-month periods commence on the date of your first use of such leave after the preceding 12-month period has ended.

The maximum amount of FMLA Leave for an employee wishing to take Military Caregiver Leave will be a combined leave total of twenty-six (26) workweeks in a single 12-month period. A "single 12-month period" begins on the date of your first use of such leave and ends twelve (12) months after that date.

If both spouses work for The Company and are eligible for leave under this policy, the spouses will be limited to a total of twenty-six (26) workweeks off between the two when the leave is for Military Caregiver Leave only or is for a combination of Military Caregiver Leave, Military Emergency Leave, Bonding Leave, and/or Family Care Leave taken to care for a parent.

VI. Intermittent Leave

In some instances, FMLA leave may be taken intermittently or on a reduced leave schedule due to a serious health condition or to care for an immediate family member with a serious health condition. **Upon the birth or placement of a child, intermittent leave or working a reduced number of hours is not permitted unless both the employee and The Company agree**. Leave taken intermittently may be taken in increments of no less than one (1) hour. If the need for medical leave is foreseeable, based on planned medical treatment, the employee must make reasonable efforts to schedule the treatment so it will not unduly disrupt The Company's operations. Further, if an employee requests intermittent or reduced leave and the need for leave is foreseeable, the employee may be temporarily transferred to another position with equivalent pay and benefits in order to better accommodate recurring periods of absence.
If an employee has a previously qualified intermittent FMLA leave, the employee must notify The Company when an absence is due to that FMLA-qualifying reason.
If intermittent leave is approved, Company may later require employee to obtain recertifications of the need for intermittent leave. Company may request recertification if it received information that casts doubt on employee's report that an absence qualifies for Family and Medical Leave.

VII. Notice and Certification

A. Notice

With the exception of military family leave, if the employee's need for family/medical/military leave is **foreseeable**, the employee shall give The Company minimally, a thirty (30) business day advance notice to their supervisor.

If the need for family/medical/military leave is **unforeseeable**, the employee shall notify his or her supervisor of the need for the leave as soon as practical, but no later than within one (1) or two (2) business days of the start of the leave unless such notice is impossible due to an emergency situation.

For military family leave, notice must be provided as soon as practicable.

B. Certification

If the employee is requesting family/medical/military leave for their own or a covered relative's serious health condition or serious injury or illness for military family leave, the employee and the relevant healthcare provider must supply appropriate medical certification.

The following forms shall be used, according to the type of leave requested:

1. Certification of Health Care Provider for Employee's Serious Health Condition. Located at: https://www.dol.gov/whd/forms/WH-380-E.pdf
2. Certification of Health Care Provider for Family Member's Serious Health Condition. Located at https://www.dol.gov/whd/forms/wh-380-f.pdf
3. Certification of Qualifying Exigency for Military Family Leave. Located at https://www.dol.gov/whd/forms/WH-384.pdf
4. Certification For Serious Injury or Illness of Covered Service Member for Military Family Leave Act. Located at: https://www.dol.gov/whd/forms/WH-385.pdf

When the employee requests family/medical/military leave, Company shall notify the employee of the requirement for medical certification and that it is due within fifteen (15) calendar days after requesting leave.

If the certification is incomplete or insufficient to determine eligibility for family/medical/military leave, Company will notify the employee, in writing, what specific information is still needed. The employee will have seven (7) calendar days to cure the deficiencies.

Failure to provide the requested medical certification in a timely manner may result in denial of leave until it is provided.

Company may, at its expense, require a 2nd and 3rd examination by a Company designated healthcare provider, with the exception of military leave requests.

Company may require subsequent medical recertification every six (6) months. Failure to provide the requested certification within fifteen (15) business days, if such is practicable, may result in delay of further leave until it is provided.

Company may require proof of covered family relationship for family leave requests for caring for a family member with a serious health condition and military family leave requests.

Company may disallow or deny an employee's FMLA leave if the employee fails to follow The Company's procedures for requesting leave and calling in absent, except in unusual circumstances.

VIII. Reporting While on Leave

Company requires periodic reporting, on the 1st and 3rd Tuesday every month unless employee and Company agree otherwise, regarding the status of employee's condition and intended return to work date.

IX. Recertification

Once medical leave is certified, Company may later require medical recertification in connection with an absence that employee reports as qualifying for Family and Medical Leave. For example, Company may request recertification if 1) the employee requests an extension of leave; 2) the circumstances of the employee's condition as described by the previous certification change significantly (e.g., employee's absences deviate from the duration or frequency set forth in the previous certification; employee's condition becomes more severe than indicated in the original certification; employee encounters complications); or 3) Company receives information that casts doubt upon employee's stated reason for the absence. In addition, Company may request recertification in connection with an absence after six (6) months have passed since employee's original certification, regardless of the estimated duration of the serious health condition necessitating the need for leave. Any recertification requested by The Company shall be at the employee's expense.

X. Failure to Provide Certification and to Return from Leave

Absent unusual circumstances, failure to comply with these notice and certification requirements may result in a delay or denial of the leave.
Company may disallow or deny an employee's FMLA leave if employee fails to follow The Company's procedures for requesting leave and calling absent, except in unusual circumstances.
If an employee's anticipated return to work date changes and it becomes necessary for the employee to take more or less leave than originally anticipated, the employee must provide The Company with reasonable notice (i.e., within two (2) business days that the employee becomes aware of the change) of the employee's changed circumstances and new return to work date. If employees give The Company unequivocal notice of their intent not to return to work, they will be considered to have voluntarily resigned and its obligation to maintain health benefits (subject to COBRA requirements) and to restore their positions will cease.

XI. Health Benefits During Leave

During an approved family/medical/military leave, Company shall maintain the employee's healthcare benefits, as if they continued to be actively employed.

However, the employee must continue to pay their portion of the premium.

During any period in which paid leave is substituted for unpaid family/medical/military leave, Company shall deduct the employee's portion of the healthcare premium as a regular payroll deduction.

If the leave is unpaid, the employee must pay their portion of the premium by the first day of every month.

Healthcare coverage shall cease if the employee's premium payment is more than thirty (30) days late.

Company may recover premium paid to maintain health coverage if employee fails to return to work following FMLA leave except in certain, discretionary circumstances where the failure to return to work is due to circumstances beyond employee's control.

XII. Compensation During Leave

Family/medical/military leave is unpaid unless the employee has paid time off available.

Employees may be eligible to receive benefits through state-sponsored or Company-sponsored wage-replacement benefit programs.

If the employee requests a leave because of their own or a covered relative's serious health condition, any accrued paid benefit time for unpaid leave time will not extend the length of FMLA leave.

In no case, can the substitution of paid leave time for unpaid leave time result in the employee receiving more than one hundred percent (100%) of their salary.

Family/medical/military leave runs concurrently with other types of leave (e.g., paid vacation or worker's compensation absence), with the exception of Military Caregiver Leave.

XIII. Returning from Leave

Employee must be reinstated to the same position held at the time of the leave or to an equivalent position with equivalent pay, benefits, and other employment terms and conditions. However, employee has no greater right to reinstatement than if employee had been continuously employed rather than on leave.

An employee wishing to return from a Serious Health Condition Leave must submit an acceptable release from a healthcare provider that certifies the employee can perform the essential functions of the job as those essential functions relate to the employee's serious health condition. For an employee on intermittent FMLA leave, such a release may be required if reasonable safety concerns exist regarding the employee's ability to perform his or her duties, based on the serious health condition for which the employee took the intermittent leave.

Employees failing to provide Company with a Return-to-Work Certification/Release shall not be permitted to return to work until provided.

An employee who fraudulently obtains Family and Medical Leave from Company is not protected by FMLA's job restoration or maintenance of health benefits provisions. In addition, Company will take all available appropriate disciplinary action against such employee due to such fraud.

"Key employees," as defined by law, may be subject to reinstatement limitations in some circumstances. If employee is a "key employee," employee will be notified of the possible limitations on reinstatement at the time of leave request. See FMLA Notice of Eligibility and Rights & Responsibility form: https://www.dol.gov/whd/forms/WH-381.pdf

Policy Number: WM 2.7

Policy Title: Nondiscrimination

Policy Statement/Purpose: The Company has policies that enforce nondiscrimination consistent with applicable laws and regulations.

Policy Interpretation and Implementation: Nondiscrimination is a component of The Company Compliance and Ethics program.

A. DIVERSITY POLICY

1). *Overview:* The Company is committed to fostering, cultivating, and preserving a culture of diversity and inclusion.

2). *Procedure:*

a. The Company embraces and encourages all differences in age, color, disability, ethnicity, family or marital status, gender identity or expression, language, national origin, physical and mental ability, political affiliation, race, religion, sexual orientation, socio-economic status, veteran status, and other characteristics that make our employees and residents unique.
b. The Company's diversity initiatives are applicable, but not limited, to Company practices and policies on admissions, employee recruitment, selection, compensation and benefits, professional development and training, promotions, transfers, social and recreational programs, layoffs, terminations, and the ongoing development of a residential and work environment built on the premise of gender and diversity equity that encourages and enforces:
    1. Respectful communication and cooperation between all employees and residents
    2. Representation of all groups and perspectives
    3. Contributions to the communities we serve to promote a greater understanding and respect for the diversity
c. All employees of The Company have a responsibility to treat others with dignity and respect at all times.
    1. All employees are expected to exhibit conduct that reflects inclusion during work, at work functions on or off the work site, and at all other Company-sponsored and participative events
    2. All employees are also required to attend and complete annual diversity awareness training to enhance their knowledge to fulfill this responsibility
d. Any employee found to have exhibited any inappropriate conduct or behavior against others may be subject to disciplinary action. Reference Policy WM 2.9
e. Employees who believe they have been subjected to any kind of discrimination that conflicts with The Company's diversity policy and initiatives should seek assistance from a supervisor or an HR representative.

Reference BP 1.0 Section F, *Nondiscrimination Policy* and WM 2.7, *Nondiscrimination*

B. Information Communication

1). *Overview:* The Company does not discriminate against any person based on age, gender, ethnic background, disability, race, color, or any other protected class.

2). *Procedure:*

a. Any brochures must contain a nondiscrimination statement.
b. Employee applications must contain a nondiscrimination statement.
c. A nondiscrimination statement must be posted in the facility for staff and public to see.
d. Company's publications must contain The Company nondiscrimination statement. *Should you have any questions, concerns, or complaints regarding this policy, please contact the Compliance and Ethics Officer, at* _____.

C. Communication With Persons of Limited English Proficiency

Reference BP 1.0 Section E, *Communication with Persons with Limited English Proficiency (LEP)*

D. Auxiliary Aids and Communication With Persons With Sensory Impairment

Reference Policy BP 1.0, Section D, *Auxiliary Aids and Services for Persons with Disabilities*

E. Age Restrictions Requirements

Reference Policy BP 1.0, Section C, *Age Restrictions*

F. Section 504 Notice of Program Accessibility

Reference Policy BP 1.0, Section G, *Section 504 Notice of Program Accessibility*

G. Section 504 Grievance

Reference Policy BP 1.0, Section G, *Section 504 Notice of Program Accessibility,* *Section 504 Grievance Procedure*

Policy Number: WM 2.8

Policy Title: Workplace Violence

Policy Statement/Purpose: The Company provides a work environment that is pleasant, healthful, comfortable, and free from intimidation, hostility, or other offenses that might interfere with work performance. Harassment of any sort—verbal, physical, electronic, and/or visual—will not be tolerated.

Policy Interpretation and Implementation: Workforce violence prevention is a component of The Company Compliance and Ethics Program and includes a workplace violence prevention plan, a policy against harassment/sexual harassment, and equal employment and nondiscrimination.

A. WORKPLACE VIOLENCE PREVENTION PLAN

1). *Overview:* To ensure The Company remains consistent with applicable legal requirements and standards of practice, it is important that The Company identifies applicable state specific workplace violence prevention plan requirements. In the absence of state specific requirements and standards of practice, this plan can be adapted to Company specific policy and procedure.

The Workplace Violence Prevention Program will be accessible to all employees, and a copy will be provided upon request. The Company:

a. is committed to employees' safety and health;
b. will provide adequate authority and budgetary resources to responsible parties so that identified goals and assigned responsibilities can be met;
c. includes and encourages employee participation in the design and implementation of its workplace violence prevention program;
d. refuses to tolerate violence at the workplace and has developed and implemented a program to reduce incidents of violence;
e. applies workplace violence policies consistently and fairly to all employees, including supervisors and managers;
f. requires prompt and accurate reporting of violent incidents, whether physical injury has occurred; and
g. will not retaliate against victims of workplace violence.

2) *Implementation of a Violence Prevention Plan:* The Company develops a detailed, written violence prevention plan that identifies and outlines violence prevention policies, procedures, and responsibilities. The plan shall, at a minimum, describe the following:

a. The establishment of a violence prevention committee
b. The Company's violence prevention policies
c. The recordkeeping processes
d. Incident reporting, investigation, and evaluation methods
e. Available resources for follow-up medical and psychological care, which may include support groups, family crisis intervention, and professional referrals
f. How employees shall access a post-incident response system

The plan shall:

a. Require an annual comprehensive violence risk assessment
b. Identify methods to reduce identified risks, including, at a minimum: Company modifications, changes to equipment, job design, staffing and security, and revision of violence prevention training content
c. Be updated and submitted to The Company administration annually

3) *Violence Prevention Committee:* The Company shall establish a Violence Prevention Committee, which can be an integrated component of The Company QAA/QAPI Committee as long as it maintains distinct documentation and records as required by law.

The Violence Prevention Committee shall include a representative of management who shall serve as the Violence Prevention Officer and be responsible for overseeing all aspects of the Program. He/she shall also chair the committee.

a. At least 50% of the committee members shall be healthcare workers who provide direct resident care or otherwise have direct contact with residents.
    1. If healthcare workers are represented by one or more collective bargaining agents, the management of The Company or system shall consult with the applicable collective bargaining agents regarding the selection of the healthcare worker committee members
    2. The remaining committee members shall have experience, expertise, or responsibility relevant to violence prevention
b. If The Company owns or operates more than one covered healthcare company, the violence prevention program and the committee may be operated at the system or department level, provided that:
    1. Committee membership includes at least one healthcare worker from each company that provides direct care to residents
    2. The committee develops a violence prevention plan for each company
    3. Data related to violence prevention remain distinctly identifiable for each company
c. The Violence Prevention Committee shall, at a minimum:
    1. Meet quarterly to review reports of violent incidents
    2. Complete review of the following records:
        - OSHA 300 logs for the last three years
        - Incident reports
        - Records of, or information compiled for recording of, assault incidents or near assault incidents
        - Medical records
        - Insurance records
        - Workers Compensation records
        - Police reports
        - Accident investigations
        - Training records
        - Grievances
        - Minutes of meetings
        - Other relevant records or information: _____
    3. From these record reviews identify issues that need to be addressed

4. The Violence Prevention Committee shall make any appropriate adjustments to the violence prevention plan

4) *Annual Violence Risk Assessment:* The Company shall conduct an annual comprehensive violence risk assessment that shall review OSHA's 2004 Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (OSHA 3148-2004) and adhere to the General Duty Clause;

a. The Company shall conduct a job task analysis in collaboration with and for each healthcare worker that shall be used by the Violence Prevention Committee to identify improved security measures and controls based on potential risk factors including, but not limited to:
   1. Working with unstable or volatile persons, prevalence of weapons onsite, or presence of gang members–for violent incidents
   2. Impact of staffing, including security personnel, if applicable
   3. The presence of hazards, conditions, operations, and situations that might place workers at risk of occupational assault incident
   4. The presence of individuals who may pose a risk of violence
   5. A review of any records relating to violent incidents at The Company (see *Policy CP Appendix 2.0 B Compliance Incident Report Log*), including incidents required to be reported pursuant to the Occupational Safety and Health Administration Log of Work-Related Injuries and Illnesses (OSHA Form 300), and workers' compensation records
b. At least two (2) members of the Violence Prevention Committee, at least one (1) of whom is a direct care staff member, shall conduct walk-through surveys of all worksite areas at least once annually, and as needed, to identify existing or potential physical environmental risk factors for workplace violence.
   1. Such risk factors shall include, at a minimum, The Company's layout, access restrictions, crime rate in surrounding areas, lighting, and communication and alarm devices
   2. The results from the walk through shall be discussed and analyzed during the annual comprehensive violence risk assessment

5). *Violence Prevention Training:* The Company develops and annually reviews, evaluates, and revises the content of violence prevention training.
a. The training shall be at least two (2) hours in duration and shall be held during paid work time.
b. The Company shall provide interim training for individuals who begin work between annual training sessions.
c. The training methods shall include, but not be limited to, at least two (2) of the following: handouts, presentations, discussion, role playing, and DVD or computer-based training activities.
d. All employees, regardless of their title or level of risk, should receive training to include, at a minimum:
   1. A review and definition of workplace violence
   2. A full explanation and full description of the Program
   3. Techniques to de-escalate and minimize violent behavior
   4. Appropriate responses to workplace violence, including the use of restraining techniques
   5. Reporting requirements and procedures
   6. Location and operation of safety devices
   7. Resources for coping with violence

8. A summary and analysis of The Company's risk factors, identified in the violence risk assessment, and preventative actions taken in response to the identified risk factors
9. Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences
10. Assurance that The Company will not take any retaliatory action for reporting any threat or violent incident

6). *Specialized training:* The Company provides specialized training.

a. Employees with job tasks or locations that place them at higher risk for violent incidents should be provided with specialized training in addition to those topics outlined above. Training shall be designed to deal with the nature of this risk.
b. Managers and supervisors shall undergo the training outlined thus far, plus additional training to enable them to recognize a potentially hazardous situation and to make necessary changes in the physical company, resident care treatment program, and staffing policy and procedures to reduce security hazards.
c. Managers and supervisors shall also be trained to ensure that employees are not placed in assignments that compromise safety as well as how to behave compassionately toward coworkers when an incident does occur.
d. Security personnel, if any, shall receive training regarding The Company layout, security hardware on premises, and high-risk jobs.

7) *Training records:* All training records shall be filed with the Human Resource Department/Personnel Department.
a. Develop strategies for encouraging the reporting of all incidents of workplace violence and procedures for reporting such incidents.
b. Review de-identified, aggregated data that has been compiled from incident investigation reports by the appropriate department to identify trends and, if needed, to make recommendations to prevent similar incidents.

8). *Availability of Plan:* The Company shall make a copy of the plan available, upon request, to the Commissioners of Health and Senior Services, and Human Services for on-site inspection to each healthcare worker and collective bargaining agent that represents healthcare workers at The Company.
a. If the committee determines that the plan contains information that would pose a threat to security if made public, any such information shall be excluded before providing copies to workers or collective bargaining agents.

9). *Managing Risk Factors:* The Company shall implement prevention and control measures to counteract the risk factors identified by the risk assessment, including, at a minimum:
a. Lighting indoors and in parking lots
b. The installation and maintenance as necessary of items including alarm systems, closed circuit TVs, metal detection systems, cell phones, personal alarm devices, codes, panic alarms, and audio surveillance systems
c. Assigning and training appropriate personnel to respond to each alarm system

d. The training and posting of security personnel in emergency departments, psychiatric wards, and in other locations, as needed
e. Controlled access, as needed, to staff offices and employee work areas

10). *Personnel Guidance:* The Company shall have personnel sufficiently trained to identify aggressive and violent predicting factors and the ability to appropriately respond to and manage violent disturbances. The following guidelines will be issued to all personnel:
a. If an incident is an emergency, follow The Company's Emergency Management Plan and Chain of Command.
b. Once an incident occurs, the Violence Prevention Officer and/or designee should, if warranted:
    1. Report the incident to the local police department
    2. Secure work areas where the disturbance occurred
    3. Ensure the physical safety of employees and others remaining in the area as soon as possible
    4. Ensure that no work area is left short-staffed while others assist the victim or help in securing the area
    5. Quickly assess the work area, if it was disturbed or damaged during an incident to determine if it is safe
    6. Provide critical incident debriefing to victims, witnesses, and other affected employees; these conversations must be strictly confidential

11). *Incident report:* An *Incident Report* shall be completed for any type of violent incident, whether physical injury has occurred or not (e.g., verbal abuse, threats of violence, menacing, etc.). Issues of confidentiality shall be considered.
a. The record shall be analyzed to determine changes needed to prevent the recurrence of violence in the workplace and to determine required training.
b. The Company shall provide the Department of Health and Senior Services with immediate access to the records and any de-identified and/or aggregated data.
c. An employee and/or his/her authorized representatives shall have access to the employee's identifiable records and to de-identified and/or aggregated data within two (2) business days.
d. The incident report shall initially be assessed by the Violence Prevention Officer.
e. The Company shall provide written, de-identified incident investigation reports to the Violence Prevention Committee.
    1. After reviewing the de-identified incident reports, The Company, in collaboration with the Violence Prevention Committee, shall encourage appropriate follow-up, consider changes in procedures, and add elements to training as needed
    2. Appropriate revisions shall be made to the violence action plan. All revisions shall be put in writing and notification shall be given to all employees
    3. The Violence Prevention Committee shall decide when the de-identified data shall be aggregated

12). *Medical Care:* The Company shall ensure that prompt and appropriate medical care is provided to healthcare workers injured during an incident.

13). *Incident Response System:* The Company shall establish a post-incident response system that provides, at a minimum, an in-house crisis response team for employee-victims and their coworkers,

and individual and group crisis counseling that may include support groups, family crisis intervention, and professional referrals.
The Company shall ensure that provisions for medical confidentiality and protection from discrimination are included in Company policies and procedures to prevent victims from suffering further loss.

14*).* *Record Keeping:* The Company shall keep a record of all violent acts against employees while at work. The records shall be maintained for at least five (5) years following the reported act, during which time employees, their authorized representatives, and the Department of Health and Senior Services shall have access to the record. The records shall include OSHA Reports:

a. OSHA 300 Log – OSHA regulations require entry on the Injury and Illness log of any injury that requires more than first aid, causes loss of consciousness, requires modified duty, or results in lost time from work. Assaults shall be entered on the log. Doctors' reports of work injury and supervisors' reports shall be kept of each recorded assault. Fatalities or catastrophes must be reported to OSHA.

   On January 25, 2019, the U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) has issued a final rule that eliminates the requirement for establishments with 250 or more employees to electronically submit information from OSHA Form 300 (Log of Work-Related Injuries and Illnesses) and OSHA Form 301 (Injury and Illness Incident Report) to OSHA each year. These establishments are still required to electronically submit information from OSHA Form 300A (Summary of Work-Related Injuries and Illnesses). The final rule does not alter an employer's *duty to maintain* OSHA Forms 300 and 301 on-site, and OSHA will continue to obtain these forms as needed through inspections and enforcement actions.

   The agency is also amending the recordkeeping regulation to require covered employers to electronically submit their Employer Identification Number with their information from Form 300A. For more information, visit www.osha.gov.

b. State specific logs such as NJOSH 300 (New Jersey)
c. Employee deaths – resulting from an employment accident or illness caused by or related to a workplace hazard or the hospitalization (not examination and release) of three (3) or more employees resulting from an employment accident or illness caused by a workplace hazard must be orally reported by the employer within eight (8) hours
d. Incidents of assaults – shall describe who was assaulted, the type of activity, (e.g., unprovoked sudden attack), and all other circumstances of the incident. The records should include a description of the location/environment, potential or actual costs, lost time, nature of injuries sustained, etc. (Reference Appendix CP 2.0 B *Compliance Incident Report Log*)
e. Incidents of abuse, verbal attacks, or aggressive behavior – any acts of aggression shall be recorded; they may be threatening to the worker but may not result in injury (e.g., pushing or shouting). These records may be assault incident reports that are evaluated routinely by the Violence Prevention Committee
f. Other Accident Investigation Reports
g. Minutes of safety meetings and inspection reports – shall include corrective actions recommended relative to workplace violence and The Company's response and completion dates for

action items. Minutes of the Violence Prevention Committee meetings shall be kept for three (3) years

h. Training records – shall include dates on which training was conducted, type of training given, employees trained, etc. Records of training program contents, and the sign-in sheets of all attendees, shall be kept for five (5) years. Qualifications of the trainers shall be maintained along with the training records
i. Inspection records – shall include dates of inspection, areas inspected, all findings and recommendations, any control measures implemented, etc.
j. Employee questionnaires/surveys – that assess their views of high-risk work areas and activities
k. Staff termination records
l. Union grievances and complaints
m. Police reports
n. Insurance records
o. Workers' compensation records
p. Medical records

16). *Workforce Violence Enforcement:* The Company has a zero-tolerance policy for violence. If an employee engages in any violence in the workplace, or threatens violence in the workplace, he/she may be terminated immediately for cause. No talk of violence or joking about violence will be tolerated.

Note: 29 C.F.R. § 1604.11(e)—one of Title VII's sexual harassment provisions— "an employer may… be responsible for the acts of non-employees (including residents), with respect to sexual harassment of employees in the workplace, where the employer (or its agents or supervisory employees) knows or should have known of the conduct and fails to take immediate and appropriate corrective action."

In an effort to fulfill this commitment to a safe work environment for employees, residents, and visitors:

a. All employees must display Company identification.
b. All visitors must register and display identification while on the property.
c. The Company specifically prohibits the possession of weapons by any employee while on Company property unless authorized for security personnel. Employees are also prohibited from carrying a weapon while performing services off The Company premises. Appropriate disciplinary action, up to and including termination, will be taken against any employee who violates this policy.
d. Desks, telephones, and computers are the property of The Company. The Company reserves the right to enter or inspect employees' work area including, but not limited to, desks, email, and computer storage disks, with or without notice.
e. Any private conversations overheard or transmitted via telephone, electronic communication, mail, or fax on Company premises that constitute threats against other individuals can and will be used as the basis for termination for cause.
f. Employees are encouraged to report any incident that may involve a violation of any of the policies that are designed to provide a comfortable workplace environment. Any concerns may be presented to employees' immediate supervisor and/or the Compliance and Ethics Officer. All reports will be investigated, and information will be kept confidential.

17). *Anti-Retaliation:* The Company shall not take any retaliatory action against any healthcare worker for reporting violent incidents. Thus, an employee shall not be discharged, suspended, demoted, or have any other adverse employment action taken against him/her for making a good faith report of violence.

18). *Definitions:*

Covered Healthcare Company – A general or special hospital or nursing home licensed by the Department of Health and Senior Services, a state or county psychiatric hospital, or a state developmental center.

Healthcare Worker – An individual who is employed by a covered healthcare company.

Workplace Violence or Violent Act – Any physical assault, threatening behavior, verbal abuse, or damage of personal property occurring in the work setting. It includes, but is not limited to, beatings; stabbing; suicides; shootings; rapes; near suicides; murders; psychological traumas such as threats, obscene phone calls, use of berating language, an intimidating presence, and harassment of any nature such as being followed, sworn at, or shouted at. Acts of vandalism, arson, and sabotage are also considered workplace violence.

Workplace – May be any location, either permanent or temporary, where an employee performs any work-related duty. This includes, but is not limited to, the buildings and the surrounding perimeters, including the parking lots, field locations, clients' homes, off-site business-related functions such as trade shows and business conferences, social events such as Company party, and traveling to and from work assignments.

Violence by Strangers – In this type of incident the violence is committed by a stranger. This stranger has no legitimate relationship to the worker or workplace and enters the workplace, usually on the pretense of being a customer or visitor, to commit a robbery or other violent act. Workers also may be victimized by strangers outside the "traditional" workplace but while acting within the course and scope of their employment.

Violence by Residents/Clients – In these incidents, the violence is committed by someone who receives a service such as a current or former resident or a family member. The violence can be committed in the workplace or, as with service providers, outside the workplace but while the worker is performing a job-related function.

Violence by Coworkers – In coworker incidents, the perpetrator has an employment relationship with the workplace. The perpetrator can be a current or former employee, a prospective employee, a current or former supervisor or a manager. Coworker violence that occurs outside the workplace but that resulted or arose from the employment relationship would be included in this category. This type of violence can be divided into two types: violence between supervisors and subordinates, and violence between workers at the same levels.

Violence by Personal Relations – In personal relations incidents, the violence is committed by someone who has a personal relationship with the worker, such as a current or former spouse or partner, a relative, or a friend. Included in this category is the perpetrator who has a personal dispute with the worker and enters the workplace to harass, threaten, injure, or kill.

Violence by an Ancillary Service Provider – In these incidents, the violence is committed by someone who enters the workplace to provide a service such as an ambulance attendant, lab/x-ray technician, delivery person, or physician.

Definitions of Incidents:

Assault – The intentional use of physical injury (impairment of physical condition or substantial pain) to another person, with or without a weapon or dangerous instrument.

Criminal Mischief – Intentional or reckless damaging of the property of another person without permission.

Disorderly Conduct – Intentionally causing public inconvenience, annoyance, or alarm, or recklessly creating a risk thereof by fighting (without injury) or in violent numinous or threatening behavior, or making unreasonable noise, shouting abuse, misbehaving, disturbing an assembly or meeting of persons, or creating hazardous conditions by an act that serves no legitimate purpose.

Harassment – Intentionally striking, shoving, or kicking another, or subjecting another person to physical contact, or threatening to do the same (without physical injury). Any behavior that demeans, embarrasses, humiliates, annoys, alarms, or verbally abuses a person and that is known or would be expected to be unwelcome. This includes abusive or obscene language, insults, gestures, intimidation, stalking, bullying, or other inappropriate activities.

Inappropriate use of Electronic Communications - See Textual harassment, below.

Larceny – Wrongful taking, depriving, or withholding property from another (no force involved). Victim may or may not be present.

Menacing – Intentionally places or attempts to place another person in fear of imminent serious physical injury.

Reckless Endangerment – Subjecting individuals to danger by recklessly engaging in conduct that creates substantial risk of serious physical injury.

Robbery – Forcible stealing of another's property by use of threat of immediate physical force. (Victim is present and aware of theft).

Textual Harassment-Sexting - "sext" Sexting: the act of sending or receiving sexually explicit messages, videos, or photos is a form of sexual harassment. Even if sexting occurs outside the workplace, it can impact the workplace environment and be considered severe and pervasive workplace harassment.

Sex Offense:
Public Lewdness – Exposure of sexual organs to others.
Sexual Abuse – Subjecting another to sexual contact without consent.
Sodomy – A deviant sexual act committed as in rape.
Rape – Sexual intercourse without consent.

Sexting in the Workplace

The "sext." Sexting is the act of sending or receiving sexually explicit messages, videos, or photos, and is a form of sexual harassment. If sexting occurs outside the workplace, it can impact the workplace environment and be considered severe and pervasive workplace harassment.

When sexting occurs from a supervisor to an employee, it is a clear case of sexual harassment. When it occurs from one coworker to another, the employer is only liable if the employer knew, or should have known, about the textual harassment and its negative impact on the work environment.

Sexting between two consenting adults is not illegal unless it is done while misusing company equipment. Employers must intervene when they become aware that the behavior has impacted the work environment by creating a hostile work environment for any of the parties. If even one employee feels he or she is negatively impacted, the employer must investigate and intervene.

Policy:
- It is the policy of this Company that harassment in the workplace (electronic or otherwise) based on sex is prohibited.
- All employees must follow the Code of Conduct and treat their coworkers with dignity and respect.
- Although sending of sexts between two adults is not a prohibited activity during nonwork hours, sharing the content of sext messages with others in the workplace to whom they were not sent is a violation of our Code of Conduct.
- Inappropriate cyber communications while the employee is off the clock that impact the work environment can be investigated as potential harassment because of the professional connection between the two individuals.
- Any behavior by the parties involved in the sexting that is disrespectful, negatively impacts the reputation of a coworker, either actual or perceived, or creates any form of hostile work environment is prohibited.
- Employees who suffer or observe electronic harassment must report it.
- Harassment and retaliation against anyone who reports a concern or participates in an investigation is strictly prohibited.
- Employees can be disciplined for inappropriate use of electronic communications that create a hostile work environment up to and including termination of employment.

B. POLICY AGAINST HARASSMENT
(Reference Section CP 2.1 *Code of Conduct*)

1). Overview: The Company is committed to equal opportunity and nondiscrimination in all aspects of employment, including hiring, promotions, and the work environment. The Company endeavors

to foster a congenial work environment in which all individuals are treated with respect and dignity. Each individual has the right to work in an environment that promotes equal opportunity and prohibits discriminatory practices, including sexual and other forms of harassment.

The Company expressly prohibits any form of employee harassment or discrimination based on sex, race, color, religion, national origin, age, disability, sexual orientation, marital status or veteran status, or any other factor illegal under federal, state, or city law (any of which is referred to as an "Unlawful Category"). Improper interference with the ability of employees to perform their expected job duties is not tolerated.

Harassment or discrimination is unacceptable on The Company's property or in other work-related settings.

2). Definitions and Examples of Harassment: For purposes of this policy, harassment is defined as unwelcome or unwanted conduct, whether verbal, physical, or electronic based upon race, sex, religion, or any other Unlawful Category. Harassment occurs when the unwelcome or unwanted conduct is made a condition of employment, utilized for decisions affecting employment (including, but not limited to, promotions, hiring, and firing), used to create an intimidating or hostile work environment, or found to unreasonably interfere with an individual's ability to work.

Examples of the type of conduct that constitutes harassment include, but are not limited to, physical conduct, verbal conduct, display of harassing pictures or materials, electronic or otherwise, name calling, and jokes that are based on Unlawful Categories such as race, sex, national origin, sexual orientation, disability, etc.

3). Coverage: This policy covers all Company employees and independent contractors without exception. The Company will not tolerate, condone, or allow harassment, whether engaged in by fellow employees, supervisors, managers, independent contractors, or other nonemployees who conduct business with The Company. The Company encourages the reporting of all incidents of harassment, regardless of who the offender may be.

4). Complaint Procedures: While the Company encourages individuals who are being harassed, or subject to discrimination, to promptly notify the offender that his or her behavior is unwelcome, The Company also recognizes that power and status disparities between an alleged harasser and a target may make such confrontation extremely difficult. Whether or not such informal, direct communication between individuals is effective, The Company requires that the complaint be reported in the following manner:

If an individual has been subjected to harassment based on an Unlawful Category, or believes he or she has been treated in an unlawful, discriminatory manner, whether by a coworker, superior, or other nonemployee who conducts business with The Company, the individual should promptly report the incident, either verbally or in writing, to his or her immediate supervisor. In the event the employee believes it would be inappropriate to discuss the matter with his or her immediate supervisor, the employee should report it to The Company's Compliance and Ethics Officer.

All reports of harassment or discrimination will be reduced to writing by the person receiving the complaint and signed by the complainant. If a person other than the Compliance and Ethics Officer receives the complaint from a Company employee or agent, he or she will promptly confer with the Compliance and Ethics Officer who will coordinate and direct an investigation into the allegations.

Where necessary, The Company may employ a lawyer or consultant to investigate the complaint and provide guidance in handling the matter.

The complaint will be investigated expeditiously. While the Company endeavors to keep the complaint confidential throughout the investigatory process, The Company will do so to the extent practical and appropriate under the circumstances.

5). Complaint Resolution: On completing the investigation of a complaint and conferring with Counsel and The Company's management, if necessary, the Compliance and Ethics Officer will communicate his or her findings and intended action to the complainant and alleged offender.

If the Company determines that an individual is guilty of harassing or discriminating against another individual, appropriate disciplinary action, up to and including termination, will be taken against the offending person. Appropriate sanctions will be determined by the management of The Company in consultation with the person conducting the investigation or any outside counsel or consultant so engaged. In addressing confirmed incidents of harassment, The Company's response, at a minimum, will include reprimanding the offender and preparing a written record of the offense. Additional action may include, but is not limited to, referral to counseling, withholding of a promotion, reassignment, temporary suspension without pay, financial penalties, or termination.

6). Retaliation: The Company will not in any way retaliate against an individual who makes a report of harassment or unlawful discrimination, or provides information concerning such actions, nor will it permit any employee to do so. Retaliation is a serious violation of this policy and should be reported immediately. Any person found to have retaliated against another individual for reporting harassment or discrimination will be subject to the same disciplinary action provided for offenders.

7). False Accusations: If, after investigating any complaint of harassment or unlawful discrimination, The Company determines that the complainant or purported witness falsely accused another knowingly or in a malicious manner, the complainant or witness will be subject to appropriate disciplinary action.

Policy Number: WM 2.9

Policy Title: Disciplinary Standards

Policy Statement/Purpose: All of The Company's Associates are subject to disciplinary action for failure to comply with ethical standards or legal requirements. Any violation of law or corporate policy or procedures related to the Compliance and Ethics Program will result in appropriate sanctions. The disciplinary action plan includes disciplinary guidelines including a provision for non-retaliation and non-retribution.

Policy Interpretation and Implementation:

A. DISCIPLINE

1). *Overview:* Active participation in the Compliance and Ethics Program is mandatory for all Company associates. Adherence to applicable laws, rules, and regulations, as well as The Company Compliance and Ethics Program, are elements in evaluating performance. Failing to report suspected noncompliance, participating in noncompliant behavior, or encouraging, directing, facilitating or permitting, either actively or passively, noncompliant behavior may result in disciplinary action, up to and including termination.

2). *Procedure:*

a. Violations subject to disciplinary action include any of the following:
    1. Violation of federal or state law related to healthcare
    2. Violation of the Compliance and Ethics Program in performance of one's job/employment duties
    3. Failure to report the foregoing violations
    4. Failure to detect foreseeable violations
b. If The Company learns that an individual knowingly fabricated, distorted, exaggerated, or minimized a report of misconduct, either to injure someone else or to protect himself or herself, the individual will be subject to disciplinary action, up to and including termination.
c. When an individual makes a report admitting to noncompliance on his or her part does not guarantee protection from disciplinary action related to the underlying noncompliance. However, volunteering information about one's own errors, misconduct, or noncompliance is considered, if the admission is complete and truthful, and was not already known to, or about to be discovered by, The Company. The weight to be given to the report will depend on all the facts known to The Company at the time disciplinary decisions are made.
d. All disciplinary actions are applied consistently and in accordance with well-publicized guidelines. Compliance-related disciplinary policies are fairly and firmly enforced:
    1. Similarly situated employees committing similar offenses under similar circumstances shall be subject to the same consistently applied and enforced discipline.
    2. All levels of employees shall be subject to the same disciplinary action for commission of similar offenses under similar circumstances.
    3. The form of correction or discipline provided will be case specific and may be based on a variety of factors, including whether the employee promptly reported his/her own viola-

tion, severity of the offense, previous incidents involving the individual, whether the employee cooperates fully in investigating/correcting the violation, and the individual's commitment to a positive change in behavior.

4. Persons who commit violations which are negligent or reckless in nature shall be subject to more severe sanctions.

e. The range of disciplinary action to which persons may be subject include the following:
   1. Oral or Verbal Warnings
   2. Written Warnings
   3. Suspension from Employment or Revocation of Contract (paid or unpaid)
   4. Privilege revocation
   5. Termination. Some acts or omissions of employees and others associated with The Company shall result in immediate termination. Individuals who commit negligent or reckless violations of laws, rules, regulations, or Company policy shall be terminated immediately
   6. Financial penalties

f. Discipline is enforced by the Compliance and Ethics Officer, department supervisors, or other members of administration as appropriate.

g. During investigations of any person for a violation(s), such person will be either suspended or temporarily relieved of job responsibilities related to the alleged violation(s), depending upon the seriousness of the offense, in accordance with The Company policies and procedures.

h. Whether The Company ultimately imposes a disciplinary action that is more or less stringent than that called for according to the list of employee infractions and violations listed in the *Disciplinary Guidelines* (below) is left to the sole discretion of The Company, as set forth in the disciplinary protocol developed pursuant to this policy, in accordance with The Company policies and procedures.

B. Disciplinary Guidelines

1). *Overview:* The Company provides disciplinary guidelines to impose consequences for employee infractions to support and enforce the Compliance and Ethics Program.

2). *Examples of Employee Infractions and Corresponding Disciplinary Actions Applicable to The Company's Compliance and Ethics Program:* Consistent with the Federal Sentencing Guidelines, The Company will impose disciplinary actions relative to respective infractions. The disciplinary actions are listed as guidelines to be considered in determining the disciplinary action to be taken in response to employee infractions. The Company, in its sole discretion, may impose discipline less or more stringent than that called for by these guidelines, as set forth in the disciplinary protocol established under the Compliance and Ethics Program, in accordance with The Company policies and procedures.

C. Non-Retaliation and Non-Retribution

(Reference CP Section 2.0 *Company Compliance and Ethics Plan*)

1). *Overview:* The Company ensures that Associates can freely participate in The Company's Compliance and Ethics Program, without fear of intimidation, retaliation, and retribution, including but

not limited to, reporting potential issues, investigating issues, self-evaluations, audits, and remedial actions.

2). *Procedure:* No Company Associate is permitted to engage in intimidation, retaliation, retribution, or any form of harassment against another Associate for reporting compliance-related concerns including but not limited to, reporting potential issues, investigating issues, self-evaluations, audits, and remedial actions. Any retribution, retaliation, or harassment by Company Associates will be met with disciplinary action. Company Associates cannot exempt themselves from the consequences of wrongdoing by self-reporting; although self-reporting may be considered in determining the appropriate course of action.

a. *Corporate Compliance and Ethics Program Elements that Protect Associate Rights*:
    1. The Company Associate should report actual or potential wrongdoing, misconduct, or violations of the Compliance and Ethics Program to their supervisor, Compliance and Ethics Officer, or Compliance Hotline immediately
    2. The Company supervisors should maintain an open-door policy and take aggressive measures to assure The Company that there is no subsequent retaliation, retribution, or harassment for reporting a problem
    3. If the Company Associate has a concern, it should be addressed in order of the following individuals:
        - Immediate Supervisor
        - Manager
        - Administrator
        - Compliance and Ethics Officer
        - Governing Body/Owner
    4. If the Company Associate is uncomfortable reporting the issue in the manner noted above, The Company Associate should report directly to the Compliance Hotline
    5. Confidentiality regarding Company Associates' concerns and problems are maintained always, insofar as legal and practical, informing only those Associates who have a need to know

Policy Number: WM 2.10

Policy Title: Controlled Substances and Abuse

Policy Statement/Purpose: It is The Company's policy to provide a work environment that is free from the use, sale, possession, or distribution of illegal drugs or the improper or abusive use of legal drugs or alcohol on Company's premises, and to require Company employees to perform all job-related duties, either on or off Company's premises, without the presence of illegal drugs, alcohol, or inappropriate legal drugs in their systems.

Policy Interpretation and Implementation: Providing a workplace without the presence of illegal drugs, alcohol, or inappropriate legal drugs is a component of The Company Compliance and Ethics program.

The Compliance and Ethics Officer will work with the Pharmacy, Pharmacy Consultant, and the Director of Nursing to assemble all existing policies and procedures pertaining to storing, handling, destroying, and dispensing controlled substances and incorporate them into a single set of policies and procedures, adding such policies and procedures as are deemed necessary. These policies and procedures will be maintained as part of the Corporate Manual.

Testing Applicants:

1. All applicants will be informed of The Company's Substance Abuse Program.
2. Applicants may be drug-tested as part of the application process after receiving a conditional offer of employment.
3. Applicants will be advised of the testing requirements in detail by an authorized Company official prior to an offer of hire. The Substance Abuse Program will be explained to all applicants, and applicants must complete, sign, and date a Chemical Screening Consent and Release Form and their signature must be witnessed and dated. If The Company deems it necessary to require testing, an application will not be processed further, unless the applicant submits to the testing procedure.
4. The applicant's ability to meet Company's medical standards will be transmitted directly to Company's Administrator or designated official, who will keep the results strictly confidential. If an applicant's test is positive, he or she will not be considered for employment at that time and will be so informed that he or she has failed to meet The Company's medical standards. The applicant will be offered referral to professional evaluation at the applicant's own expense.

Testing Employees: Current employees may be asked to submit a test if cause exists to indicate that their health or ability to perform work may be impaired. Factors which could establish cause include, but are not limited to:

1. Documented change in work performance
2. Repeated failure to follow instructions or operation procedures
3. Violation of Company safety policies
4. Involvement in an incident/accident or near-incident/accident
5. Discovery or presence of substances in an employee's possession or near the employee's workplace
6. Odor of alcohol and/or residual odor peculiar to some chemical or controlled substances
7. Unexplained and/or frequent lateness and/or absenteeism

8. Personality changes or disorientation
9. Arrest or conviction for violation of a criminal drug statute
10. Discrepancy in controlled drug count or documentation of doses

Testing Procedures:

1. If, after consulting the employee's manager, The Company's In-service and Infection Control Director, or designee, believes cause exists, or has a reasonable suspicion that an employee may be impaired or using substances, these findings and observations will be documented. Upon review and approval by the In-service and Infection Control Director, or designee, the employee will be required to consent to a test and sign a Chemical Screening Consent and Release Form if the employee did not previously sign the form as an initial applicant.
2. If the employee refuses to sign the Chemical Screening Consent and Release Form when knowingly able, he or she will either be terminated or referred for outside help (i.e., non-Company) at the sole discretion of The Company.
3. All the testing will be done either internally by The Company (per established protocols, CLIA, etc.) or at an external testing lab chosen by The Company's Administrator. The Company will determine the controlled substances for which testing will be performed.
4. If any initial drug test is positive, a confirmation test will be performed on the specimen.
5. The procedure for collecting and testing the specimens is the same for employees as for applicants. The Company's In-service and Infection Control Director, or designee, will explain to the employee the testing procedures and The Company's Substance Abuse Program.
6. All testing results are to be kept confidential. The employee will be informed of the results by The Company's In-service and Infection Control Director, or designee.
7. Employees with negative test results may return to work. A confirmed positive test will result in appropriate disciplinary action including, but not limited to, termination or referral of the employee to outside help for assessment, which may include suitable medical treatment and/or rehabilitation, at the sole discretion of The Company and at the expense of the employee without pay.
8. Alternatively, employees with confirmed positive test results may, at their option and expense, have a second confirmation test made on the same specimen. An employee will not be allowed to submit another specimen for testing.
9. If The Company chooses to refer the employee for outside assistance, and if an employee agrees to seek outside assistance, The Company's In-service and Infection Control Director, or designee, will stay in contact with the employee's physician or counselor during the treatment to ensure that the employee is in compliance with the prescribed treatment.
10. The employee will be considered to have taken leave under the Family Medical Leave Act during his or her absence as long as the employee timely provides the requisite physician certificate required under the Family Medical Leave Act.
11. Once The Company has been informed in writing by the physician or counselor that the employee is again suitable for employment, before the employee may be reinstated, the employee must sign the Surveillance Agreement Form and agree to probation and random drug testing for a period of one (1) year.
12. If The Company chooses to refer the employee for outside assistance, and if employee refuses to seek the assistance of outside help after testing positive and being informed of Company's policy, or the employee agrees to seek outside assistance but fails to timely provide the requisite physician certification required under the Family and Medical Leave Act, he or she may be terminated for

violation of Company's policy and failing to meet Company's medical standards, or the employee may be given the opportunity to resign.

13. After so agreeing, and before returning to work, the employee must test negative on the drug test.
14. An employee awaiting pending test results may be placed on probationary status and may be sent home without pay during the time required for a specimen to be evaluated.

Relapse by Employee: Any employee who is rehabilitated through the EAP must remain alcohol-free or drug-free. Any relapse by an employee will be considered a violation of this policy and the employee will be subject to disciplinary action, up to and including termination.

Search of Company Premises: The Company reserves the right to conduct searches of Company premises and equipment, and employee work areas, lockers, bags, and vehicles on Company premises, at any time. An employee who fails to cooperate with such a search will be subject to disciplinary action, up to and including termination. If you do not want your bags searched, do not bring them on the premises.

Referral of Questions: Application of this policy or any questions concerning this policy should be directed to a Human Resources Department Representative.

Reporting:
For reporting requirements for Healthcare Professional Impairment, visit your state specific professional boards or Department of Consumer Affairs.

Definitions:

Company Premises include all areas in which The Company operates, including, but not to limited to, its property; company-owned or leased equipment, privately owned vehicles entering or parked on the property, or in the use of the property; lockers; desks; equipment; work space; and storage facilities.

Legal drugs include alcohol, medications prescribed by a physician, and over-the-counter medications. Company prohibits the use of alcohol during working hours and the use or abuse of prescription medications to the extent that job performance or fitness for duty is adversely affected. Employees shall notify their superior when taking prescribed medication. Upon request, the employee shall furnish Company with the physician's statement regarding the possible/probable side effects of the medication.

Illegal drugs include those controlled substances under federal or state law that are not authorized for sale, possession, or use, and legal drugs that are obtained or distributed illegally. Company prohibits the use of illegal drugs during working hours or in such a manner as to adversely affect job performance or fitness for duty.

Policy Number: WM 2.11

Policy Title: Termination

Policy Statement/Purpose: The Company has policies to govern employee termination consistent with applicable laws, regulations, and practices.

Policy Interpretation and Implementation: Termination is a component of The Company Compliance and Ethics program.

1. It is the policy of The Company to terminate employment because of an employee's resignation, discharge, or retirement; the expiration of an employment contract; or a permanent reduction in the workforce.
2. Discharge can be for any reason not prohibited by law. In the absence of a specific written agreement, employees are free to resign at any time and for any reason, and The Company reserves the right to terminate employment at any time for any reason.
3. Employees are requested to give written notice of their intent to resign. Failure to give written notice may result in forfeiture of benefits (such as accrued, unused paid leave time) and ineligibility for reemployment. The following guidelines are suggested:
   a. Supervisory and management personnel should give at least four weeks' notice
   b. All other employees should give at least two weeks' notice
4. Supervisors should send notices of resignation or recommendation for termination to the Business Office.
5. The department manager must provide any needed supporting documents for termination, such as performance appraisals or disciplinary reports.
6. All terminations will be reviewed by the Administrator.
7. Notice of involuntary terminations should be handled carefully and discreetly, preferably in a private meeting including the employee to be terminated, the immediate supervisor, and another member of management. All union members must have another union member or the union steward if available.
8. In cases of resignation, the Administrator or Compliance and Ethics Officer should conduct an *exit interview* not later than the employee's last working day.
9. The Business Office should maintain written reports of the termination notice meeting and exit interview.
10. If the employee owes The Company any money or is responsible for any lost or damaged property, those accounts are to be settled as originally agreed or by deduction from final pay, unless prohibited by law.
11. The Human Resources Department representative will be responsible for notifying the COBRA plan administrator of a qualifying event for terminated employees who are covered by The Company's health plan.
12. Requests for employment references should be made in writing to the Business Office and should include an authorization by the employee for release of the requested information.
13. Generally, the Business Office will not release reference information without the employee's authorization or will limit the information to verification of the employee's position, job location, and dates of employment.
14. Termination and discharge procedures outlined in this policy are only guidelines and do not create a legal contract between The Company and its employees. The Company reserves the right to

implement its policies and procedures as it sees fit. In addition, specified grounds for termination are not all-inclusive because The Company reserves the right to terminate employment for any reason.

9. SAFETY MANAGEMENT (SM)

9. SAFETY, SECURITY, AND RISK MANAGEMENT (SM)

Policy Number	POLICY
SM 1.0	SAFETY MANAGEMENT PLAN
SM 1.1	RISK MANAGEMENT PLAN A. GOVERNING BODY APPROVAL
SM 1.2	EMERGENCY PREPAREDNESS PLAN A. RISK ASSESSMENT REPORT B. HAZARD VULNERABILITY ANALYSIS C. VIOLENCE PREVENTION
SM 1.3	SAFETY COMMITTEE
SM 2.0	SECURITY INSPECTION AND ANALYSIS
SM 2.1	EMPLOYEE WORK-RELATED INJURY AND ILLNESS REPORTING
SM 2.2	BED SAFETY INSPECTIONS
SM 2.3	ELOPEMENT DRILLS
SM 2.4	RESIDENT SMOKING POLICY
SM 2.5	WORKPLACE VIOLENCE

Policy Number: SM 1.0

Policy Title: Safety Management Plan

Policy Statement/Purpose: It is the goal of The Company to provide all residents, employees, and visitors with a safe and healthy environment. Company shall comply with all applicable safety and health regulations.

Policy Interpretation and Implementation: Safety management is a component of The Company Compliance and Ethics program.

1. This Company will create a Safety Committee that will meet on a regular basis to review reported accidents and implement precautions as needed.
2. The Safety Committee will inspect the facility on an annual basis to identify any health and/or safety issues that may need to be addressed.
3. General orientation for new employees will include a discussion of safety practices.
4. Individual employees are responsible for following safety rules and procedures.
5. Failure to follow safety rules and/or procedures will be reported to the appropriate department head.

Policy Number: SM 1.1

Policy Title: Quality and Risk Management Plan

Policy Statement/Purpose: The Company develops and implements policies and procedures that ensure continuous measurable quality improvement in resident care, clinical processes, risk management and resident safety, efficiency, and effectiveness of clinical services and management, community, and financial accountability.

Policy Interpretation and Implementation: Risk management is a component of The Company Compliance and Ethics program.

A. Governing Body Approval

Reviewed by the QAPI and Risk Management Committee
Date: _____

Approved by the Governing Body

Date: _____

Signature: _____

B. Quality and Risk Management Plan

I. Philosophy and Purpose:

The Company develops and implements policies and procedures that ensure continuous measurable quality improvement in resident care, clinical processes, risk management and resident safety, efficiency, and effectiveness of clinical services and management, community, and financial accountability. Policies and procedures are designed to directly support The Company Mission, Values, and Strategic Plan. The Company's Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI), and risk management (RM) procedures are imbedded in the day-to-day operations of The Company, involve all staff, and contribute to a culture of clinical and operational excellence.

QAA/QAPI and RM performance measures address clinical services and management, quality of care and services, resident access, resident experience, healthcare costs, care coordination, compliance, network quality, adverse events, and utilization of services.

QAA/QAPI activities will incorporate those measures/standards required by insurers and regulators. The Company will include the elements required for qualification and meaningful use of our EHR. In addition, QAA/QAPI will provide measures of excellence to justify third-party quality recognition. The Company aspires to be compliant by design while individualizing the QAA/QAPI process to meet unique needs of the Company.

The Company wishes to measure progress toward success, meeting the "Triple Aim" of improving the health of our community, resident satisfaction and retention, and reducing the per patient cost of care. resident

II. Guiding Principles

Quality Assessment and Assurance and Quality Assurance and Performance Improvement: The key attributes that support The Company's vision of a health delivery system describes a system that promotes excellence of resident safety, risk prevention and management, quality care, and services. This system:

- Is centered upon treating people with dignity
- Focuses on patient-centered care
- Provides an integrated continuum of care
- Demands service excellence
- Focuses on the triple aim concepts of improving patient care, improving the patient experience, and reducing costs
- Requires effective communication and information sharing
- Continually improves its operating and clinical practices
- Integrate with risk management principles and practice
- Is best achieved by teamwork
- Uses resources optimally
- Is scientific and results oriented
- Provides a safe environment for clients, visitors, and staff
- Delivers care based on the best scientific evidence combined with judgment of expert clinicians
- Integrate with compliance and ethics principles and practice

Risk Management: RM is an overarching, conceptual framework that guides the development of a systematic approach to management of risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety plan. RM activities support The Company's philosophy that patient safety and risk management are everyone's responsibility. Teamwork and participation among management, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program. The program will be implemented through compliance with all policies relevant to patient safety and risk management, the coordination of multiple organizational functions, and the activities of multiple departments.

The Company supports the establishment of a just culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified, medical or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are still held accountable for compliance with patient safety and risk management policies and practices. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions can be taken.

Through RM the Company stimulates the development, review, and revision of The Company's policies, practices, and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of The Company's RM provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management
- Complaint resolution
- Confidentiality and release of information
- Event investigation, root-cause analysis, and follow-up
- Failure mode and effects analysis
- Referral Management
- Infection Control
- Clinical supervision and back-up of clinical and non-clinical staff
- Provider and staff education, competency validation, and credentialing requirements
- Reporting and management of adverse events and near misses
- Trend analysis of events, near misses, and claims

Reference: http://ams.aha.org/EWEB/DynamicPage.aspx?WebCode=ProdDetailAdd&ivd_prc_prd_key=0258a970-1c88-48e3-a800-cf1b02e33324

Policy Number: SM 1.2

Policy Title: Emergency Preparedness Plan

Policy Statement/Purpose: The Company has emergency preparedness policies consistent with federal and state law, regulation, and practices.

Policy Interpretation and Implementation: Emergency management is a component of The Company Compliance and Ethics program.

1. CMS Emergency Preparedness Check List
2. Hazard Vulnerability Analysis
3. Violence prevention

A. Risk Assessment Report

1. CMS Emergency Preparedness Check List

2. Hazard Vulnerability Analysis

3. Violence Prevention:

The QAA/QAPI Committee has completed a risk assessment and completed the following Violence Prevention reports:

- ❑ Records Review
- ❑ Security Inspection and Analysis
- ❑ Review of Tasks & Employee Surveys

Upon review of the reports and the issues identified, the QAA QAPI Committee recommends the following action(s) to reduce the risk of workplace violence:

Building and Work Area Design

_____

_____

_____

Security and Security Equipment

_____

_____

_____

Work Practices and Procedures

_____

_____

_____

Management has instituted the following because of the Violence Prevention Report recommendations:

Action Taken	Date Completed
_____	_____
_____	_____
_____	_____

The following Policies and Procedures have been edited or developed because of the Violence Prevention Report recommendations:

Name of Policy and Procedure	Date Completed
_____	_____
_____	_____

B. HAZARD VULNERABILITY ANALYSIS

https://www.calhospitalprepare.org/post/revised-hva-tool-kaiser-permanente

Policy Number: SM 1.3

Policy Title: Safety Committee

Policy Statement/Purpose: The purpose of the Safety Committee is to provide a framework/mechanism to address safety issues within The Company. Also, the purpose of a Safety Committee is to regularly bring workers and management together in a non-adversarial, cooperative effort to promote safety and health in the workplace. The committee's primary focus is to detect and correct workplace hazards. A Safety Committee is a key element to achieving continuous improvement in a safety process.

Policy Interpretation and Implementation: The Safety Committee is a component of The Company Compliance and Ethics program.

a. In accordance with The Company's commitment to safety, The Company will establish a Safety Committee for the following purposes:
    1. To maintain and enhance employee interest in health and safety issues
    2. To help ensure that managers, supervisors, and employees are aware through training activities that they are responsible for the prevention of workplace accidents and for maintaining a safe workplace
    3. To help make health and safety activities an integral part of The Company's operating procedures, culture, and programs
    4. To provide an opportunity for discussion of health and safety problems and possible solutions
    5. To inform and educate employees and supervisors about health and safety issues and research findings
    6. To help reduce the risk of workplace injuries and illnesses
    7. To help ensure compliance with federal and state health and safety standards
b. To accomplish these objectives, the Safety Committee will:
    1. Develop a written mission statement in accordance with corporate/company requirements
    2. Define duties and responsibilities of committee members
    3. Identify and prioritize goals and establish action plans to achieve each goal
    4. Include representation from different levels and areas of The Company
    5. Meet at least monthly
    6. Record and disseminate minutes of meetings, documenting attendance, problems, and issues, as well as corrective action proposed and actions taken to address each issue
    7. Make attendance mandatory with the penalty of committee removal for repeated absences
    8. Develop methods to increase and maintain safety awareness
    9. Organize special subcommittees to address specific issues, projects, or programs
c. The Administrator, in concert with The Company's Human Resource department, will determine the composition of The Company's Safety Committee and ensure that each functional area/department has a member assigned to serve on the committee. Human Resources will advise corporate/company of the committee structure and membership and provide periodic reports as determined by corporate/company health and safety staff. No less than annually, The Company's Safety Committee will be required to prepare an overview of the activities undertaken in the furtherance of its health and safety mission for submission to corporate/company health and safety staff.

1. Each committee member will be on the Safety Committee for at least one (1) year. After the member's one-year anniversary date, new members will be recruited to replace not more than 50% of the existing members. This will ensure a core group of members from one year to the next.
2. When a committee member needs to be replaced, employees currently not on the committee will be asked if any would be interested in serving on the Safety Committee. Applicant/potential member names will be submitted to the committee for review. The existing Safety Committee, together with HR and the Administrator, will determine if a candidate is acceptable.
3. If no new employees volunteer nor can be recruited, the existing member will continue to serve for another year or until replacement members can be obtained.

d. The specific functions of the Safety Committee are to:
   1. Detect hazards
   2. Analyze and solve problems
   3. Assist in the management of safety

e. At a minimum, the committee should do the following:
   1. Evaluate existing employer accident and illness prevention programs
   2. Establish procedures for conducting and documenting the findings of periodic workplace inspections
   3. Make recommendations to correct hazards
   4. Review, in a timely manner, incidents resulting in work-related deaths, injuries, illnesses, and complaints
   5. Conduct follow-up evaluations on the effectiveness of new safety equipment or health and safety procedures

f. Accident Investigation and Review
   1. The committee will be responsible for reviewing accidents (including near-miss accidents) that have occurred since the previous meeting.
   2. The committee will attempt to determine the cause of each accident as well as any corrective actions that have been done or will be done to prevent the same type of accident from occurring again in the future.
   3. Human Resources will forward all accident reports to the Safety chairman.
   4. Safety inspections will be performed by the Safety Committee.
   5. The committee will determine the frequency of the inspections as well as who will conduct the inspection:
      - Reports of the inspections will be reviewed during the following Safety Committee meeting
   6. Employees cannot serve effectively if subject to employer retaliation for engaging in Safety Committee activities. Therefore, the employer shall not discharge, threaten with discharge, demote, suspend, or in any manner discriminate against any employee because they have participated in any Safety Committee function. This includes, but does not limit, any activity serving as a Safety Committee member, making statements, complaints, or suggestions to the Safety Committee, or participating in a Safety Committee workplace inspection.

Policy Number: SM 2.0

Policy Title: Security Inspection and Analysis

Policy Statement/Purpose: The Company has security inspection and analysis policies that support law, regulation, and practice.

Policy Interpretation and Implementation: Security and Inspection and analysis are components of The Company Compliance and Ethics program.

The Violence Prevention Committee has completed inspection of the workplace on _____ (Date).

GENERAL BUILDING, WORKSTATIONS, AND AREA DESIGNS

- ❑ Review the design of all new or renovated facilities to ensure safe and secure conditions for employees. Ensure that facilities are designed to ensure the privacy of residents and visitors, yet permit employees to communicate with other staff in emergency situations.

- ❑ Review all entrance/exit locations. Utilize a visitor-only entrance at reception. All other entrance/exit locations should be secured with locks, card keys, or intercom buzzers. All exits should be locked to prevent unauthorized entry, but still allow egress from inside the building. Review employment termination policy for employees with access to keys.

- ❑ Design work areas and arrange furniture to prevent entrapment of the employees and/or minimize potential for assault incidents.

- ❑ Public areas are free of objects that could be used as weapons.

- ❑ Chairs and furniture in public areas are secured to prevent use as weapons.

- ❑ Clear partitions ☐In Use ☐Not Used ❑ Recommended
  Utilize clear partitions, Plexiglas, glass guard, or wire glass to provide protection, yet allow for communication.

- ❑ Private, locked restrooms are available for staff.

- ❑ A secure place is provided for employees to store personal belongings.

- ❑ Employee-only work areas are secured. Medication rooms are locked.

- ❑ Floor plans are posted showing exits, entrances, and location of security equipment.

- ❑ Exits are unobstructed.

- ❑ Emergency numbers are posted by phones.

- ❑ Provide appropriate lighting systems for all indoor building areas as well as grounds around the facility. Lighting should meet the requirements of nationally recognized standards, as well as local building codes.

- ❑ Parking is prohibited in fire zones.

Is there a nearby parking lot reserved for employees only?
☐Yes ☐No

Is the parking lot attended or otherwise secured?
☐Yes ☐No

Is the parking lot free of bushes or other hiding places?
☐Yes ☐No

Is there enough lighting to see clearly in the parking lot and when walking to the building?
☐Yes ☐No

Are security escorts available to employees walking to and from the parking lot?
☐Yes ☐No

Have neighboring facilities and businesses experienced violence or crime?
☐Yes ☐No

Are broken windows and locks repaired promptly?
☐Yes ☐No

Comments on General Building, Workstations, and Area Design:

_____

_____

_____

_____

SECURITY PERSONNEL

Who is responsible for building security? _____

Are employees told who is responsible for security?
☐Yes ☐No

Are trained security personnel accessible to employees in a timely manner?
□Yes □No

What type of security personnel is being utilized?
□Contracted Security Guards or □In-house Employees

Are the Security Guards knowledgeable of the Workplace Violence Prevention Program?
□Yes □No

Is the number of Security Guards appropriate for the site?
□Yes □No

Do the security personnel receive specific training on workplace violence situations?
□Yes □No

Do security personnel have sufficient authority to take all necessary action to ensure employee safety?
□Yes □No

Location of Security Guards:
□At Entrance
□Inside Building Patrol
□Outside Building Patrol

Type of communication devices security personnel are provided with: _____

_____

Is there an established liaison with local police?
□Yes □No

Comments on Security Personnel:

_____

_____

_____

_____

SECURITY EQUIPMENT

Are security devices tested on a regular basis and repaired promptly when necessary?
☐Yes ☐No

☐Door Buzzers ☐In Use ☐Not Used ❑ Recommended

☐Card Access ☐In Use ☐Not Used ❑ Recommended
Utilize door buzzers or card access to control access to employee work areas.

☐Mirrors ☐In Use ☐Not Used ❑ Recommended
Utilize mirrors to see around corners and in blind spots both inside and outside the building.

☐Alarm System/Panic Button ☐In Use ☐Not Used ❑ Recommended
Utilize electronic alarm systems activated visually or audibly. Systems should identify the location of the room or location of the employee by means of an alarm sound and/or a lighted indicator or equally effective measure. Adequate personnel must be available to render prompt assistance if such systems are utilized.

☐Closed Circuit Television ☐In Use ☐Not Used ❑ Recommended
Utilize closed circuit television that permits security guards to monitor high-risk areas, both inside and outside the building.

☐Internal Emergency Notification System ☐In Use ☐Not Used ❑ Recommended

Location(s) of surveillance: _____

_____

_____

☐Metal Detectors ☐In Use ☐Not Used ❑ Recommended
Utilize metal detection systems to identify persons with weapons.

☐Cellular telephones ☐In Use ☐Not Used ❑ Recommended
☐Beepers ☐In Use ☐Not Used ❑ Recommended
☐CB Radios ☐In Use ☐Not Used ❑ Recommended
☐Hand-held Alarms ☐In Use ☐Not Used ❑ Recommended
Utilize cellular telephones, beepers, CB radios, or hand-held alarms or noise devices for emergency communication and in field situations.

Review the effectiveness and/or need for the following security measures:

☐Intrusion Detection System	☐In Use	☐Not Used	❑ Recommended
☐Monitor(s)	☐In Use	☐Not Used	❑ Recommended
☐Video Tape Recorder	☐In Use	☐Not Used	❑ Recommended
☐Hand-Held Metal Detector	☐In Use	☐Not Used	❑ Recommended
☐Hand-Held Video Camera	☐In Use	☐Not Used	❑ Recommended

Comments on Security Equipment:

_____

_____

_____

WORK PRACTICE CONTROLS AND PROCEDURES

☐Employee I.D. Badge	☐In Use	☐Not Used	❑ Recommended

Utilize identification cards for all employees and establish sign-in and sign-out procedure. When identification badges are provided, employees should be required to wear them.

Reception Area/Visitor Policies and Procedures
☐Review visitor sign-in/out procedure
☐Review escort policy for nonemployees
☐Review visitor entrance security measures
☐Review visitor use of identification badges

Security Policies and Procedures
☐Workplace Violence Prevention Program is reviewed and updated annually
☐Workplace Violence Prevention Program is accessible to all employees
☐Workplace Violence Prevention Program is reviewed and updated when tasks are added or changed
☐Emergency Action Plan, Evacuation Plan, and/or Disaster Contingency Plan is reviewed and updated annually
☐Safety meetings are held regularly with all personnel on all shifts. Meetings are conducted in a manner to allow free and open discussions
☐Review internal communication systems to respond to emergencies
☐Review policy on how to deal with emergency or hostage situations
☐Review policy on when to involve in-house security or local law enforcement
☐Review policy for employees who work late or off-hours
☐Review policy for accounting for field staff
☐Review procedures for employee dismissal
☐Review policy for notifying employees of past violent acts in the workplace
☐Review policy for "buddy system" for when employees are in a potentially dangerous situation

Incident Policies and Procedures

☐Review incident reporting procedures for effectiveness and timeliness of response
☐Review recordkeeping of incident reports
☐Review injury reports (and if employee loses time)
☐Review counseling (EAP) procedures
☐Provide information and give assistance to employees who are victims of domestic violence and review procedures to ensure confidentiality and safety for affected employees

Training Policies and Procedures
☐Review written training records for content, methods of training, and effectiveness
☐Training is completed at orientation and annually thereafter
☐Utilize crime prevention services and/or lectures provided by the local or state police
☐Active Shooter Training provided annually

Off Premises Work Practice Controls (For staff who work away from a fixed workplace, such as: social services, transportation, sales/delivery, messengers, and others.
☐Trained in hazardous situation avoidance
☐Briefed about areas where they work (gang colors, neighborhood culture, language, drug activity, etc.
☐Have reviewed past incidents by type and area
☐Know directions and routes for day's schedule including alternate routes
☐Previewed client/case histories
☐Left an itinerary with contact information
☐Have periodic check-in procedures
☐After-hours contact procedures
☐Partnering arrangements if deemed necessary
☐Know how to control/defuse potentially violent situations
☐Supplied with personal alarm/cellular phone/radio
☐Limit visible clues of carrying money/valuables
☐Carry forms to record incidents by area
☐Know procedures if involved in incident

Comments on Work Practice Controls and Procedures:

_____

_____

_____

From this inspection, the following issues have been identified:

_____

_____

Policy Number: SM 2.1

Policy Title: Employee Work-Related Injury and Illness Reporting

Policy Statement/Purpose: The Company provides a safe and health work environment for all employees and contract workers.

Policy Interpretation and Implementation:

1. *Overview:* The Company provides a safe and healthy work environment for all employees and contract workers. Timely and accurate reporting of work-related injuries and illness are important components of compliance.

2. *Policy Guidelines:*
   a. Employees are asked to practice safe workplace techniques throughout their workday, to follow all policies and procedures, and to comply with manufacturers' instructions when using equipment. Compliance with these elements of workplace safety will help ensure that employee health and safety, as well as the health and safety of residents and others, are protected.
   b. In the event of an incident involving an employee's work-related illness or injury, the employee involved must report the event immediately to his or her supervisor and participate in the preparation of a report to be made on the appropriate incident report form before leaving the shift during which the incident occurred.
   c. Supervisors are responsible for seeing that the report reflects the facts, that the report has been signed and dated by the employee, and that all signed and dated witness statements are attached.
   d. If an employee refuses to sign the incident report, the supervisor will so note and have the refusal witnessed.
   e. All employees injured on the job may be subject to drug and/or alcohol testing if signs of impairment are present.
   f. If an employee is unable to participate in the completion of the incident report due to being incapacitated by the work-related injury or illness, he or she must submit a report as soon as able.
   g. In the case that the employee is unable to complete an employee incident report due to being incapacitated from the work-related injury or illness, the supervisor must complete as much detail on a report form as possible, including obtaining written and signed statements from witnesses, and submit to administration before the end of the shift.

Policy Number: SM 2.2

Policy Title: Bed Safety Inspections

Policy Statement/Purpose: To provide residents with bed safety through annual and periodic inspections of bed frames, mattresses, and bed rails.

Policy Interpretation and Implementation:

1. Environmental Services staff will conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment.
2. When bed rails and mattresses are used and purchased separately from the bed frame, the facility will ensure that the bed rails, mattresses, and bed frame are compatible.
3. Bed gap analysis of a bed will be conducted upon admission, before bed rails are put into use, and when a resident receives a new bed or mattress.
4. Information can be obtained from the FDA approved resource found at the following address: http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072662.htm

Policy Number: SM 2.3

Policy Title: Elopement Drill

Policy Statement/Purpose: Elopement drills will be held to help prepare staff to search for a resident who is missing or has eloped.

Policy Interpretation and Implementation:

1. An elopement drill will be performed annually, and/or as recommended by The Company QAA/QAPI Committee.
2. If The Company has a secured unit, elopement drills will be held every six months.
3. Prior to the drill, a staff person will be assigned to act as a missing resident. This staff member will also be assigned to a location in or out of the facility.
4. All staff will be alerted that an elopement drill is in progress. A description and name of the fictitious resident will be provided.
5. Staff will be assigned areas to search and a designated time to report back to the drill coordinator.
6. Once the individual is located, the drill is complete.
7. An Elopement Drill Log will be kept noting the time the drill was conducted, a list of participants, and the length of time it took to locate the individual.
8. Results of the drill will be reviewed and evaluated to determine the need for additional staff education.
9. The results of the elopement drill will be submitted to the QAA/QAPI Committee for review and recommendations.

Policy Number: SM 2.4

Policy Title: Resident Smoking Policy

Policy Statement/Purpose: The Company shall establish and maintain safe resident smoking practices.

Policy Interpretation and Implementation:

1. Prior to, or upon admission, residents shall have a smoking assessment completed and be informed about any limitations on smoking, including designated smoking areas, and the extent to which the facility can accommodate their smoking or nonsmoking preferences.
2. Smoking restrictions shall be strictly enforced throughout the building.
3. The staff shall consult with the attending physician and the director of nursing services to determine any restrictions on the resident's smoking privileges.
4. Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and personnel caring for the resident shall be alerted to these issues.
5. Updates will be kept in the smokers' logbook which will be kept by the smoking monitor during smoking times and stored at the front desk.
6. The Company may impose smoking restrictions on residents at any time if it is determined by the interdisciplinary care team that the residents cannot smoke safely with the available levels of support and supervision.
7. The staff will review the status of the resident's smoking privileges as needed and consult as needed with the director of nursing services and the attending physician. These methods may include assessment of a resident's cognitive ability, judgment, manual dexterity, and mobility.
8. The Company will designate a smoking area for residents.
9. Residents may keep cigarettes or tobacco on them but must turn in all matches, lighters, etc. to the designated person.
10. Any smoking materials that are being held by The Company or designated person will be kept labeled with the owners' names in a common smoking materials box, and only accessible by staff.
11. Anyone who provides smoking supervision to residents shall be advised of any restrictions/concerns and the plan of care related to smoking.
12. A smoking apron may be required for some residents while smoking. The aprons will be kept available during smoking times and will be handed out before smoking.
13. For the safety of our residents, oxygen use is prohibited in smoking areas.
14. Staff members and volunteer workers shall not purchase and/or provide any smoking articles for residents unless approved by the Administrator or director of nursing.
15. This facility may check periodically to determine if residents have any smoking articles in violation of our smoking policies. Staff should confiscate any such articles and shall notify the Director on duty that they have done so.
16. The designated smoking area will be in compliance with law and regulation including the use of non-combustible ashtrays and access to fire extinguishing equipment.

Policy Number: SM 2.5

Policy Title: Workplace Violence

Policy Statement/Purpose: The Company shall establish and maintain a safe workplace.

Policy Interpretation and Implementation: Reference WM 2.8 *Workplace Violence*

10. QUALITY CARE AND IMPROVEMENT (QAPI)

10. QUALITY CARE AND IMPROVEMENT (QAPI)

Policy Number	POLICY
QAPI 1.0	QAPI PLAN (New 2017) A. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT COMMITTEE
QAPI 2.0	QUALITY OF CARE

Policy Number: QAPI 1.0

Policy Title: Quality Assurance and Performance Improvement

Policy Statement/Purpose: The Company has QAPI policies to ensure compliance with federal and state laws and regulations.

Policy Interpretation and Implementation: The CMS guide *QAPI at a Glance* is a resource for nursing homes and facilities striving to embed QAPI principles into their day-to-day work of providing quality care and services for patients. The QAPI Plan is overseen by the Quality Assessment and Assurance (QAA)/Quality Assurance and Performance Improvement (QAPI) Committee.

A. Quality Assurance And Performance Improvement Committee

1). *Overview:* This Company shall establish and maintain a Quality Assessment and Assurance (QAA)/Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program.

2). *Policy:* The Governing Body shall delegate the necessary authority for the QAA/QAPI Committee to establish, maintain, and oversee the QAPI program. The committee shall be a standing committee of The Company and shall provide reports to the Administrator and Governing Body.

The primary goals of the QAA/QAPI Committee are to:

a. Establish, maintain, and oversee Company systems and processes to support the delivery of quality of care and services
b. Promote the consistent use of Company systems and processes during provision of care and services
c. Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately
d. Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problems
e. Help departments, consultants, and ancillary services implement systems to correct potential and actual issues in quality of care
f. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals
g. Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between Company staff, residents, and family members

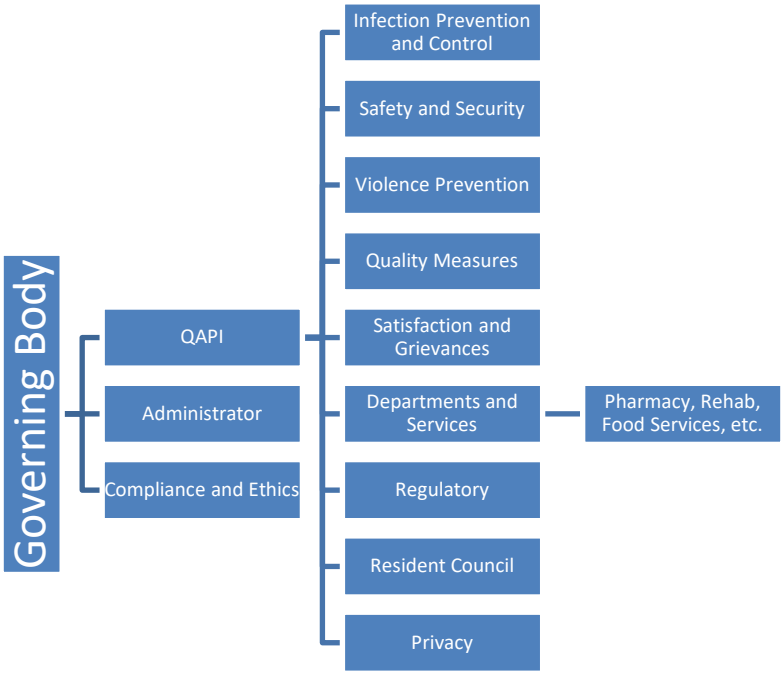
3). *Committee Authority*

a. The QAA/QAPI Committee advises the Administrator and Governing Body (board).
b. The committee has the full authority to oversee the implementation of the QAPI Program including, but not limited to, the following:
    1. Establishing performance and outcome indicators for quality of care and services delivered in The Company

2. Choosing and implementing tools that best capture and measure data about the chosen indicators
3. Appropriately interpreting data within the context of standards of care, benchmarks, targets, and the strengths and challenges of The Company
4. Communicating the information gathered and their interpretation to the owner/Governing Body

c. The QAPI Coordinator/Champion shall coordinate the activities of the QAA/QAPI Committee.

d. Committee Structure



e. Committee Membership
1. The Administrator shall appoint both permanent and rotating members of the QAA/QAPI Committee
2. The Administrator shall appoint individuals to fill any vacancies occurring on the committee
3. The following individuals may serve on the committee:
   - Director of Nursing Services (required member)
   - Medical Director or designee (required member)
   - At least three other staff, one of whom must be the Administrator, owner, Governing Body member, or other individual in a leadership role with knowledge of facility systems and authority to change those systems (required members)
   - Dietary Representative
   - Pharmacy Representative
   - Social Services Representative
   - Activities Representative
   - Environmental Services Representative
   - Infection Preventionist

- Rehabilitative/Restorative Services Representative
- Staff Development Representative
- Safety Representative
- Nursing Staff (non-management) Representative
- Medical Records Representative

f. Committee Meetings
   1. The committee will meet at least quarterly at an appointed time
   2. Special meetings may be called by the coordinator as needed to address issues that cannot be held until the next regularly scheduled meeting

g. Committee Reports and Records - The committee shall maintain minutes of all regular and special meetings that include at least the following information:
   1. The date and time the committee met
   2. The names of committee members present and absent
   3. Conclusions and recommendations from the committee
   4. A summary of any approaches and action plans to be implemented
   5. The time the meeting adjourned

h. The QAPI Coordinator shall ensure that meeting minutes are distributed to all committee members and others as needed.

i. Confidentiality of Information
   1. All QAA/QAPI minutes, reports, findings, etc., are confidential and shall be filed separately from other committee documentation to maintain such confidentiality
   2. Committee members shall keep confidential all information that they obtain as a result of their participation in/on committee
   3. The Administrator may authorize sharing of summaries or periodic evaluations of the QAPI Program with residents and/or other interested persons or organizations. These should not include confidential information

j. Instituting QAPI Privilege
   1. Documents compiled for the express use by the QAA/QAPI Committee, or under the direction of the Committee, are protected under QAPI Privilege
   2. To ensure the protection of the QAPI documents, each document must bear a mark indicating it is protected under 42 CFR §483.75(h), (i)
   3. Mark each document with the following or a similar statement: "This document is prepared for the express use of the QAA/QAPI Committee and meets the requirements of 42 CFR §483.75(h), (i)."
      - Place this statement as a footer, watermark, or ink-stamped phrase on all pages created for the QAA/QAPI Committee
      - Indicate that every page in the QAA/QAPI Committee record is part of the QA process to ensure there is no mistaking the purpose of the document
   4. QAPI Privilege protects the self-release of documents to individuals who are outside of the intended communication
      - Documents are protected under federal law from free access by people outside of the committee
      - Individuals who provide information to the QAA/QAPI Committee are protected as well and may not be required to disclose QAPI evidence or content of discussions
      - A plaintiff attorney will not be able to obtain QAPI protected documents unless there is a court order

5. Documents otherwise available from their original source are not protected by QAPI Privilege
6. Memos, policies, and other similar documents considered part of day-to-day business are not QAPI documents and are not protected by QAPI Privilege

k. Committee Audit Process
   1. The QAA/QAPI Committee will scrutinize all department reports and summarize the findings in the committee minutes
   2. The QAA/QAPI Committee shall help various departments/committees/disciplines/individuals develop and implement plans of correction and monitoring approaches. These plans and approaches should include specific time frames for implementation and follow-up
   3. The committee shall track the progress of any active plans of correction
   4. The Administrator shall advise the Governing Body of the need for policy or procedural changes and, as appropriate, monitor to ensure that such changes are implemented

l. Annual Review
   1. The QAA/QAPI Committee shall review the QAPI Plan at least annually for necessary revisions and shall document any such changes

Policy Number: QAPI 2.0

Policy Title: Quality of Care
(Reference CP Appendix 1.0.1 A: *Compliance Risk Areas: Quality of Care*)

Policy Statement/Purpose: To ensure quality of care consistent with applicable legal requirements and standards of practice. It is Company policy that each resident receives the necessary care to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care.

Policy Interpretation and Implementation: Quality of Care is a component of The Company Compliance and Ethics Program. Elements include:

a. The Company must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. The assessment must be based on a uniform data set specified by the state and approved by CMS.
b. The Company must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:
    1. Be developed within 48 hours of a resident's admission
    2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
        - Initial goals based on admission orders
        - Physician orders
        - Dietary orders
        - Therapy services
        - Social services
        - PASARR recommendation, if applicable
c. The Company must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.
d. Each resident must receive, and The Company must provide, the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
e. A resident must be given the appropriate treatment and services to maintain or improve his or her ability to bathe, dress, groom, transfer, and ambulate.
f. The Company must ensure that a resident who enters The Company without pressure sores does not develop them, unless the resident's clinical condition demonstrates that they were unavoidable.
g. A resident with pressure injuries must receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.
h. A resident who enters The Company without an indwelling catheter may not be catheterized, unless the resident's clinical condition demonstrates that catheterization is necessary.
i. A resident who is incontinent of bladder must receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

j. A resident who displays mental or psychosocial adjustment difficulty must receive a psychological evaluation with appropriate treatment and services to correct the assessed problem.
k. The Company must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern or decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.
l. The Company must ensure that the resident's environment remains as free of accident hazards as possible and must provide adequate supervision and assistive devices to prevent accidents.
m. The Company must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.
n. Each resident's drug regimen must be free from unnecessary drugs.
o. Resident must be free of significant medication errors.
p. The Company must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and plans of care.
q. The Company must use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week.
r. The Company must employ a qualified dietitian full-time, part-time, or on a consulting basis.
s. Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.
t. Each resident must receive, and The Company must provide, at least three meals daily, at regular times, comparable to normal mealtimes in the community.
u. The medical care of each resident must be supervised by a physician.
v. The resident must be seen by a physician at least once every thirty (30) days for the first ninety (90) days after admission and at least once every sixty (60) days thereafter.
w. The Company must provide or arrange for the provision of physician services twenty-four (24) hours a day, in case of an emergency.
x. If required by the written order of a physician, The Company must provide or obtain specialized rehabilitative services including, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental rehabilitative services.
y. The Company must assist residents in obtaining routine and 24-hour emergency dental care, including assistance in making appointments and arranging for transportation.
z. The Company must provide pharmaceutical services, and have in place procedures that assure accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident.
aa. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.
bb. The Company must establish an infection prevention and control program under which it investigates, controls, and prevents the spread of infections in The Company.

11. INFECTION PREVENTION AND CONTROL (IC)

11. INFECTION PREVENTION AND CONTROL (IC)

Policy Number	POLICY
IC 1.0	INFECTION PREVENTION AND CONTROL
IC 1.1	ANTIBIOTIC STWEWARDSHIP

11. INFECTION PREVENTION AND CONTROL (IC)

Med-Net's mission focuses on Corporate Compliance and Ethics with supporting policies in fraud, waste, abuse, privacy, quality, data integrity, and workforce management. As such, infection prevention and control policies and procedures are referred to Med-Pass. Med-Net customers receive a special discount to the Med-Pass policies. The Med-Pass policies can be accessed at http://www.med-pass.com/ and using the discount code: **MedNet10**.

*Please note that the discount is not on every product, but a range of the Med-Pass Heaton policy and procedure manuals.

Compliance with Governmental, Regulatory, and Accrediting Agencies

Facility leadership reviews and assesses compliance with pertinent governmental, regulatory, and accreditation agencies including, but not limited to, OSHA, State Specific Departments of Health, County Health Department, EPA, CDC, and FDA.

a. State Specific - mandatory reporting of specific infectious conditions as serious event
b. OSHA - Exposure Control Plans for TB and Bloodborne Pathogens
c. CDC - compliance with published standards for prevention infections

Policy Number: IC 1.0

Policy Title: Infection Prevention and Control Plan

Policy Statement and Purpose: The Infection Prevention and Control Plan (IPCP) consists of the Infection and Prevention Control policy and procedures, and the Antibiotic Stewardship policy and procedures. The facility staff and its associates adhere to the mission and goals set forth in the IPCP which is reviewed annually and approved and adopted by the facility Infection Control committee.

A. Mission and Goals

Facility leadership is committed to a comprehensive Infection Prevention and Control Plan (IPCP) focused on both employee health and resident care practices. The IPCP encompasses the prevention of adverse outcomes such as healthcare associated infections (HCAI) [1], supporting staff in all areas of the facility to improve resident care, minimizing healthcare associated occupational hazards, optimizing antibiotic use, and fostering evidence-based decision making. To that end, the IPCP provides staff with a coordinated organizational structure, technical procedures, comprehensive work practices and guidelines to reduce the risk of infection transmission, and exercise antibiotic stewardship. The goals of the IPCP are to:

1. Provide a safe, sanitary, and comfortable environment for residents, visitors, and staff.
2. Improve resident and facility outcomes related to the risk of infection to residents and staff through:
    a. Proactively preventing, identifying, reporting, investigating, and controlling infections and communicable diseases
    b. Initiating proper measures to limit unprotected exposure to pathogens or further their spread from identified sources of contagion, including infections associated with procedures and with the use of medical equipment and medical services
    c. Collecting, analyzing, and trending data, and instituting appropriate corrective actions
3. Provide education to identify and correct problems relating to infection control practices including, but not limited to, hand hygiene, Standard Precautions, transmission-based precautions, immunization protections, injection safety, infection versus colonization, and competency testing/evaluation.
4. Optimize the use of antibiotics to meet resident- and community-specific needs per The Company *Antibiotic Stewardship* policy.
5. Facilitate compliance with federal, state, and local regulations relating to infection control and antibiotic stewardship.

B. Scope

The Infection Prevention and Control Plan is based on the latest recommendations from the Centers for Disease Control and Prevention (CDC) [2]. The major components include:

1. Surveillance of Infections - ongoing monitoring for occurrence of infections for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment.
2. Implementation of Control Measures and Precautions - basics such as cleaning procedures, hand hygiene practices, and Standard and Transmission Based Precautions.

3. Prevention of Infection - staff and resident education focusing on risk of infection, practices to decrease infection risk, infection control policies and procedures, availability of immunizations and their administration to residents and staff, as appropriate.
4. Report of Infection - specific Department of Health reporting according to both state and local regulations.
5. Population Served - The IPCP is based on the needs of the population served and the environment of care. The population consists of predominantly elderly and compromised individuals living in a post-acute or long-term environment. Underlying disease processes and comorbidities put the residents at high-risk for infection. The challenges of providing care and services to this unique population are woven into the policies, procedures, and protocols of the IPCP. Efforts are directed toward employees, visitors, contract staff, and licensed independent practitioners including medical staff.
6. National Health Emergency – response to and mitigation of any identified national health emergency such as a Pandemic (e.g. COVID-19). Following of all directives issued from CMS, CDC, WHO, local health departments, and issued 1135 Waivers.
7. Antibiotic Stewardship - Specific elements as defined by the CDC [3]

C. Committee Oversight

1. The multi-disciplinary Infection Prevention and Control Committee (IPCC) is a reporting component of the facility Quality Assessment and Performance Improvement (QAPI) committee and the facility Compliance and Ethics Committee. The IPCC:
   a. Implements infection prevention and control policy and protocol
   b. Monitors and evaluates infection prevention and control activities and outcomes
   c. Reviews and analyzes data monthly to identify trends
   d. Documents and implements corrective action as appropriate.
   e. Meets monthly and reports to the QAA/QAPI Committee and facility management at least quarterly
   f. Documents IPCC attendance and maintains committee minutes
2. The QAPI Committee
   a. Provides oversight for continuous improvement and sustainability of infection prevention and control and antibiotic stewardship practices and outcomes
   b. Reviews drugs identified to be included in the monthly Drug Regimen Review (DRR) including antibiotics
      - The pharmacist conducts the DRR which includes a review of the medical record concurrently with the MAR (or other list of current medications) and reviews if the taking of an antibiotic supports the infection prevention and control program, especially the antibiotic stewardship program
   c. Conducts an annual review of the IPCP and updates the plan as necessary in conjunction with the IPCC and facility leadership
   d. QAA/QAPI Committee record disclosure of information is limited to demonstrating compliance to the QAA/QAPI Committee requirements to identify and correct quality deficiencies.
3. IPCC committee members include:
   a. Medical Director/Designee
   b. Director of Nursing
   c. Infection Preventionist

d. Administrator/Designee
e. Facility Safety Officer
f. Pharmacy Representative
g. Lab Representative
h. Maintenance representative
i. Community representative (annually)
j. Others as designated by the facility may include: Business office representative, dietary, social service, etc.

4. The Compliance and Ethics Committee
   a. Provides oversight that effective internal controls are in place to mitigate and reduce infection rates
   b. To ensure that plans of correction for infection and prevention control deficiencies are appropriately put into place.
   c. The QAPI Committee should report all Adverse Events to the Compliance and Ethics Committee (Found on the E5-QAPI Monitoring Tool)
      i. Certain adverse events and temporary harm events are likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.
      ii. The OIG offers a resource from the Institute of Healthcare Improvement on its website entitled, "IHI Skilled Nursing Facility Trigger Tool for Measuring Adverse Events"

D. Authority Statement

1. The facility Infection Preventionist, in conjunction with the Infection Prevention and Control committee (IPCC):
   a. Investigates the etiology of infections
   b. Monitors infection control practices pertaining to residents, employees, visitors, and the environment including any COVID-19 outbreak
   c. Promotes and monitors immunization protocols for residents and staff including COVID-19 protocols as issued
   d. Generates and reviews data such as infection rates and antibiotic resistance rates
   e. Monitors and reports on the use of antibiotics to meet resident- and community-specific needs
   f. Monitors weekly reports of COVID-19 activity levels in the local community when requirement is activated to monitor the county positivity rate that will determine point of care testing
   g. Recommends procedures for asepsis, disinfection, sterilization, isolation, and environmental control of microorganisms
   h. Reports relevant information to facility leadership
2. The facility Medical Director and Infection Preventionist are authorized to initiate action as indicated when there is sufficient reason to believe that an infectious, hazardous condition exists that could endanger any resident, employee, or visitor. This includes the initiation of Transmission Based Precautions and any necessary restrictions during an outbreak situation that includes COVID-19.
3. The facility Administrator designates one or more individual(s) as the infection Preventionist(s) (IPs) who are responsible for the facility's IPCP. The IP must:

a. Have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field
b. Be qualified by education, training, experience, or certification
c. Work at least part-time at the facility
d. Have completed specialized training in infection prevention and control

4. The individual designated as the IP, or at least one of the individuals if there is more than one IP, is a member of the facility's QAA/QAPI Committee and reports to the QAA/QAPI Committee on the IPCP on a regular basis.

This statement of authority is reviewed and authenticated annually by the facility IPCC Team, the facility Medical Director and clinical management team, including the Administrator and the Director of Nursing.

E. Infection Surveillance System

Facility leadership maintains written standards, policies, and procedures for the Infection Prevention and Control Program, designed to detect, control, and prevent possible communicable diseases or infections before they can spread to other persons in the facility.

1. Detection

Detection of infections is accomplished through an ongoing, facility based, system of surveillance. All infections are identified and reported to the Infection Control Preventionist (IP). The IP maintains, tracks, and trends an ongoing monthly line listing of residents with infections and monitors for outbreak potential including any outbreak related to COVID-19. The IP reviews and compares follow-up lab data and completes a monthly review to identify trends.

a. Definitions:
   - ***Healthcare-associated infection*** (HCAI) (***Facility associated)*** - any infection in a resident that is not present at the time of admission or readmission and doesn't develop before the first 72 hours of admission or readmission; an infection in a resident while receiving healthcare for another condition[1]
   - ***Other healthcare associated infections*** - any infection in a recently hospitalized resident (within 8 weeks) which is present at the time of admission to the facility or develops within the first 72 hours of admission or readmission.
   - ***Community associated infections*** - any infection in a resident who has not been in another healthcare facility within the prior 8 weeks that is present at the time of admission or developing within the first 72 hours of admission or readmission.

2. Control

To control the potential spread of infection, the type and duration of precaution is based on the resident's condition and follows the CDC guidelines.[4, 5] Elements of the Infection Prevention and Control Plan include[7]:

a. Surveillance and Disease Reporting
   - Epidemic infections
   - Urinary tract infections
   - Respiratory tract infections
   - Tuberculosis
   - Skin and soft tissue infections, infestations

- COVID-19 infections
- Other infections

b. Standard and transmission-based precautions
   - Hand Hygiene
   - Respiratory and cough etiquette
   - OSHA Respiratory Protection Program
   - Work exclusion policies - The circumstances under which employees with a communicable disease or infected skin lesions are prohibited from direct contact with residents or their food, if direct contact will transmit the disease.

c. Isolation Precautions - When and how isolation should be used for a resident, including but not limited to:
   - A requirement that the isolation is the least restrictive for the resident
   - Antibiotic resistant bacteria - Multi drug resistant organisms (MDRO) such as MRSA, vancomycin-resistant enterococci (VRE), or antibiotic-resistant gram-negative bacilli
   - Immunosuppressed residents
   - Personal Protective Equipment
   - Injection safety
   - Point of Care Testing (including glucometer cleaning)
   - Linen management
   - COVID-19 cohorting

d. Antibiotic Stewardship
   - Sufficient time for staff from relevant departments to contribute to stewardship activities
   - Training and education ensuring participation from the many groups that can support stewardship activities
   - Stewardship-related duties in job descriptions and annual performance reviews

e. Facility Management including environmental control, waste management, product evaluation and disinfection, sterilization, and asepsis

f. Facility *Exposure Control Plan* for OSHA Bloodborne Pathogens[6]
   - Competency Evaluation

g. Emergency Preparedness
   - Outbreak Control
     - Pandemic Influenza
     - Pandemic COVID-19
   - Natural Disaster

h. Screening and immunization for residents, staff, and volunteers
   - Baseline TB Screen
   - Influenza Vaccination (and goal)
   - Hepatitis B Vaccination
   - Pneumococcal considerations
   - COVID-19 considerations

i. Resident Care and Health
   - COVID-19 policies for screening, testing, and cohorting

j. Employee Health
   - COVID-19 policies for screening, testing, return to work

k. Education in infection prevention and control policy and practices
   - Employee
   - Visitor
   - Resident

3. Prevention

Prevention of infection is a priority and is stressed through the promotion and compliance with Standard Precautions and CDC Hand Hygiene Guidelines as well as compliance with immunization recommendations.

F. Organization Assessment

The Department of Health and Human Services Centers for Disease Control and Prevention recommend that the long-term care organization conducts a comprehensive assessment of its infection prevention and control programs and practices. It has made an assessment tool available (Nursing Home COVID-19 Infection Control Assessment and Response (ICAR) Tool Facilitator Guide) updated January 7, 2022, which includes:

- Section 1: Facility Demographics and Critical Infrastructure
- Section 2: Routine Infection Prevention Practices During the COVID-19 Pandemic
- Section 3: Infection Prevention and Control Program
- Section 4: Evaluating and Managing Healthcare Personnel (HCP) and Visitors
- Section 5: Evaluating and Managing Residents
- Section 6: Care of Residents Suspected or confirmed to Have SARS-CoV-2 Infection
- Section 7: SARS-CoV-2 Testing
- Section 8: New SARS-CoV-2 Infection among HCP or Residents
- Section 9: Continuous Quality Improvement
- Section 10: Facility Tour

This assessment tool contains checklists, surveillance monitors, and resources to assist the IPCC in evaluating the effectiveness of the Infection Prevention and Control Plan, to identify gaps, and to develop an action plan for improvement and approval.

G. Infection Preventionist Responsibilities

In collaboration with the Infection Prevention and Control Committee (IPCC), the Infection Preventionist coordinates activities related to:

a. COVID-19 Surveillance

b. Culture Surveillance
   - Monitor, review, and track all cultures and lab data for resolution of infections, infectious trends, and potential for outbreaks including:
     - *Monthly Line Listing* of infections and cultures
       - Track new infections monthly
       - Initiate a new list monthly, eliminating resolved infections from the past month
       - Differentiate nosocomial and community acquired infections
       - Analyze potential outbreaks

        - Summarize infections monthly
    - Targeted review for *Clostridium difficile* infection (C-diff); Methicillin-Resistant Staphylococcus Aureus (MRSA); Vancomycin-Resistant Enterococci (VRE) and other Multi Drug Resistant Organisms (MDRO); Acinetobacter; Strep Pneumonia, Legionella, Coronavirus, and others as required by specific states (Example: Candida Auris as required in New York State)
    - Case review as indicated
c. Routine Surveillance
    - Communicate with staff during walking rounds
    - Review information sources daily:
        - The *24-Hour Report*
        - Medical progress notes
        - Lab/Radiology reports
        - Nurses' Notes
        - Treatment/medication records
        - Assessments
        - Transfer information
    - Observe the environment by conducting purposeful walking rounds in resident care and nonresident care areas
d. Antibiotic Drug Resistance Management
    - Identify and designate residents known to be colonized or infected (with MRSA & MDRO) for early detection and initiation of precautions to decrease the risk of transmission to other residents
        - Evaluate residents admitted with known infection or colonization of MDRO for appropriate precautions and room placement
        - Evaluate residents newly diagnosed with MDRO infection for appropriate precautions and room placement. Complete room transfer as indicated
        - Implement policies and procedures for Transmission Based Precautions for cases of MDRO
        - Adhere to cohorting guidelines: Residents colonized or infected with a MDRO cannot be placed in room with another resident who has:
            - A different multi-drug resistant organism
            - An invasive device such as a port, IV-line, track, or indwelling bladder catheter
            - A recent post-operative wound
            - Open wound(s) (including pressure ulcer)
            - Severe immunosuppression (e.g., cancer, HIV, transplant residents, etc.)
    - Provide care management for residents with MDRO according to the specific transmission-based precaution restrictions. When possible, residents are not restricted to their rooms
        - Provide cover/containment of infected area when resident is outside his/her room
        - Limit the resident's activity outside his/her room if unable to contain infectious material or resident has poor hygiene
        - Observe health-care providers and interactions with MDRO colonized/infected residents to determine if infection control policies are being observed
        - Provide employee reeducation and/or disciplinary action as needed

e. Staff Exposure Management
   - Arrange for necessary testing and/or follow up in the event staff members are exposed to an infectious disease in accordance with federal regulations and CDC recommendations. Prevention and management of employee exposure is provided through:
     - Complete new employee pre-placement evaluations and screening tests
     - Coordinate employee immunizations including Hepatitis B and influenza vaccinations
     - Coordinate employee annual surveillance testing and lab work as needed
     - Maintenance of the employee medical records
     - Evaluate and coordinate care for employees who are exposed to bloodborne pathogens and infectious diseases (including potential exposure to MDRO)

f. Outreach Notification
   - Notify the receiving hospital or other facility and transporting service (ambulance) when a resident with MDRO is being transferred for treatment, evaluation, or testing. Include:
     - Verbal report to transporting service and receiving facility
     - Identification of MDRO on the transfer form

g. Antibiotic Stewardship Oversight
   - Conduct a formal review for the appropriateness of any antibiotics prescribed on a regular basis

h. Resident Safety Advisories
   - Post and share resident safety advisories as indicated

i. Resident /Family education documented (signs and symptoms to watch for, sepsis, etc.)

H. Antibiotic Use Protocols and Systems

a. Facility leadership reduces a resident's risk of adverse drug reactions and preserves drug efficacy in the face of rising multidrug-resistant pathogens by establishing elements of antibiotic stewardship[3] including:
   - Leadership commitment - Necessary human, financial, and information technology resources to develop and manage the antibiotic stewardship program, improve antibiotic use and the frequency with which they are used, with a commitment to quality improvement
   - Accountability - A single leader responsible for program outcomes
   - Drug Expertise - A pharmacist leader to co-lead the antibiotic stewardship program responsible for working to improve antibiotic use
   - Monitoring and tracking - Audit and analyze facility wide antibiotic prescribing and resistance patterns
   - Reporting - Antibiotic use, resistance, and customer data integration (CDI) trends to doctors, nurses, and relevant staff
   - Documenting - Corrective action identified under the facility IPCP
   - Educating and engaging - Clinicians and department heads to improve antibiotic use and implement strategies to optimize the use of antibiotics

- Provide education and regular updates on antibiotic prescribing, antibiotic resistance, and infectious disease management that address both national and local issues
- Share facility-specific information on antibiotic use as a tool to motivate improved prescribing
- Utilize options for providing education on antibiotic use such as:
  - Didactic presentations in formal and informal settings
  - Messaging through posters, flyers, and newsletters
  - Electronic communication to staff groups
  - Review de-identified cases with providers where changes in antibiotic therapy could have been made
  - Web-based educational resources to help staff develop educational content
  - Pair education with corresponding interventions and measurement of outcomes to enhance educational effectiveness

- Evaluating - Coordinating with quality improvement staff to regularly review and analyze QAPI incident and antibiotic use data, including data resulting from drug regimen reviews, and acting on available data to make improvements to ensure optimum use, quality, and patient safety
- The Infection Prevention and Control Plan provides specific interventions to improve antibiotic use that can be divided into three categories (See the Company *Antibiotic Stewardship Policy*)
  - Broad
  - Pharmacy driven
  - Infection and syndrome specific
- The Infection Prevention and Control Committee:
  - Reviews and identifies facility interventions highlighted in the CDC/Institute for Healthcare Improvement "Antibiotic Stewardship Driver Diagram and Change Package" [9]
  - Collaborates with laboratory services staff to:
    - Guide empiric therapy
    - Create and interpret cumulative antibiotic resistance report (an antibiogram)
    - Ensure that lab reports present data in a way that supports optimal antibiotic use
    - Ensure that lab information provided is useful to stewardship efforts
    - Ensure lab partner contracts are written accordingly
  - Coordinates with information technology staff to integrate stewardship protocols into existing workflow such as:
    - Embedding relevant information and protocols at the point of care
    - Implementing clinical decision support for antibiotic use
    - Creating prompts for action to review antibiotics in key situations
    - Facilitating the collection and reporting of antibiotic use data
  - Places performance expectations on nurses to:
    - Assure cultures are performed before starting antibiotics
    - Review medications as part of their routine duties
    - Prompt discussions of antibiotic treatment, indication, and duration

- Monitors antibiotic prescribing and prepares periodic reports for the QAA/QAPI Committee. Antibiotic stewardship measurement is critical to identify opportunities for improvement and assess the impact of improvement efforts

I. Influenza, pneumococcal, and COVID-19 vaccination

a. Influenza

- Before offering the influenza vaccination, each resident or the resident's representative receives education regarding the benefits and potential side effects of the vaccination
- Each resident is offered an influenza vaccination October 1 through March 31 annually, unless the vaccination is medically contraindicated, or the resident has already been immunized during this time period
- The resident or the resident's representative has the opportunity to refuse vaccination
- The resident's medical record includes documentation that indicates, at a minimum:
  - That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza vaccination
  - That the resident either received the influenza vaccination or did not receive the influenza vaccination due to medical contraindications or refusal

b. Pneumococcal disease

- Before offering the pneumococcal vaccination, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization
- Each resident is offered a pneumococcal vaccination, unless the vaccination is medically contraindicated, or the resident has already been immunized
- The resident or the resident's representative has the opportunity to refuse vaccination
- The resident's medical record includes documentation that indicates, at a minimum:
  - That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal vaccination
  - That the resident either received the pneumococcal vaccination or did not receive the pneumococcal vaccination due to medical contraindication or refusal

c. COVID-19

- Before offering the COVID-19 vaccination, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization
- Each resident is offered a COVID-19 vaccination, unless the vaccination is medically contraindicated, or the resident has already been immunized
- The resident or the resident's representative has the opportunity to refuse vaccination
- The resident's medical record includes documentation that indicates, at a minimum:
  - That the resident or resident's representative was provided education regarding the benefits and potential side effects of COVID-19 vaccination
  - That the resident either received the COVID-19 vaccination or did not receive the COVID-19 vaccination due to medical contraindication or refusal

J. Infection Prevention and Control Manual

The Infection Prevention and Control Policies and Procedures Manual is state specific. Policies and the IPCP are reviewed annually, and revisions made as needed.

K. Compliance with Governmental, Regulatory, and Accrediting Agencies

Facility leadership reviews and assesses compliance with pertinent governmental, regulatory, and accreditation agencies, including but not limited to OSHA, State Specific Departments of Health, County Health Department, EPA, CDC, and FDA.

d. State Specific - mandatory reporting of specific infectious conditions as serious event
e. OSHA - Exposure Control Plans for TB and Bloodborne Pathogens
f. CDC and APIC - compliance with published standards for prevention of healthcare-associated infections and Antibiotic Stewardship
g. NHSN – the nation's most widely used healthcare acquired infection tracking system

COVID RESOURCES

CDC - Vaccine Safety Monitoring and Reporting in Your Facility - For LTCF administrators and clinical leadership
https://www.cdc.gov/vaccines/covid-19/toolkits/long-term-care/safety-monitoring-reporting.html
January 11, 2022

CMS QSO-20-31-All Revised 1/4/2021
Revised COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes
https://www.cms.gov/files/document/qso-20-31-all-revised.pdf **Rev. 1/4/2021**

QSO-21-08-NLTC REVISED (cms.gov) Revised 2/4/22
COVID-19 Focused Infection Control Survey Tool for Acute and Continuing Care
https://www.cms.gov/files/document/qso-21-08-nltc-revised.pdf

CMS QSO-20-30-NH Nursing Home Reopening Recommendations for State and Local Officials
REVISED 9/28/20; ORIGINAL ISSUE: 5/19/20
https://www.cms.gov/files/document/nursing-home-reopening-recommendations-state-and-local-officials.pdf

Resources:

1. National Action Plan to Prevent Healthcare-Associated Infections: Road Map to Elimination - https://health.gov/healthypeople/tools-action/browse-evidence-based-resources/national-action-plan-prevent-health-care-associated-infections-road-map-elimination
2. https://www.cdc.gov/longtermcare/index.html
3. https://www.cdc.gov/antibiotic-use/core-elements/index.html
4. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
5. *Guidelines for Isolation Precaution: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007*
6. Recommendations for LTC from the *Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006*
7. http://dr.carondelet.org/dl/Clinical%20Syndromes.pdf
8. *https://www.osha.gov/Publications/osha3186.pdf*
9. SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility. HHS Public Access

[10] https://www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf
[11] https://www.cdc.gov/antibiotic-use/stewardship-report/index.html
[12] https://www.train.org/cdctrain/training_plan/3697

Plan Approved: *Document that the plan was approved for the facility*
Plan Reviewed/Revised: *Date the plan was reviewed*
Revision Date: *Date the plan was last revised*

Policy Number: Infection Control (IC) 1.1

Policy Title: Antibiotic Stewardship

Policy Statement/Purpose: The Antibiotic Stewardship policy establishes antibiotic use protocols and systems for monitoring antibiotic use and recording incidents in order to reduce a resident's risk of adverse drug reactions and preserve drug efficacy in the face of rising multidrug-resistant pathogens. The Antibiotic Stewardship policy is a compliance component of the Antimicrobial Stewardship Program.

Policy Interpretation and Implementation:

1. Centers for Disease Control and Prevention (CDC) Core Elements of an Antibiotic Stewardship Program (ASP)
   - Leadership Commitment - Dedicating necessary human, financial, and information technology resources
   - Accountability - Appointing a single leader responsible for program outcomes
   - Drug Expertise - Appointing a pharmacist leader responsible for working to improve antibiotic use
   - Action - Formal review procedure for the appropriateness of any antibiotics prescribed after 48 hours from the initial orders
   - Tracking - Monitoring antibiotic prescribing and resistance patterns
   - Reporting - Regular reporting information on antibiotic use and resistance to doctors, nurses, and relevant staff
   - Education - Educating clinicians about resistance and optimal prescribing
2. Leadership Commitment - The Company:
   - Supports efforts to improve and monitor antibiotic use including:
     - Stewardship-related duties in job descriptions and annual performance reviews
     - Sufficient time for staff from relevant departments to contribute to stewardship activities
   - Supports training and education ensuring participation from the many groups that can support stewardship activities
   - Provides financial support to support the capacity and impact of a stewardship program
3. Accountability and Drug Expertise - The Company:
   - Identifies a stewardship program leader responsible for program outcomes

- Identifies a pharmacy leader to co-lead the antibiotic stewardship program

4. Formal training in infectious diseases and/or antibiotic stewardship - The Company:
   - Ensures staff expertise to develop and manage the antibiotic stewardship program, improve antibiotic use, and the frequency with which they are used, with a commitment to quality improvement
   - The pharmacy and therapeutics committee may expand its role to assess and improve antibiotic use
5. Key Support - The Company:
   - Engages clinicians and department heads in efforts to:
     - Improve antibiotic use
     - Coordinate facility-wide monitoring and prevention of healthcare-associated infections
     - Audit, analyze, and report data
     - Monitor and report resistance and customer data integration (CDI) trends
     - Educate staff on the importance of appropriate antibiotic use and implementing strategies to optimize the use of antibiotics
   - Coordinates with quality improvement staff to optimize antibiotic use to ensure quality and patient safety
   - Collaborates with laboratory services staff to guide empiric therapy, creating and interpreting a cumulative antibiotic resistance report (an antibiogram), and ensuring that lab reports present data in a way that supports optimal antibiotic use. Information provided should be useful to stewardship efforts and partner contracts should be written accordingly
   - Ensures Information technology staff integrates stewardship protocols into existing workflow such as embedding relevant information and protocols at the point of care, implementing clinical decision support for antibiotic use, creating prompts for action to review antibiotics in key situations, and facilitating the collection and reporting of antibiotic use data
   - Places performance expectations on nurses to assure cultures are performed before starting antibiotics, review medications as part of their routine duties, and prompt discussions of antibiotic treatment, indication, and duration
6. Policies and Interventions to Improve Antibiotic Use - The Company:
   - Implements written policies and procedures whose purpose is to improve antibiotic use
   - Utilizes specific interventions that can be divided into three categories: broad, pharmacy driven, and infection and syndrome specific
     - Broad interventions
       i. Antibiotic "Time outs." Antibiotics are often started empirically while diagnostic information is being obtained. An antibiotic "time out", 48 hours after antibiotics are initiated, prompts a reassessment of the continuing need and choice of antibiotics when the clinical picture is clearer and more diagnostic information (including culture results) is available. The "time out" answers key questions:
          - Does this patient have an infection that will respond to antibiotics?
          - Is the patient on the right antibiotic(s), dose, and route of administration?
          - Can a more targeted antibiotic be used to treat the infection (de-escalate)?
          - How long should the patient receive the antibiotic(s)?

       ii. Prior authorization - Ensure that antibiotic use is reviewed with an antibiotic expert before therapy is initiated. This intervention requires the availability of expertise in

antibiotic use and infectious diseases and authorization needs to be completed in a timely manner

iii. Prospective audit and feedback - Audits are conducted by staff other than the treating team. Audit and feedback require the availability of expertise and may engage external expert advice on case reviews

- Pharmacy-driven Interventions
  i. Automatic changes from intravenous to oral antibiotic therapy in appropriate situations and for antibiotics with good absorption which improves patient safety by reducing the need for intravenous access
  ii. Dose adjustments in cases of organ dysfunction such as renal adjustment
  iii. Dose optimization including dose adjustments based on therapeutic drug monitoring and optimizing therapy for highly drug-resistant bacteria
  iv. Automatic alerts where therapy might be unnecessarily duplicative including simultaneous use of multiple agents with overlapping spectra
  v. Time-sensitive automatic stop orders for specified antibiotic prescriptions, especially antibiotics administered for prophylaxis
  vi. Detection and prevention of antibiotic-related drug-drug interactions
- Infection and syndrome specific interventions
  i. Interventions are intended to improve prescribing for specific syndromes but should not interfere with prompt and effective treatment for severe infection or sepsis
  ii. Community-acquired pneumonia. Interventions for community-acquired pneumonia should focus on correcting recognized problems in therapy, including improving diagnostic accuracy, tailoring of therapy to culture results, and optimizing the duration of treatment to ensure compliance with guidelines
  iii. Urinary tract infections (UTIs). Antibiotics may actually be prescribed for asymptomatic bacteriuria and not infections. Interventions for UTIs should focus on avoiding unnecessary urine cultures and treatment of residents who are asymptomatic and ensuring that residents receive appropriate therapy based on local susceptibilities and for the recommended duration
  iv. Skin and soft tissue infections. Interventions for skin and soft tissue infections should focus on ensuring residents do not get antibiotics with overly broad spectra and ensuring the correct duration of treatment
  v. Empiric coverage of methicillin-resistant Staphylococcus aureus (MRSA) infections. In many cases, therapy for MRSA can be stopped if the patient does not have a MRSA infection or changed to a beta-lactam if the cause is methicillin-sensitive Staphylococcus aureus
  vi. Clostridium difficile infections. Treatment guidelines for CDI urge providers to stop unnecessary antibiotics in all residents diagnosed with CDI. Reviewing antibiotics in residents with new diagnoses of CDI can identify opportunities to stop unnecessary antibiotics which improve the clinical response of CDI to treatment and reduces the risk of recurrence
  vii. Treatment of culture proven invasive infections. Invasive infections, such as blood stream infections, present good opportunities for interventions to improve antibiotic use because they are easily identified from microbiology results. The culture and susceptibility testing provide information needed to tailor antibiotics or discontinue them due to growth of contaminants

- Implements policies that apply in all situations to support optimal antibiotic prescribing, including:
  - Specifying the dose, duration, and indication for all courses of antibiotics so they are readily identifiable
  - Making this information accessible helps ensure that antibiotics are modified as needed and/or discontinued in a timely manner
- Develops and implements facility-specific treatment recommendations that:
  - Are based on national guidelines and local susceptibilities
  - Provide formulary options to optimize antibiotic selection and duration for common indications for antibiotic use like community-acquired pneumonia and urinary tract infection
- Chooses and prioritizes interventions based on the needs of the facility as well as the availability of resources and content expertise as defined by measures of overall use and other tracking and reporting metrics
  - Review potential interventions that are highlighted in the CDC/Institute for Healthcare Improvement "Antibiotic Stewardship Driver Diagram and Change Package" found at: https://www.cdc.gov/getsmart/healthcare/pdfs/Antibiotic_Stewardship_Change_Package_10_30_12.pdf
  - Assessments of the use of antibiotics as mentioned in the "Process Measures" section of this document can be a starting point for selecting specific interventions

7. Tracking and Reporting Antibiotic Use and Outcomes - The Company:
   - Monitors antibiotic prescribing - Antibiotic stewardship measurement is critical to identify opportunities for improvement and assess the impact of improvement efforts. Measurement may involve evaluation of both process and outcome
     - Antibiotic Use Process Measures
       i. Address whether policies and guidelines are being followed as expected and, if conducted over time, process reviews assess the impact of efforts to improve use
       ii. Assess the use of antibiotics or the treatment of infections to determine the quality of antibiotic use including determining if prescribers:
           - Have accurately applied diagnostic criteria for infections
           - Prescribed recommended agents for a particular indication
           - Documented the indication and planned duration of antibiotic therapy
           - Obtained cultures and relevant tests prior to treatment
           - Modified antibiotic choices appropriately to microbiological findings
       iii. Standardized tools such as those for drug use evaluations or antibiotic audit forms like those developed by CDC can assist in these reviews
       iv. Assess if antibiotics are being given in a timely manner and assess compliance with facility antibiotic use policies such as the documentation of dose, duration, and indication, or the performance of reassessments of therapy (antibiotic time outs)
           - These reviews can be done retrospectively on charts which could be identified based on pharmacy records or discharge diagnoses
           - For interventions that provide feedback to clinicians, it is also important to document interventions and track responses to feedback such as acceptance
     - Antibiotic Use Measures

i. Measure antibiotic use as either days of therapy (DOT) or defined daily dose (DDD)
ii. DOT is an aggregate sum of days for which any amount of a specific antimicrobial agent is administered or dispensed to a particular patient (numerator) divided by a standardized denominator (e.g., patient days, days present, or admissions). If a patient is receiving two antibiotics for 10 days, the DOT numerator would be 20
iii. DDD estimates antibiotic use in facilities by aggregating the total number of grams of each antibiotic purchased, dispensed, or administered during a period of interest divided by the World Health Organization-assigned DDD. DDDs are often available in facilities with pharmacy systems that cannot calculate DOTs
    - Compared to DOT, DDD estimates are not appropriate for children, are problematic for residents with reduced drug excretion such as renal impairment, and are less accurate for between-facility benchmarking
    - DDDs can be a useful measure of progress when tracked using a consistent methodology over time
iv. As part of the National Healthcare Safety Network (NHSN), CDC has developed an Antibiotic Use (AU) Option that automatically collects and reports monthly DOT data that can be analyzed in aggregate and by specific agents and patient care locations
    - The AU module is available to facilities that have information system capability to submit electronic medication administration records (eMAR) and/or barcoding medication records (BCMA) using an HL7 standardized clinical document architecture
    - To participate in the AU option, facility personnel can work with their information technology staff and potentially with their pharmacy information software providers to configure their system to enable the generation of standard formatted file(s) to be imported into NHSN

- Outcome measures
    i. Address whether interventions improved antibiotic use and patient outcomes
    ii. Track clinical outcomes that measure the impact of interventions to improve antibiotic use:
        - Reducing antibiotic resistance
        - Pathogens recovered from residents after admission (when residents are under the influence of the stewardship interventions)
        - Resistance at the patient level (i.e. what percent of residents develop resistant super-infections)
        - Drug cost savings

8. Education - The Company:
    - Provides regular updates on antibiotic prescribing, antibiotic resistance, and infectious disease management that address both national and local issues
    - Shares facility-specific information on antibiotic use as a tool to motivate improved prescribing
    - Utilizes options for providing education on antibiotic use such as:
        - Didactic presentations in formal and informal settings
        - Messaging through posters, flyers, and newsletters
        - Electronic communication to staff groups

- Reviews de-identified cases with providers where changes in antibiotic therapy could have been made
- Offers a variety of web-based educational resources to help staff develop educational content
- Pairs education with corresponding interventions and measurement of outcomes to enhance educational effectiveness

9. Emerging Developments in Antibiotic Stewardship
    - Strategies for improving antibiotic use and evidence for best practices in antibiotic stewardship are evolving
        - The integration of IT into the clinical data presentation and decision-making for antibiotic use will expand with increased uptake and capabilities of electronic health records
        - The role of rapid diagnostic laboratory testing is evolving and may become important additions to stewardship efforts
        - The use of diagnostic tools on patient care needs further research to determine how they can best be applied to stewardship efforts
        - Better characterization of the impact of antibiotic stewardship interventions on resistance by evaluating which interventions or antibiotic targets yield the greatest benefit in combating antibiotic resistance
        - CDC's NHSN launch of the Antimicrobial Resistance (AR) Option facilitates evaluation of antimicrobial resistance data using a standardized approach

12. CLINICAL PRACTICES (CL)

12. CLINICAL PRACTICES (CL)

Med-Net's mission focuses on Corporate Compliance and Ethics with supporting policies in fraud, waste, abuse, privacy, quality, data integrity, and workforce management. As such, clinical policies and procedures are referred to Med-Pass or other publishers of clinical policy and procedure manuals such as Lippincott or Long Term Care Solutions.

Med-Net customers receive a special discount to the Med-Pass policies. The Med-Pass policies can be accessed at http://www.med-pass.com/ and using the discount code: **MedNet10**.

*Please note that the discount is not on every product, but a range of the Med-Pass Heaton policy and procedure manuals.

13. STATE SPECIFIC REQUIREMENTS

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STATE	Function	STATE SPECIFIC REQUIREMENTS
Dept. of Health websites		Listing of State Department of Health websites
Dept. of Labor websites		Listing of State Department of Labor websites
A. State Specific Deficit Reduction Act	Fiscal Integrity	Deficit Reduction Act of 2005, 42 U.S.C. Section 1396a(a)(68).
B. State Specific Medical Records Storage and Retention Requirements	Business Practices P 2.1 A Medical Records Retention	Medical Records Retention Requirements
C. State specific Consumer Protection and Exclusion websites	Workforce Management	State specific consumer protection and exclusion websites
D. State Specific Rights	Workforce Management	https://www.consumer.ftc.gov/articles/pdf-0096-fair-credit-reporting-act.pdf *Contact the state or local consumer protection agency or the state Attorney General
E. State Specific Licensing/debarment Websites	Debarment	Reference: State Consumer Protection and Exclusion websites
F. State Specific Workplace Sexual Harassment Prevention Training	Workforce Management	Workplace Sexual Harassment Prevention Training Requirements
		NEW JERSEY REQUIREMENTS
New Jersey	Workforce Management	Board of Nursing Mandatory Reporting Guidelines
New Jersey	Workforce Management	Peggy's Law
New Jersey	Workforce Management	Healthcare Professional Responsibility and Reporting Enhancement Act (Nurse Cullen Law)
New Jersey	Safety	Patient Safety Act

		• Assessment Form
New Jersey	Safety	Workplace Violence Prevention NJ Stat 26:2H-5.20 and NJAC 8:43E-11.3 (see WM 2.8 A)
New Jersey	Safety	Safe Patient Handling Policy
New Jersey	Workforce Management	The New Jersey Opportunity to Compete Act "Ban the Box" law prohibits criminal background checks until after conditional offer of employment.
New Jersey	Workforce Management	Division of Consumer Affairs Licensure Databases: https://newjersey.mylicense.com/verification_4_6/ Certified Nurse Aide and Personal Care Assistant Registry: http://www.cnatips.com/registry/nurse-aide-nj.php Department of Health and Senior Services Licensure Databases: http://www.state.nj.us/health/healthfacilities/search.shtml
NEW YORK REQUIREMENTS		
New York	Workforce Management	Harassment Policy
New York	Compliance	OMIG
New York	Compliance	Compliance Plan Agreement with attachments
New York	Compliance	New York DRA standalone document
New York	Compliance	Compliance Committee Charter
New York	Compliance	NY Annual Training Plan
New York	Compliance	Hotline Poster
New York	Compliance	Governing Body Bylaws
New York	Compliance	Governing Body Training

State Department of Health Websites

Alabama Department of Public Health, http://www.alabamapublichealth.gov/
Alaska Department of Health and Human Services, http://dhss.alaska.gov/Pages/default.aspx
Arizona Department of Health Services, https://www.azdhs.gov/
Arkansas Department of Health, https://www.healthy.arkansas.gov/
California Department of Health, https://www.cdph.ca.gov/
Colorado Department of Public Health and Environment, https://www.colorado.gov/cdphe
Connecticut Department of Public Health, https://portal.ct.gov/dph
Delaware Division of Public Health, https://dhss.delaware.gov/dhss/dph/index.html
Florida Department of Health, http://www.floridahealth.gov/
Georgia Department of Public Health, https://dph.georgia.gov/
Hawaii State Department of Health, http://health.hawaii.gov/
Idaho Department of Health and Welfare, https://healthandwelfare.idaho.gov/
Illinois Department of Public Health, http://www.dph.illinois.gov/
Indiana State Department of Health, https://www.in.gov/isdh/
Iowa Department of Public Health, http://idph.iowa.gov/
Kansas Department of Health and Environment, http://www.kdheks.gov/
Kentucky Cabinet for Health and Family Services, https://chfs.ky.gov/agencies/dph/Pages/default.aspx
Louisiana Department of Health, http://ldh.la.gov/
Maine Department of Health and Human Services, https://www.maine.gov/dhhs/
Maryland Department of Health https://health.maryland.gov/pages/home.aspx
Massachusetts Department of Public Health, https://www.mass.gov/orgs/department-of-public-health
Michigan Department of Health and Human Services, https://www.michigan.gov/mdhhs/
Minnesota Department of Health, https://www.health.state.mn.us/
Mississippi State Department of Health, https://msdh.ms.gov/
Missouri Department of Health & Senior Services, https://health.mo.gov/
Montana Department of Public Health and Human Services, https://dphhs.mt.gov/
Nebraska Department of Health and Human Services, http://dhhs.ne.gov/Pages/default.aspx
Nevada Department of Health and Human Services, http://dhhs.nv.gov/
New Hampshire Department of Health and Human Services, https://www.dhhs.nh.gov/
New Jersey Department of Health, https://www.nj.gov/health/
New Mexico Department of Health, https://nmhealth.org/
New York Department of Health, https://www.health.ny.gov/
North Carolina Department of Health and Human Services, https://www.ncdhhs.gov/
North Dakota Department of Health, https://www.ndhealth.gov/
Ohio Department of Health, https://odh.ohio.gov/wps/portal/gov/odh/home
Oklahoma Department of Health, https://www.ok.gov/health/
Oregon Health Authority, https://www.ok.gov/health/
Pennsylvania Department of Health, https://www.health.pa.gov/Pages/default.aspx
Rhode Island Department of Health, http://www.health.ri.gov/
South Carolina Department of Department of Health and Environmental Control, https://www.scdhec.gov/
South Dakota Department of Health, https://doh.sd.gov/

Tennessee Department of Health, https://www.tn.gov/health.html
Texas Department of State Health Services, https://www.dshs.texas.gov/
Utah Department of Health, https://health.utah.gov/
Vermont Department of Health, http://www.healthvermont.gov/
Virginia Department of Health, http://www.vdh.virginia.gov/
Washington State Department of Health, https://www.doh.wa.gov/
West Virginia Department of Health & Human Resources, https://dhhr.wv.gov/Pages/default.aspx
Wisconsin Department of Health Services, https://www.dhs.wisconsin.gov/
Wyoming Department of Health, https://health.wyo.gov/

State Department of Labor Websites

Alabama Department of Labor, www.labor.alabama.gov/
Alaska Department of Labor and Workforce Development, www.labor.state.AK.us
Industrial Commission of Arizona, www.azica.gov
Arkansas Department of Labor, http://www.labor.arkansas.gov
California Department of Industrial Relations, www.dir.ca.gov/Contactus.html
Colorado Department of Labor and Employment, www.coloradolaborlaw.gov
Connecticut Department of Labor, www.CT.gov/dol
Delaware Works, www.Delawareworks.com
Florida Department of Economic Opportunity, www.floridajobs.org
Georgia Department of Labor, www.dol.state.GA.us
Hawaii Department of Labor and Industrial Relations, www.labor.hawaii.gov
Idaho Department of Labor, www.labor.Idaho.gov
Illinois Department of Labor, www.state.IL.us/agency/idol
Indiana Department of Labor, www.in.gov/dol
Iowa Division of Labor, www.iowadivisionoflabor.gov
Kansas Department of Labor, www.dol.KS.gov
Kentucky Labor Cabinet, www.labor.KY.gov
Louisiana Department of Labor, http://www.LAworks.net or www.ldol.state.la.us/
Maine Department of Labor, www.maine.gov/labor
Maryland Department of Labor, Licensing, & Regulation www.dllr.state.MD.us
Massachusetts Executive Office of Labor and Workforce Development, www.Mass.gov/eolwd or www.state.ma.us/
Michigan Department of Licensing and Regulatory Affairs, www.Michigan.gov/lara
Minnesota Department of Labor and Industry, www.dli.mn.gov
Mississippi Department of Employment Security, www.mdes.MS.gov
Missouri Department of Labor & Industrial Relations, www.labor.mo.gov
Montana Department of Labor & Industry, www.dli.MT.gov
Nebraska Department of Labor, www.dol.Nebraska.gov
Nevada Department of Business & Industry Office of the Labor Commissioner, labor.nv.gov
New Hampshire Department of Labor, www.nh.gov/labor

New Jersey Department of Labor & Workforce Development, lwd.dol.state.nj.us/labor/index.html
New Mexico Department of Workforce Solutions, www.dws.state.nm.us
New York Department of Labor, www.labor.ny.gov
North Carolina Department of Labor, www.labor.nc.gov
North Dakota Department of Labor and Human Rights, www.nd.gov/labor
Ohio Department of Commerce, www.com.state.OH.us
Oklahoma Department of Labor, www.labor.ok.gov
Oregon Bureau of Labor and Industries, www.Oregon.gov/boli
Pennsylvania Department of Labor & Industry, www.dli.state.PA.us
Rhode Island Department of Labor and Training, www.dlt.ri.gov
South Carolina Department of Labor, Licensing, and Regulation www.llr.state.SC.us
South Dakota Department of Labor & Regulation, www.dlr.sd.gov
Tennessee Department of Labor & Workforce Development, www.tn.gov/workforce
Texas Workforce Commission, www.twc.state.TX.us
Utah Labor Commission, www.Laborcommission.Utah.gov
Vermont Department of Labor, www.labor.vermont.gov
Virginia Department of Labor and Industry, www.doli.Virginia.gov
Washington State Department of Labor & Industries, www.lni.WA.gov
West Virginia Division of Labor, https://labor.wv.gov/Pages/default.aspx
Wisconsin Department of Workforce Development, dwd.wisconsin.gov
Wyoming Department of Workforce Services, http://www.wyomingworkforce.org/

A. Deficit Reduction Act of 2005, 42 U.S.C. Section 1396a(a)(68)

*Included with client copy of the Our Compliance and Ethics Plan document. Contact Med-Net Client Services Management department if you need a copy of your state-specific DRA policy.

B. SR BP 2.1 A Medical Records Retention Requirements

*See list of State Department of Health website links, your state laws or code, or your State Nursing Home Licensing requirements to search state specific Medical Records Retention Requirements.

A general retention period must be chosen for medical records of adult residents that do not fall within specific exceptions. Records known to be subject to an actual or potential claim or investigation are to be retained indefinitely, or until the matter is known to be finally resolved. Employee health records must be retained according to specific state and federal retention and statute of limitations requirements. Requests to review or copy employee medical records must be responded to in strict compliance with applicable statutes and regulations.

*NOTE: As a best practice, Med-Net recommends at least ten-year retention periods for medical records. In some situations, there may be even longer required retention periods to minimize potential legal exposure. HIPAA also mandates additional requirements for storage in order to safeguard the security of documents for both on-site and off-site storage.

*Some additional links that may be helpful:

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKEwjDzpj6zoPjAhXKx1kKHZqHCSoQFjABegQIEBAH&url=http%3A%2F%2Fwww.healthinfolaw.org%2Fcomparative-analysis%2Fmedical-record-retention-required-health-care-providers-50-state-comparison&usg=AOvVaw13Gv8XJ1eh-LpRz8uTxF-tn

https://www.healthit.gov/sites/default/files/appa7-1.pdf

C. STATE CONSUMER PROTECTION AND EXCLUSION WEBSITES

1. Arkansas Department of Human Services – https://ardhs.sharepointsite.net/ExcludedProvidersList/Forms/AllItems.aspx
2. Arkansas Department of the Inspector General – http://omig.arkansas.gov/providers/excluded-providers
3. Connecticut Department of Social Services Administrative Actions List – http://www.ct.gov/dss/cwp/view.asp?a=2349&q=310706
4. Connecticut Department of Public Health Regulatory Action Report – http://www.ct.gov/dph/cwp/view.asp?a=4061&q=387280
5. Florida Department of Management Services – http://www.dms.myflorida.com/business_operations/state_purchasing/vendor_information/convicted_suspended_discriminatory_complaints_vendor_lists
6. Florida Agency for Healthcare Administration – Office of Medicaid Program Integrity – http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml
7. Kansas Department of Health and Human Services – Medicaid Program Integrity – http://www.kdheks.gov/hcf/medicaid_program_integrity/index.htm
8. Kansas Termination Provider List –http://www.kdheks.gov/hcf/medicaid_program_integrity/download/Termination_List.pdf
9. Kentucky Cabinet for Health and Family Services – Department of Medicaid Services – KY Medicaid Program Terminated and Excluded Provider List – http://chfs.ky.gov/dms/term.htm
10. List of Suspended or Excluded Massachusetts Health Providers – http://www.mass.gov/eohhs/docs/masshealth/provlibrary/suspended-excluded-masshealth-providers.pdf
11. Michigan Department of Community Health (MDCH) Sanctioned Provider List – http://www.michigan.gov/documents/mdch/MI_Sanctioned_Provider_List_379358_7.pdf
12. Michigan Department of Community Health Licensing Sanctions for Health Facilities and Professionals – http://michigan.gov/lara/0,4601,7-154-63294_63302---,00.html & http://www.michigan.gov/lara/0,4601,7-154-72600_72603---,00.html
13. Michigan Department of Human Services (MDHS) Licensing Sanctions for Adult Foster Care and Other Residential Settings Licensed by MDHS – http://www.michigan.gov/mdhhs/0,5885,7-339-71551_27716---,00.html
14. Minnesota Department of Human Services – MHCP Enrolled Providers – http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177378
15. Nebraska Department of Health and Human Services - Program Integrity Nebraska Medicaid Excluded Providers at – http://dhhs.ne.gov/medicaid/Pages/med_pi_sanc.aspx
16. State of New Jersey Office of Consumer Protection – http://www.njconsumeraffairs.gov/ocp/filings.htm
17. State of New Jersey Consolidated Debarment Report – http://www.state.nj.us/treasury/debarred/
18. State of New Jersey Office of the Insurance Fraud Prosecutor – http://www.njinsurancefraud.org/new.htm
19. New York State Insurance Company Search –http://www.ins.state.ny.us/tocol4.htm

20. New York State Consumer Protection Board – http://www.consumer.state.ny.us/
21. New York State Agency Debarment List – https://dbr.labor.state.ny.us/EDList/searchPage.do
22. North Carolina State Excluded Provider List – http://dma.ncdhhs.gov/document/state-excluded-provider-list
23. Ohio Medicaid Provider Exclusion and Suspension List – http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderExclusionandSuspensionList.aspx
24. Ohio Department of Developmental Disabilities Online Abuser Registry Verification – https://its.prodapps.dodd.ohio.gov/ABR_Default.aspx
25. Ohio Auditor of the State – https://ohioauditor.gov/findings/search.aspx
26. Oklahoma Nurse Aid Registry Search – https://www.ok.gov/health/pub/wrapper/naverify.html
27. Oklahoma Nurse Aide and Nontechnical Services Workers Registry – https://www.ok.gov/health/pub/wrapper/nrsaid.html
28. Pennsylvania Office of Consumer Advocate – http://www.oca.state.pa.us/
29. Pennsylvania Insurance Fraud Prevention Authority – http://helpstopfraud.org/Shared/RighttoKnow/tabid/72/Default.aspx
30. Pennsylvania Department of General Services Debarment List – http://www.portal.state.pa.us/portal/server.pt?open=512&objID=1271&&PageID=244340&level=3&css=L3&mode=2
31. TennCare Division of Healthcare Finance & Administration – https://www.tn.gov/tenncare/topic/terminated-provider-list

D. STATE SPECIFIC RIGHTS

- See https://www.consumer.ftc.gov/articles/pdf-0096-fair-credit-reporting-act.pdf or contact the state or local consumer protection agency or the state Attorney General.

E. STATE SPECIFIC LICENSING/DEBARMENT WEBSITES

(Reference: **State Consumer Protection and Exclusion websites**)

- For state specific background check requirements, check with your state regulatory agency.

- Information on those who have been debarred is available at the State of New Jersey Consolidated Debarment Report – http://www.state.nj.us/treasury/debarred/.

- Information on those who have been debarred is available at the Pennsylvania Department of General Services Debarment List – http://www.portal.state.pa.us/portal/server.pt?open=512&objID=1271&&PageID=244340&level=3&css=L3&mode=2.

- Information on those who have been debarred is available at the New York State Agency Debarment List - New York State Agency Debarment List – https://dbr.labor.state.ny.us/EDList/searchPage.do

Kansas Department of Health and Environment License Information System Search – http://www.kdheks.gov/health/licensing.htm

Kansas State Board of Nursing License Verification – https://www.kansas.gov/ksbn-verifications/
Kansas Board of Healing Arts-License and Registrant Profile Search – http://www.ksbha.org/requests/licenseverification.shtml
Kansas Nurse Aide Registry – https://ksdhe.glsuite.us/glsuiteweb/Clients/KSDHE/public/main.html
Kansas State Board of Pharmacy License Search – https://ksbop.elicensesoftware.com/portal.aspx
Kansas Department of Aging and Disability License Search – https://ksdhe.glsuite.us/glsuiteweb/Clients/KSDHE/Public/Verification/LicVerification.aspx

F. STATE SPECIFIC WORKPLACE SEXUAL HARASSMENT PREVENTION TRAINING

State/City	Covered Employers	Covered Employees	What
California	Effective, January 1, 2019, the law applies to California employers with 5 or more employees **(used to be 50)**.	By January 1, 2020, employers must provide required training to all supervisory and nonsupervisory employees within six months of employment or assuming a supervisory position. Beginning January 1, 2020, employers must provide training for: ● Seasonal and temporary employees or any employee hired to work for less than six months, within 30 calendar days of hire or within 100 hours worked, whichever occurs first (except for those employed by a temporary services employer that must provide the training), and ● Migrant and seasonal agricultural workers.	SB 1343 requires covered employers to provide at least 2 hours of sexual harassment prevention training and education to all supervisory employees and at least 1 hour of such training to all non-supervisory employees in California, by January 1, 2020. Training and education must be provided once every two years thereafter, as specified under the new law. See Senate Bill No. 1343, amending Cal. Gov. Code sections 12950 and 12950.1.
Connecticut	Connecticut's law covers employers with 50 or more employees for a minimum of 13 weeks the previous training year.	Connecticut's law covers employers with 50 or more employees for a minimum of 13 weeks the previous training year.	Since 1993, Connecticut employers with 50 or more employees must provide 2 hours of interactive sexual harassment prevention training and education to all supervisory employees. See Conn. Gen. Stat. § 46a-54(15)(A) and Conn. Agencies Regs. § 46a-54-204).

Delaware	Effective Jan 1, 2019, employers with at least 50 employees in Delaware must provide "interactive training and education to employees regarding the prevention of sexual harassment." It also obligates employers (with 4 or more employees) to issue an information sheet on sexual harassment.	All employees: • Within one year of beginning employment for new employees. • Within one year of the law's effective date for existing employees. Employers are not required to provide training to: • Applicants. • Independent contractors. • Employees employed less than six months continuously. • Employees employed by employment agencies (the employment agency is responsible for training their employees).	Interactive training must be conducted for new employees within one year of the commencement of their employment. Existing employees must receive sexual harassment training within one year of the effective date of the statute (that is, by January 1, 2020). New supervisors must receive additional interactive training within one year of the commencement of their employment in a supervisory role. Existing supervisors must receive training by January 1, 2020. See HB360
Maine	Applies to all workplaces with 15 or more employees.	All new employees within one year of beginning employment. There are additional requirements for supervisory and managerial employees within one year of beginning employment.	Employers shall conduct additional training for supervisory and managerial employees within one year of commencement of employment that includes, at a minimum, the specific responsibilities of supervisory and managerial employees and methods that these employees must take to ensure immediate and appropriate corrective action in addressing sexual harassment complaints. See Me. Rev. Stat. Ann. tit. 26, § 807(3)).

New York State	New York's training laws apply to all employers regardless of size.	The training requirements apply to all employees working any portion of their time in New York, even if they're based in another state.	Effective immediately, New York employers must: (i) implement the State's model sexual harassment prevention policy, or create their own sexual harassment prevention policy that meets or exceeds certain minimum standards; (ii) make a complaint form available for employees to report sexual harassment; and (iii) conduct interactive sexual harassment prevention training annually, either using the state's model training materials or another program that meets the training requirements. Training must be completed for **all** employees **every** year. See New York (N.Y. Lab. Law § 201-g). model sexual harassment prevention policy minimum standards complaint form training requirements
New York City	Employers with 15 or more employees in the previous calendar year. Independent contractors count toward this threshold.	All employees, including interns, within New York City working more than 80 hours in a calendar year and have worked for at least 90 days. Employers must also train independent contractors that: • Have performed work in the furtherance of the business for more than 90 days and more than 80 hours in a calendar year. • Have not already received the mandated annual training elsewhere.	Interactive training is required annually. See (NYC Admin. Code § 8-102(30) (effective Apr. 1, 201

NEW JERSEY REQUIREMENTS

BOARD OF NURSING MANDATORY REPORTING GUIDELINES

"PEGGY'S LAW"

HEALTHCARE PROFESSIONAL RESPONSIBILITY AND REPORTING ENHANCEMENT ACT

PATIENT SAFETY ACT

WORKPLACE VIOLENCE PREVENTION

SAFE PATIENT HANDLING POLICY

- SAFE PATIENT HANDLING ASSESSMENT FORM

OPPORTUNITY TO COMPETE ACT "BAN THE BOX" LAW

EMPLOYMENT VERIFICATION FORM

BOARD OF NURSING
MANDATORY REPORTING GUIDELINES
New Jersey

POLICY

Company will appropriately assess nursing conduct and infractions to determine whether such conduct must be reported to the NJ Board of Nursing in accordance with the New Jersey Board of Nursing Mandatory Reporting Guidelines.

PROCEDURE

WHAT MUST BE REPORTED?

Level I – Conduct always required to be reported to the Board of Nursing:

1. Conduct that clearly violates expected standards of care and may result in various degrees of harm.
2. Conduct that demonstrates a pattern of poor judgment or skill.

Level II – Conduct that, depending on an analysis of the facts, may require reporting to the Board of Nursing:

1. Conduct that may be indicative of a more serious problem should be reported.
   A. Note: There is no list of what should or should not be reported under this category. It is a matter of judgment for the person(s) making the report, based upon a review of all the relevant factors.

Level III – Conduct that does not require reporting to the Board of Nursing:

1. Low level infractions that do not involve patient care, professional judgment, or wrongdoing.

WHO MUST REPORT?

1. All licensed nurses have an affirmative obligation to report suspected violations of the Nurse Practice Act and the Uniform Enforcement Act to the Board of Nursing.
   A. The highest nursing officer generally has the responsibility for reporting violations to the Board. Additionally, the Director of Security, the Director of Human Resources, and the Risk Manager may also file complaints.
   B. If the facility or agency administrators refuse or delay a report, staff nurses or nurse managers have a duty to report to the Board.

2. Consumers/residents, families of consumers/residents, the Ombudsman for the Institutionalized Elderly, the Department of Health and Senior Services, and the Criminal Authorities also may submit claims to the Board.

HOW MUST A REPORT BE MADE?

1. Initial Reports to the Board of Nursing Must:
   A. Be in writing.
   B. Contain basic information regarding the "who, what, where, why, and how" of the incident.
   C. Contain the name of a contact person and a telephone number and address where he/she can be reached during business hours.

2. All Persons Making a Report to the Board of Nursing Must Be Prepared To:
   A. Provide legible copies of all relevant records, materials, and information as requested by the Board representative.
   B. Speak with the Board's representative by telephone, in writing, or in person.
   C. Assist the Board's representative in gaining access to all relevant information, witnesses, or other persons.
   D. Agree to appear before the Board if necessary.
      i. Board's representative includes any one of the following individuals:
         a. The Board's executive director
         b. Paralegals
         c. Deputy attorneys general
         d. Enforcement Bureau investigators

TO WHERE MUST A REPORT BE MADE?

All letters of complaint must be made to:

Board of Nursing
P.O. Box 45010
124 Halsey Street, Sixth Floor
Newark, NJ 07101
Telephone Number: (973) 504-6457

Emergent complaints of drug diversion or sexual abuse may be made by telephone to the:

1. Board of Nursing at (973) 504-6457
2. Deputy Attorney General at (973) 648-7093
3. Enforcement Bureau of the Division of Consumer Affairs at (973) 504-6300

"Peggy's Law"
New Jersey

(N.J. Stats. § 52.27G-7; §52.27G-7.1; §52:27G-11)

POLICY

"Peggy's Law" is a New Jersey law, effective October 6, 2017 and amending NJ Rev Stat § 52:27G-7.1 together with §52.27G-7 and §52:27G-11. It requires any caretaker, social worker, physician, registered or licensed practical nurse, or other professional or staff member employed at a facility, and any representative of a managed care entity, who, as a result of information obtained in the course of that individual's employment, has reasonable cause to suspect or believe that an institutionalized elderly person is being or has been abused or exploited, to report such information to the Ombudsman or to the person designated by the Ombudsman to receive such report. If an individual reporting suspected abuse or exploitation has reasonable cause to suspect or believe that the institutionalized elderly person is or has been the victim of a crime, the individual shall additionally report such information to the local law enforcement agency and to the health administrator of the facility. Peggy's Law requires the Office of the Ombudsman to maintain a 24 hour, 7 day a week system to receive complaints.

PROCEDURE

1. Any caretaker, social worker, physician, registered or licensed practical nurse, or other professional or staff member employed at a facility and any representative of a managed care entity ("reporting individual") who, as a result of information obtained in the course of employment has reasonable cause to suspect or believe that an institutionalized elderly person is being or has been abused or exploited shall report such information immediately to the Ombudsman. If a reporting individual suspects or believes that the institutionalized elderly person is or has been the victim of a crime, the reporting individual **shall additionally report such information to the local law enforcement agency and to the health administrator of the facility**.
    a. If the events that cause the suspicion or belief result in serious bodily injury, the individual shall report the suspicion or belief immediately, but not later than two hours after forming the suspicion or belief.
    b. If the events that cause the suspicion or belief do not result in serious bodily injury, the individual shall report the suspicion or belief immediately, but not later than 24 hours after forming the suspicion or belief.
2. Such report shall contain the name and address of the elderly person, information regarding the nature of the suspected abuse or exploitation and any other information which might be helpful in an investigation of the case and the protection of such elderly person.
3. The name of any person who reports suspected abuse or exploitation pursuant to this act shall not be disclosed, unless the person who reported the abuse or exploitation specifically requests such disclosure or a judicial proceeding results from such report.
4. Any person who reports suspected abuse or exploitation pursuant to this act or who testifies in any administrative or judicial proceeding arising from such report or testimony shall have

immunity from any civil or criminal liability on account of such report or testimony, unless such person has acted in bad faith or with malicious purpose.

5. The Office of the Ombudsman is required to provide a complaint reporting system that is active and in effect 24 hours a day, seven days per week.
6. Any person required to report suspected abuse or exploitation pursuant to this act who fails to make such report shall be fined not more than $500, and the facility employing the individual shall be fined
7. When a person has been penalized under this section, a letter making note of the penalty shall immediately be sent by the court to the licensing authority or the professional board, if any, having jurisdiction over the person who has been penalized.
8. The Office of the Ombudsman provides on its website links to written notices/posters in English, Spanish and other languages, setting forth the address and telephone number for the office and a brief explanation of the function of the office and the procedure to follow in filing a complaint. These can be found and downloaded at http://www.state.nj.us/ooie/publications.shtml#.
   a. The administrator of the facility is required to ensure that such written notice is given to every patient, resident, or client or the patient's, resident's, or client's guardian upon admission and to every person already in residence or the person's guardian in a format and language that the recipient understands.
   b. The administrator is required to ensure that such written notice is posted in public areas in the facility.
9. The administrator of the facility MUST provide a copy of this policy ("Peggy's Law Policy") **annually** to all employees, caretakers, social workers, physicians, registered or licensed practical nurses and other professionals employed by the facility ("staff") explaining the requirements of this law concerning the reporting of suspected abuse or exploitation of an institutionalized elderly person.
   a. All "staff" must sign receipt of the annual notice as a condition of continued employment.
   b. The signed receipt shall be retained in the "staff's" personnel file.

Receipt of Policy

I, _____, acknowledge that I received a copy of the attached policy regarding NJ Peggy's Law.

_____
Date

_____
Employee Signature

_____
Employee Name (Print)

HEALTHCARE PROFESSIONAL RESPONSIBILITY AND REPORTING ENHANCEMENT ACT

New Jersey

*For the official language of, and forms pertaining to, this Act, please click the title of this Act to be redirected to the NJ Division of Consumer Affairs website.

PATIENT SAFETY ACT
NEW JERSEY

NJAC 26:2H-12.23
NJAC 8:43E-10.11

PURPOSE

To ensure The Company remains consistent with applicable legal requirements and standards of practice.

POLICY

Pursuant to the New Jersey Patient Safety Act, The Company is committed to increasing the safety of our residents by reducing the frequency and severity of preventable adverse events.

The Patient Safety Act applies to both sub-acute residents and long term care residents.

PROCEDURE

PATIENT SAFETY COMMITTEE

The Company shall establish a Patient Safety Committee.

1. The Patient Safety Committee shall be comprised of at least the following individuals:
   A. A chairperson appointed by the chief executive officer (CEO) or administrator of The Company.
      i. For all matters related to the Patient Safety Committee, the chairperson of the Patient Safety Committee shall report directly to the CEO or other administrative head of The Company.
   B. The medical director, or the medical director's designee, who must also be a physician.
   C. The director of nursing of The Company, or the designee of the director of nursing, who must also be a nurse.
   D. The Compliance and Ethics Officer, another employee of The Company exercising primary responsibility for monitoring adverse events within The Company, or the Compliance and Ethics Officer's designee.
   E. The chairperson of the Patient Safety Committee shall also select ad hoc members for the Patient Safety Committee, based on the relevance of their job responsibilities and professional experience, to conduct a root cause analysis of a specific adverse event or near-miss under investigation.

2. In the case of a company that is part of a healthcare system that owns or operates multiple New Jersey facilities, the Patient Safety Committee may be operated at the system level, provided the following conditions are met:
   A. There is a representative from each New Jersey-licensed company on the committee.

B. The system Patient Safety Committee ensures that each company's data related to patient safety remains distinctly identifiable.

3. The Patient Safety Committee shall not constitute a subcommittee of any other committee within The Company.

4. The Patient Safety Committee shall meet at least quarterly but may meet on a more frequent basis as needed and determined by the committee.

5. The Patient Safety Committee shall document the proceedings of each meeting in the minutes, which shall contain, at a minimum, the following:
   A. The date and time of the meeting.
   B. The attendees at the meeting.
   C. A brief description of the issues discussed.
   D. The recommendations made by the committee.
   E. An evaluation of the effectiveness/outcome of previous committee recommendations.

6. The Patient Safety Committee shall perform the following activities:
   A. Develop a written patient safety plan for The Company.
   B. Review and revise, if appropriate, the patient safety plan as often as the committee deems necessary, but at least once every three years.
   C. Foster attitudes, beliefs, and behaviors supporting open communication within the company about adverse events and near-misses by developing and implementing a training program for all professional and direct patient care employees and medical staff, enabling them to recognize and report to the Patient Safety Committee all serious preventable adverse events, as well as other adverse events and near-misses.
   D. Develop and recommend implementation of measures to minimize the risk of preventable adverse events.
   E. Review developments in evidence-based patient safety practices appropriate to the services offered within The Company and recommend appropriate modification of company policies and procedures to enhance patient safety.
   F. Assemble an appropriate team to conduct a root cause analysis of near-misses and adverse events that occur within The Company and conduct a root cause analysis of every serious preventable adverse event.
      i. Facilities may assemble a team and/or retain a consultant to perform the root cause analysis.
      ii. The Patient Safety Committee shall review the results of each root cause analysis and, as appropriate, recommend the modification of company systems, technology, policies or procedures to enhance patient safety.
   G. Analyze, on a quarterly basis, the aggregated data in the internal company-specific tracking system to determine patterns of similar problems or events, which may otherwise not be detected by the Patient Safety Committee, in order to identify problems or events appropriate for further analysis.
   H. Document whether The Company accepted, rejected, or modified the recommendations of the Patient Safety Committee for modifications in company policies or procedures.

i. In the case of rejection or modification of a recommendation, the Patient Safety Committee shall ensure that the documentation includes the rationale for the action taken.

I. Monitor modified policies and procedures after implementation to determine the impact of the revised policies.

PATIENT SAFETY PLAN

The Company's Patient Safety Committee shall develop, implement, and comply with a patient safety plan that includes the following elements:

1. A process for company staff to follow in reporting preventable adverse events and near-misses to the Patient Safety Committee.
   A. The reporting system established by The Company shall be accessible to company staff at all times The Company is operating.

2. A process for conducting ongoing review and application of evidence-based patient safety practices in order to reduce the probability of preventable adverse events.

3. A process for the Patient Safety Committee to conduct root cause analyses of all serious preventable adverse events, adverse events, and near-misses.

4. A process for monitoring the impact of changes recommended by the Patient Safety Committee and implemented by The Company.

5. Policies and procedures for providing ongoing training for company personnel, including professional and direct patient care employees and medical staff, as to the requirements of The Company's policies and procedures for assuring patient safety.
   A. Current employees and staff shall undergo such training no later than one (1) year following the operative date of this policy.

   B. New employees and staff shall undergo such training during the employee orientation.

   C. The policies and procedures shall include a method for The Company to document that personnel have completed the required training.

The processes, policies, and procedures established shall not eliminate or lessen a company's obligation under applicable Federal Medicare Conditions of Participation to implement and maintain a continuous quality improvement program.

Investigation and analysis, as well as the recommendation and monitoring of the implementation of related corrective actions, of preventable adverse events and near-misses shall fall within the jurisdiction of the patient safety program rather than the continuous quality improvement program.

REPORTING REQUIREMENTS UNDER THE PATIENT SAFETY ACT

The Company is required to report to the Department of Health and Senior Services every serious preventable adverse event that occurs in The Company.

The Company is encouraged to report near-misses, preventable events and adverse events that are not subject to mandatory reporting.

DISCLOSURE TO PATIENT

A healthcare company shall ensure that a patient or, in the case of a minor or incompetent adult, the patient's personal representative, guardian, parent, or other family member, as appropriate, and provided disclosure is permissible under applicable confidentiality law, is informed of the following:

1. Any serious preventable adverse event that affected the patient.

2. Any adverse event resulting from an allergic reaction that was not previously documented in the patient's medical history.
   A. In the case of an allergic reaction, a company shall arrange that the patient be informed of other circumstances, if known, in which the same allergic reaction might occur, and of known preventive measures, if any, and shall arrange that the patient be advised to inform any healthcare professionals providing future care of the allergic reaction.
   B. The patient or, in the case of a minor or incompetent adult, the patient's personal representative, guardian, parent, or other family member, as appropriate, shall be informed of the event or allergic reaction in the following manner:
      i. In person, if the patient is still in The Company.
      ii. By telephone, if the patient has left The Company and The Company is unable to arrange a face-to-face meeting.
      iii. By certified mail, if The Company is unable to contact the patient by telephone.

The patient's attending physician, The Company administrator, The Company's medical director or another healthcare professional authorized in accordance with company policies shall make the disclosure within twenty-four (24) hours of the time The Company discovers the event.

If the patient's attending physician determines that informing the patient of the event would seriously and adversely affect the health of a patient who is a competent adult, then The Company shall ensure that the attending physician, The Company administrator, The Company's medical director, or another healthcare professional authorized in accordance with company policies informs a family member of the event, if a family member is available and can be so informed without violating any applicable confidentiality or privacy law.

1. In selecting a family member to whom to make the disclosure required, The Company shall accord first preference to a spouse, a partner in a civil union, or a domestic partner, then to adult children or parents, and then to siblings.

2. The Company shall ensure that the attending physician documents in the patient's medical record the basis of the determination that disclosure of the adverse event to the patient would seriously and adversely affect the patient's health.

3. The Company shall ensure that information concerning the serious preventable adverse event or allergic reaction is not disclosed to a family member who is not the guardian or who does not have a medical power of attorney, if the patient has prohibited disclosure of his or her protected health information to any family members.

In disclosing information, The Company shall ensure that the following information is recorded in the patient's medical record:

1. The time, date, and individuals present when the disclosure was made, and the person to whom the disclosure was made.

2. A statement that the occurrence of a serious preventable adverse event or adverse event related to an allergic reaction, as applicable, was disclosed.

The Company may request written acknowledgement from the patient, or the patient's parent, guardian, or family member, as applicable, that the patient or family member received information about the serious preventable adverse event or an allergic reaction.

1. If a company requests written acknowledgment, The Company shall advise the patient, or the patient's parent, guardian, or family member, as applicable, that signing the acknowledgement is voluntary and in no way constitutes either a release from liability by the patient or an admission of liability on the part of the physician or healthcare company.
   A. The Company shall provide this advice orally at the time it makes the request, and the acknowledgment form shall state at the beginning, in easily readable print, that signing the acknowledgement is voluntary and in no way constitutes either a release from liability by the patient or an admission of liability on the part of the physician or healthcare company.

The patient's medical record shall be available to the patient upon request, subject to discovery, and admissible as evidence or otherwise disclosed in a civil, criminal, or administrative action or proceeding.

CONFIDENTIALITY PROTECTIONS AND RESTRICTIONS ON DISCLOSURE AND USE

1. If information submitted to or developed by the Patient Safety Committee provides a reasonable basis for the healthcare company to take disciplinary action against a healthcare professional in a case in which the professional has displayed recklessness, gross negligence or willful misconduct or where there is evidence, based on similar cases known to The Company, of a pattern of significant substandard performance that resulted in serious preventable adverse events, The Company must do so.

2. If information submitted to or developed by the Patient Safety Committee provides a reasonable basis to suspect criminal behavior on the part of anyone employed by, on the medical staff

of, or acting as an agent of, a healthcare company, The Company shall report such information to the appropriate police authorities.

3. The Patient Safety Committee may release de-identified aggregate trend data on preventable adverse events and near-misses, and a company may file reports, analyses or plans to the reporter of such information, the Patient Safety Committee and the underlying data.

REPORTING REQUIREMENTS UNRELATED TO THE PATIENT SAFETY ACT

1. A healthcare company shall immediately report to the appropriate police authorities all criminal acts or potentially criminal acts that occur within a company and pose a danger to the life or safety of residents, employees, medical staff, or members of the public present in The Company.

2. A licensed company shall notify the Department of Health and Senior Services immediately of the types of events reportable described below.
   A. The Department of Health and Senior Services anticipates the development of an Internet web-based electronic reporting system but shall, in the interim, require facilities to submit the notice required as outlined above by means of telephone, facsimile, or email, or a combination thereof.
      i. The Department of Health and Senior Services shall provide notice to facilities on the reporting medium to be used, including telephone and facsimile numbers, email addresses and/or web addresses.
   B. In the case of acute care facilities, 'immediately' means no later than three hours after discovery of the event.
   C. In the case of long-term care facilities, "immediately" means telephonic notification to the Department of Health and Senior Services at (609) 392-2020, followed by written notification within 72 hours.

3. Examples of reportable events in the nature of physical plant and operational interruptions include, but are not limited to, the following:
   A. Loss of heat or air conditioning.
   B. Loss or significant reduction of water, electrical power, or any other essential utilities necessary to the operation of The Company.
   C. Fires, disasters, or accidents that result in injury or death of residents or employees, or in evacuation of residents from all or part of The Company.
   D. A labor stoppage or staffing shortage sufficient to require the temporary closure of a service.
   E. Notices of a potential strike that a company receives from an employee bargaining unit.
      i. The report shall be accompanied by The Company's plan to continue service operations in the event the strike occurs.
      ii. Such a plan shall be considered proprietary, emergency and/or security information and therefore shall not be considered a 'government record' subject to public access or inspection.
      iii. In the event the strike is either averted or settled, the Department of Health and Senior Services shall destroy all copies it has received of The Company's strike plan.

4. Examples of reportable events in the nature of potentially criminal acts include, but are not limited to, the following:
   A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
   B. Abduction of a patient of any age.
   C. Sexual assault on a patient, staff member, or visitor within or on the grounds of a company.
   D. Death or significant injury of a patient, staff member, or visitor resulting from a physical assault that occurs within or on the grounds of The Company.

5. A healthcare company shall report incidents of infectious and communicable diseases to the Department of Health and Senior Services.

DEFINITIONS

The following words and terms shall have the following meanings, unless the context clearly indicates otherwise:

1. "Adverse event" means an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

2. "Allergic reaction" means an abnormal immune response to a substance or allergen that does not normally cause a reaction and that results in a broad range of inflammatory responses.
   A. Allergies are caused by inherited sensitivity or sensitivity acquired over time to a foreign substance.
   B. Immediate reactions may be local, such as urticaria, angioedema, or systemic, such as severe bronchial obstruction, vasodilation, pulmonary edema, and shock.

3. "Covered individual" means anyone who is an owner, operator, employee, manager, agent, or contractor of a long-term care company.

4. "Criminal sexual abuse" shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law.

5. "Disability" means a physical or mental impairment that substantially limits one or more major life activities of an individual.
   A. A physical impairment is any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic, lymphatic, skin, and endocrine.
   B. A mental impairment is any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

6. "Event" means a discrete, auditable, and clearly defined occurrence.

7. "Healthcare company" or "company" means a licensed healthcare company.

8. “Healthcare professional” means an individual who, acting within the scope of her or his licensure or certification, provides healthcare services, and includes, but is not limited to, a physician, dentist, nurse, pharmacist or other healthcare professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes.

9. “Healthcare system” means a licensed healthcare provider or entity that either owns and operates more than one licensed company within the State or can document operational control over more than one licensed company within the State, but is not a management company.

10. “Medical device” or “device” means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar article that is intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease.

11. “Medicare and/or Medicaid nursing homes” means a long-term care company participating in Title XVIII (Medicare) and/or Title XIX (Medicaid) programs of the Federal Social Security Act.

12. “Near-miss” means an occurrence that could have resulted in an adverse event, but the adverse event was prevented.

13. “Preventable event” means an event that could have been anticipated and prepared against, but occurs because of an error or other system failure.

14. “Root cause analysis” or “RCA” means an in-depth analysis of a preventable adverse event that is designed to identify both direct and underlying causes of the event, in order to develop corrective actions that could reduce the potential for similar preventable adverse events in the future.

15. “Serious bodily injury” means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

16. “Serious preventable adverse event” means an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a healthcare company.

17. “Surgery” means an invasive operative procedure in which skin or mucous membranes and connective tissue is resected, including minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar.
    A. “Surgery” includes a range of dermatological procedures including biopsy, excision and deep cryotherapy for malignant lesions to extensive multi-organ transplant.
    B. Surgery begins at point of surgical incision, tissue puncture, or insertion of an instrument into tissues, cavities or organs.

C. Surgery ends after the surgical incision has been closed and operative devices, such as probes, have been removed and counts have concluded, regardless of setting (recovery room or surgical suite.)

WORKPLACE VIOLENCE PREVENTION

New Jersey

NJ Stat 26:2H-5.20
NJAC 8:43E-11.3

POLICY

Pursuant to the New Jersey Violence Prevention in Health Care Facilities Act, Company will have a Workplace Violence Prevention Program that will be accessible to all employees and a copy will be provided upon request.

Company:

1. Is committed to employees' safety and health;

2. Will provide adequate authority and budgetary resources to responsible parties so that identified goals and assigned responsibilities can be met;

3. Includes and encourages employee participation in the design and implementation of its workplace violence prevention program;

4. Refuses to tolerate violence at the workplace and has developed and implemented a program to reduce incidents of violence;

5. Applies workplace violence policies consistently and fairly to all employees, including supervisors and managers;

6. Requires prompt and accurate reporting of violent incidents, whether or not physical injury has occurred;

7. Will not retaliate against victims of workplace violence.

PROCEDURE

1. Company shall establish a Violence Prevention Committee.

    A. The Violence Prevention Committee shall include a representative of management who shall serve as the Violence Prevention Officer and be responsible for overseeing all aspects of the program. He/She shall also chair the committee.
    B. At least 50% of the committee members shall be healthcare workers who provide direct resident care or otherwise have direct contact with residents.
        i. If healthcare workers are represented by one or more collective bargaining agents, the management of the facility or system shall consult with the applicable collective bargaining agents regarding the selection of the healthcare worker committee members.

C. The remaining committee members shall have experience, expertise, or responsibility relevant to violence prevention.
D. If Company owns or operates more than one covered healthcare facility, the violence prevention program and the committee may be operated at the system or department level, provided that:
    i. Committee membership includes at least one healthcare worker from each facility who provides direct care to residents;
    ii. The committee develops a violence prevention plan for each facility; and
    iii. Data related to violence prevention remain distinctly identifiable for each facility.

2. The Violence Prevention Committee shall, at a minimum:

A. Meet quarterly to review reports of violent incidents. The Committee shall make any appropriate adjustments to the violence prevention plan.
B. Develop a detailed, written violence prevention plan that identifies and outlines violence prevention policies, procedures, and responsibilities.
    i. The plan shall, at a minimum, describe the following:
        a. The establishment of a violence prevention committee;
        b. The facility's violence prevention policies;
        c. The recordkeeping process;
        d. Incident reporting, investigation, and evaluation methods;
        e. Available resources for follow-up medical and psychological care, which may include support groups, family crisis intervention, and professional referrals; and
        f. How employees shall access a post-incident response system.
    ii. The plan shall require an annual comprehensive violence risk assessment.
    iii. The plan shall identify methods to reduce identified risks, including, at a minimum: facility modifications, changes to equipment, job design, staffing and security, and revision of violence prevention training content.
    iv. The plan shall be updated and submitted to the facility administration annually.
C. Conduct an annual comprehensive violence risk assessment (See Policy *SM 1.2 A: Risk Assessment Report*) for Company that shall review:
    i. OSHA's 2004 Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (OSHA 3148-2004);
        a. The facility shall conduct a job task analysis in collaboration with and for each healthcare worker that shall be used by the violence prevention committee to identify improved security measures and controls based on potential risk factors – including, but not limited to, working with unstable or volatile persons, prevalence of weapons on site, presence of gang members – for violent incidents.
    ii. impact of staffing, including security personnel, if applicable;
    iii. the presence of hazards, conditions, operations, and situations which might place workers at risk of occupational assault incident
    iv. the presence of individuals who may pose a risk of violence; and
    v. a review of any records relating to violent incidents at the facility (See *Appendix SM 1.2 A: Violence Incident Report Form*), including incidents required to be reported pursuant to the Occupational Safety and Health Administration Log of Work-Related Injuries and Illnesses (OSHA Form 300), and workers' compensation records

D. At least two (2) members of the violence prevention committee, at least one (1) of whom is a direct care staff member, shall conduct walk through surveys of all worksite areas at least once annually, and as needed, to identify existing or potential physical environmental risk factors for workplace violence.
   i. Such risk factors shall include, at a minimum, the facility's layout, access restrictions, crime rate in surrounding areas, lighting, and communication and alarm devices (See Policy *SM 2.0: Security Inspection and Analysis*).
   ii. The results from the walk through shall be discussed and analyzed during the annual comprehensive violence risk assessment.

E. Develop and annually review, evaluate, and revise the content of violence prevention training.
   i. The training shall be at least two (2) hours in duration and shall be held during paid work time.
      a. Company shall provide interim training for individuals who begin work between annual training sessions.
   ii. The training methods shall include, but not be limited to, at least two (2) of the following: handouts, presentations, discussion, role playing, and DVD or computer-based training activities.
   iii. All employees, regardless of their title or level of risk, should receive training to include, at a minimum:
      a. A review and definition of workplace violence;
      b. A full explanation and full description of the program;
      c. Techniques to de-escalate and minimize violent behavior;
      d. Appropriate responses to workplace violence, including the use of restraining techniques;
      e. Reporting requirements and procedures;
      f. Location and operation of safety devices;
      g. Resources for coping with violence;
      h. A summary and analysis of the facility's risk factors, identified in the violence risk assessment, and preventative actions taken in response to the identified risk factors;
      i. Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences; and
      j. Assurance that Company will not take any retaliatory action for reporting any threat or violent incident.

In addition, employees with job tasks or locations that place them at higher risk for violent incidents should be provided specialized training in addition to those topics outlined above. Training shall be designed to deal with the nature of this risk. Managers and supervisors shall undergo the training outlined thus far plus additional training to enable them to recognize a potentially hazardous situation and to make necessary changes in the physical facility, resident care treatment program, and staffing policy and procedures to reduce security hazards.

Managers and supervisors shall also be trained to ensure that employees are not placed in assignments that compromise safety and how to behave compassionately towards coworkers when an incident does occur.

Security personnel, if any, shall receive training regarding the facility layout, security hardware on premises, and particular high-risk jobs.

All training records shall be filed with the Human Resource Department/Personnel Department.

F. Develop strategies for encouraging the reporting of all incidents of workplace violence and procedures for reporting such incidents;

G. Review de-identified, aggregated data that has been compiled from incident investigation reports by the appropriate department in order to identify trends and, if needed, to make recommendations to prevent similar incidents.

3. Company shall make a copy of the plan available, upon request, to the Commissioners of Health and Senior Services, and Human Services for on-site inspection to each healthcare worker and collective bargaining agent that represents healthcare workers at the facility.
   A. In the event that the committee determines that the plan contains information that would pose a threat to security if made public, any such information shall be excluded before providing copies to workers or collective bargaining agents.

4. Company shall implement prevention and control measures to counteract the risk factors identified by the risk assessment, including, at a minimum:
   A. lighting indoors and in parking lots;
   B. the installation, as necessary, and maintenance of items including alarm systems, closed circuit TVs, metal detection systems, cell phones, personal alarm devices, codes, panic alarms, and audio surveillance systems;
   C. assigning and training appropriate personnel to respect to each alarm system;
   D. the training and posting of security personnel in emergency departments, psychiatric wards, and in other locations, as needed; and
   E. controlled access, as needed, to staff offices and employee work areas.

5. Company shall have personnel sufficiently trained to identify aggressive and violent predicting factors and the ability to appropriately respond to and manage violent disturbances. The following guidelines will be issued to all personnel:
   A. If an incident is an emergency, follow Company's Emergency Management Plan and Chain of Command.
   B. Once an incident occurs, the Violence Prevention Officer and/or designee should, if warranted:
      i. Report the incident to the local police department.
      ii. Secure work areas where the disturbance occurred.
      iii. Ensure the physical safety of employees and others remaining in the area as soon as possible.

iv. Ensure that no work area is left short-staffed while others assist the victim or help in securing the area.
v. Quickly assess the work area, if it was disturbed or damaged during an incident to determine if it is safe.
vi. Provide critical incident debriefing to victims, witnesses, and other affected employees; these conversations must be strictly confidential.

C. An Incident Report (See *Appendix SM 1.2 A: Violence Incident Report Form*) shall be completed for any type of violent incident, whether or not physical injury has occurred (i.e. verbal abuse, threats of violence, menacing, etc.). Issues of confidentiality shall be taken into account.
   i. The record shall be analyzed to determine changes needed to prevent the reoccurrence of violence in the workplace and to determine required training.
   ii. Company shall provide the Department of Health and Senior Services with immediate access to the records and any de-identified and/or aggregated data.
   iii. An employee and/or his/her authorized representatives shall have access to the employee's identifiable records and to de-identified and/or aggregated data within two (2) business days.

D. The incident report shall initially be assessed by the Violence Prevention Officer.

E. Company shall provide written, de-identified incident investigation reports to the Violence Prevention Committee.
   i. After reviewing the de-identified incident reports, Company, in collaboration with the Violence Prevention Committee, shall encourage appropriate follow-up, consider changes in procedures, and add elements to training as needed.
   ii. Appropriate revisions shall be made to the violence action plan. All revisions shall be put into writing and notification shall be given to all employees.
   iii. The Violence Prevention Committee shall decide if and when the de-identified data shall be aggregated.

F. Company shall ensure that prompt and appropriate medical care is provided to healthcare workers injured during an incident.
   i. In addition, Company shall establish a post-incident response system that provides, at a minimum, an in-house crisis response team for employee-victims and their coworkers, and individual and group crisis counseling, which may include support groups, family crisis intervention, and professional referrals.
   ii. Company shall ensure that provisions for medical confidentiality and protection from discrimination is be included in facility policies and procedures to prevent victims from suffering further loss.

6. Company shall keep a record of all violent acts against employees while at work. The records shall be maintained for at least five (5) years following the reported act, during which time employees, their authorized representatives, and the Department of Health and Senior Services shall have access to the record. The records shall include:
   A. OSHA 300 Log – OSHA regulations require entry on the Injury and Illness log of any injury which requires more than first aid, causes loss of consciousness, requires modified duty, or results in lost time from work. Assaults shall be entered on the log. Doctors' reports of work injury and supervisors' reports shall be kept of each recorded assault. Fatalities or catastrophes must be reported to OSHA.

B. NJOSH 300 (Delete if non-NJ)
C. Employee deaths – resulting from an employment accident or illness caused by or related to a workplace hazard or the hospitalization (not examination and release) of three (3) or more employees resulting from an employment accident or illness caused by a workplace hazard must be orally reported by the employer within eight (8) hours.
D. Incidents of assaults – shall describe who was assaulted, the type of activity, (i.e. unprovoked sudden attack), and all other circumstances of the incident. The records should include a description of the location/environment, potential or actual costs, lost time, nature of injuries sustained, etc. (See *Appendix SM 1.2 A: Violence Incident Report Form*).
E. Incidents of abuse, verbal attacks or aggressive behavior – any acts of aggression shall be recorded; they may be threatening to the worker, but may not result in injury (i.e. pushing or shouting). These records may be assault incident reports that are evaluated routinely by the Violence Prevention Committee. (See *Appendix SM 1.2 A: Violence Incident Report Form*).
F. Other Accident Investigation Reports
G. Minutes of safety meetings and inspection reports – shall include corrective actions recommended relative to workplace violence and Company's response and completion dates for action items. Minutes of the Violence Prevention Committee meetings shall be kept for three (3) years.
H. Training records – shall include dates on which training was conducted, type of training given, employees trained, etc. Records of training program contents, and the sign-in sheets of all attendees, shall be kept for five (5) years. Qualifications of the trainers shall be maintained along with the training records.
I. Inspection records – shall include dates of inspection, areas inspected, all findings and recommendations, any control measures implemented, etc. (See attached Security Inspection and Analysis).
J. Employee questionnaires/surveys – that assess their views of high-risk work areas and activities. (See attached Review of Tasks & Employee Surveys and Employee Survey).
K. Staff termination records
L. Union grievances and complaints
M. Police Reports
N. Insurance records
O. Workers' Compensation Records
P. Medical records

ENFORCEMENT

Company has a zero-tolerance policy for violence. If an employee engages in any violence in the workplace, or threatens violence in the workplace, he/she may be terminated immediately for cause. No talk of violence or joking about violence will be tolerated.

In an effort to fulfill this commitment to a safe work environment for employees, residents, and visitors:
1. All employees must display company identification.
2. All visitors must register and display identification while on the property.

3. Company specifically prohibits the possession of weapons by any employee while on company property unless authorized for security personnel. Employees are also prohibited from carrying a weapon while performing services off The Company premises. Appropriate disciplinary action, up to and including termination, will be taken against any employee who violates this policy.
4. Desks, telephones, and computers are the property of Company. Company reserves the right to enter or inspect employees' work area including, but not limited to, desks, email, and computer storage disks, with or without notice.
5. Any private conversations overheard or transmitted via telephone, electronic communication, mail, or fax on facility premises that constitute threats against other individuals can and will be used as the basis for termination for cause.
6. Employees are encouraged to report any incident that may involve a violation of any of the policies that are designed to provide a comfortable workplace environment. Any concerns may be presented to employees' immediate supervisor and/or the Compliance and Ethics Officer. All reports will be investigated and information will be kept confidential.

ANTI-RETALIATION

Company shall not take any retaliatory action against any healthcare worker for reporting violent incidents. Thus, an employee shall not be discharged, suspended, demoted, or have any other adverse employment action taken against him/her for making a good faith report of violence.

DEFINITIONS

Covered Healthcare Facility: A general or special hospital or nursing home licensed by the Department of Health and Senior Services, a State or county psychiatric hospital, or a State developmental center.

Healthcare Worker: An individual who is employed by a covered healthcare facility.

Workplace Violence or Violent Act: Any physical assault, threatening behavior, verbal abuse, or damage of personal property occurring in the work setting. It includes, but is not limited to, beatings, stabbing, suicides, shootings, rapes, near suicides, murders, psychological traumas such as threats, obscene phone calls, use of berating language, an intimidating presence, and harassment of any nature such as being followed, sworn at or shouted at. Acts of vandalism, arson and sabotage are also considered workplace violence.

Workplace: May be any location, either permanent or temporary, where an employee performs any work-related duty. This includes, but is not limited to, the buildings and the surrounding perimeters, including the parking lots, field locations, clients' homes, off-site business-related functions such as trade shows and business conferences, social events such as company party, and traveling to and from work assignments.

Violence by Strangers: In this type of incident the violence is committed by a stranger. This stranger has no legitimate relationship to the worker or workplace and enters the workplace, usually on the pretense of being a customer or visitor, to commit a robbery or other violent act. Workers also may be victimized by strangers outside the "traditional" workplace but while acting within the course and scope of their employment.

Violence by Residents/Clients: In these incidents, the violence is committed by someone who receives a service such as a current or former resident or a family member. The violence can be committed in the workplace or, as with service providers, outside the workplace but while the worker is performing a job related function.

Violence by Coworkers: In co-worker incidents, the perpetrator has an employment relationship with the workplace. The perpetrator can be a current or former employee, a prospective employee, a current or former supervisor or a manager. Co-worker violence that occurs outside the workplace, but which resulted or arose from the employment relationship would be included in this category. This type of violence can be divided into two types: Violence between supervisors and subordinates, and violence between workers at the same levels.

Violence by Personal Relations: In personal relations incidents, the violence is committed by someone who has a personal relationship with the worker, such as a current or former spouse or partner, a relative or a friend. Included in this category is the perpetrator who has a personal dispute with the worker and enters the workplace to harass, threaten, injure or kill.

Violence by an Ancillary Service Provider: In these incidents, the violence is committed by someone who enters the workplace to provide a service such as an ambulance attendant, lab/x-ray technician, delivery person or physician.

Assault: The intentional use of physical injury (impairment of physical condition or substantial pain) to another person, with or without a weapon or dangerous instrument.

Criminal Mischief: Intentional or reckless damaging of the property of another person without permission.

Disorderly Conduct: Intentionally causing public inconvenience, annoyance or alarm or recklessly creating a risk thereof by fighting (without injury) or in violent numinous or threatening behavior or making unreasonable noise, shouting abuse, misbehaving, disturbing an assembly or meeting or persons or creating hazardous conditions by an act which serves no legitimate purpose.

Harassment: Intentionally striking, shoving or kicking another or subjecting another person to physical contact, or threatening to do the same (without physical injury). Any behavior that demeans, embarrasses, humiliates, annoys, alarms or verbally abuses a person and that is known or would be expected to be unwelcome. This includes abusive or obscene language, insults, gestures, intimidation, stalking, bullying or other inappropriate activities.

Larceny: Wrongful taking, depriving or withholding property from another (no force involved). Victim may or may not be present.

Menacing: Intentionally places or attempts to place another person in fear of imminent serious physical injury.

Reckless Endangerment: Subjecting individuals to danger by recklessly engaging in conduct which creates substantial risk of serious physical injury.

Robbery: Forcible stealing of another's property by use of threat of immediate physical force. (Victim is present and aware of theft).

Public Lewdness: Exposure of sexual organs to others.

Sexual Abuse: Subjecting another to sexual contact without consent.

Sodomy: A deviant sexual act committed as in rape.

Rape: Sexual intercourse without consent.

SAFE PATIENT HANDLING POLICY

New Jersey

NJ Law: NJSA 26:2H-14.8
NJAC 8:43E-12.11
Do not replace current "Patient" with "Resident"

PURPOSE

To minimize unassisted patient handling in order to decrease the number of job-related musculoskeletal injuries and disorders suffered by healthcare workers and to improve the comfort, dignity, satisfaction and quality of care for residents. Nothing in this policy shall be construed to limit the right of a patient to refuse the use of assisted patient handling.

POLICY

Pursuant to the New Jersey Safe Patient Handling Act and the rules adopted thereunder at N.J.A.C. 8;43E-12, Company wants to ensure that its residents are cared for safely, while maintaining a safe work environment for employees by minimizing unassisted patient handling. To accomplish this, Company will establish a Safe Patient Handling Committee and a Safe Patient Handling Program to ensure the performance of assessments of patient need for assisted patient handling and to provide standards and procedures for conducting these assessments.

PROCEDURES

COMPLIANCE

1. Company is committed to patient and healthcare worker safety and well-being and has created this policy in furtherance of this commitment. It is the duty of employees to take reasonable care of their own health and safety, as well as that of their coworkers and their residents during patient handling activities, by following this policy. Noncompliance will indicate a need for retraining.
2. Company shall post a summary statement of this policy in a location easily visible to staff, residents, and visitors.
3. If a language other than English is the exclusive language spoken by at least 10 percent of Company's healthcare workers, the covered Company shall translate the safe patient handling policy into that language and make it available to those workers.

SAFE PATIENT HANDLING COMMITTEE

The Administrator shall appoint staff members to this committee, with 50% of the committee to be made up of direct patient care staff and include therapy staff and maintenance staff. The purpose of the Committee is to facilitate and oversee the Safe Patient Handling Program, with tasks that include but are not limited to: establish expertise in using patient handling equipment, oversee care of equipment, oversee training, complete an annual patient handling hazard assessment, review

incident reports involving patient lifting or movement injuries, make recommendations, and report information to the Safety Committee.

1. The Safe Patient Handling Committee shall meet as needed, but no less than quarterly.
2. The Safe Patient Handling Committee shall select a chairperson from among its members.
3. If healthcare workers are represented by one or more collective bargaining agents, the management of the facility or system shall consult with the collective bargaining agents regarding the selection of the healthcare worker committee members.
4. The Safe Patient Handling Committee shall be responsible for all aspects of the development, implementation and periodic evaluation and revision of the facility's safe patient handling program, including the evaluation and selection of patient handling equipment.
5. The Safe Patient Handling Committee shall ensure that all decisions about the selection and appropriate use of equipment shall be based on the patient assessments;
6. The Safe Patient Handling Committee shall ensure that the patient assessments are communicated to everyone who may be responsible for lifting, transferring, or repositioning that patient.
7. The Safe Patient Handling Committee shall determine and ensure the availability of an adequate number and variety of assisted patient handling equipment on each patient care unit.
8. The Safe Patient Handling Committee shall recommend a financial for the Safe Patient Handling Program to include an annual budget and a realistic three-year plan to purchase the requisite safe patient handling equipment.
9. The Safe Patient Handling Committee shall recommend equipment selection and ensure that healthcare workers and other employees who may handle safe patient handling equipment shall have the opportunity to participate in the selection and evaluation of equipment prior to purchase and that such employee evaluations shall be factored into purchasing decisions before the facility determines which equipment to purchase.
10. The Safe Patient Handling Committee shall develop a plan to ensure that equipment users have prompt access to and availability of assisted patient handling equipment.
11. The Safe Patient Handling Committee shall develop an evaluation process to determine whether selected assisted patient handling equipment is appropriate for the task to be accomplished, comfortable for the patient and safe and stable for both patient and;

SAFE PATIENT HANDLING PROGRAM

The Administrator shall establish a Safe Patient Handling program. The purpose of the program is to reduce the risk of injury to both residents and healthcare workers in the facility.

1. The Administrator shall designate a representative of administration who shall be responsible for overseeing all aspects of the safe patient handling program.
2. The Administrator and the Safe Patient Handling Committee will ensure that no person shall use patient handling equipment prior to completing the mandatory training as set forth in below section entitled “Training”.
3. The representative shall ensure that The Company supports the program by providing assistance that includes:
   A. Recognizing problems related to patient handling;
   B. Developing clear goals;
   C. Assigning responsibilities to designated staff members;

D. Allocating fiscal resources for planning and training;
E. Allocating fiscal resources for the purchase, implementation, and maintenance of the required equipment in the time allowed; and
F. Ensuring follow-up and revisions to the plan.

4. The Administrator shall allow employee input regarding the program through means developed by the safe patient handling committee.
5. The Administrator shall maintain a detailed written description of the program and its components.
6. The Administrator shall make a copy of the written description of the program available upon request, to the Office of Certificate of Need and Health Care Facility Licensure in the Department of Health and Senior Services.
7. The Administrator shall make the written description available within two business days after a request by a healthcare worker or collective bargaining agent who represents healthcare workers at the facility.
8. If a language other than English is the exclusive language spoken by at least 10 percent of Company's healthcare workers, the covered Company shall translate the description of the safe patient handling program into that language and make it available to those workers.
9. Company shall not take any retaliatory action against a healthcare worker because the worker refuses to perform a patient handling task due to a reasonable concern about worker or patient safety, or the lack of appropriate and available patient handling equipment.
   A. A healthcare worker who refuses to perform a patient handling task pursuant to this section shall promptly notify her or his supervisor of the refusal and the reason for refusing.

PATIENT HANDLING AND MOVEMENT REQUIREMENTS

1. Avoid hazardous patient handling and movement tasks whenever possible. If unavoidable, assess them carefully prior to completion.
2. Use mechanical lifting devices and other approved patient handling aids for high-risk patient handling and movement tasks.
3. Use mechanical lifting devices and other approved patient handling aids in accordance with instructions and training.

SAFE PATIENT HANDLING ASSESSMENT

1. Initial Safe Patient Handling Assessment and need for assisted patient handling will be completed by the therapist within 72 hours of admission for every patient. (See *NJ Safe Patient Handling Assessment Form*).
2. Assisted patient handling shall be used for patient handling tasks, except when not required based on an assessment of a patient's need for assisted patient handling or in the case of a medical emergency, during which a patient's life would be threatened if the required safe patient handling equipment were not immediately available
3. The nurse will provide the weight and height information and other assessed information to be used to determine strength, physical ability and cognitive ability; preferences; and any special circumstances likely to affect transfer or repositioning tasks;
4. The therapist will inform nursing regarding specific interventions.

5. The quarterly re-assessments will be completed by the therapist on the same schedule as the MDS.
6. The Safe Patient Handling Assessment Form will be kept in the resident record with the Quarterly Assessments.
7. The Safe Patient Handling Committee shall conduct a needs assessment for each unit or department within the facility every three years, or sooner if needed, to determine the type and quantity of assisted patient handling equipment required and, if necessary, to prioritize the need for equipment among the units or areas within The Company based on the needs assessments. The needs assessment for each unit or department shall focus on, at a minimum, the following**:**
   A. Typical patient type and care needs on each unit;
      a. The categories of staff and types of residents to whom injuries are occurring;
      b. When and where injuries are occurring (department, unit, date, time, and shift);
      c. The number and leading types of musculoskeletal injuries and disorders among healthcare workers;
      d. Types of tasks that caused injury (or are difficult or painful to perform) including, at a minimum, lifting, repositioning, and transferring residents;
      e. Specific equipment associated with employee or patient injuries;
      f. Available patient handling equipment and any problems associated with its use;
      g. Potential problems with new equipment and assurance of access, storage, and maintenance;
      h. Facility costs associated with unassisted and assisted patient handling injuries including, at a minimum, medical and workers' compensation costs; and
      i. Indirect impact of injuries on staff turnover and replacement.

8. The needs assessment shall be conducted using, at a minimum, the following resources:
   A. New Jersey Occupational Safety and Health Form 300 (N.J.A.C. 12:110-5.1);
   B. OSHA Log of Work-Related Injuries and Illnesses (OSHA Forms 300 and 301) required by 29 CFR Part 1904, which is incorporated herein by reference, as amended and supplemented;
   C. Reports of workers' compensation claims;
   D. Accident and incident reports;
   E. Facility incident reports for employees and residents;
   F. Insurance company reports;
   G. Employee interviews and surveys; and
   H. Reviews and observations of workplace conditions.

9. Residents shall have the right to refuse the use of assisted patient handling.

TRAINING

Company shall require all supervisors, all equipment users, members of the safe patient handling committee and all departments and staff that are engaged in patient handling activities to participate in mandatory, annual safe patient handling training. Trainings and handouts will be made available in any language, in addition to English, if such language is the exclusive language of 10% of Company’s healthcare workers.

1. The Safe Patient Handling Committee shall:
   A. Ensure that the training shall be based on researched and proven approaches for performing safe patient handling;
   B. Ensure that the patient handling training for a healthcare worker required by this section is conducted prior to any use of the safe patient handling equipment by the healthcare worker, and at least annually thereafter;
   C. Provide that training shall be at least two hours in duration and shall be held during paid work time;
      i. Provide appropriate interim training for healthcare workers beginning work between annual training sessions; and
      ii. Provide refresher training, as needed;
   D. Annually, or more frequently if necessary, review the training content and methods and make necessary revisions.

2. Training shall include:
   A. An explanation of The Company's safe patient handling policies and practices
   B. Causes and prevention of musculoskeletal injuries and disorders
   C. How to recognize and address early indications of musculoskeletal injuries and disorders before serious injury develops
   D. Identification, assessment and control of patient handling risks, including use of assessments of patient need for assisted patient handling and appropriate communication with residents
   E. A demonstration of safe, appropriate and effective use of patient handling equipment
   F. Trainee participation in operating unit-specific patient handling equipment and demonstration that they are proficient in using such equipment for residents with a range of physical limitations
   G. Company Name’s procedures for reporting work-related injuries and illnesses pursuant to the New Jersey Public Employees' Occupational Safety and Health Act, as required by N.J.S.A. 34:6A-40, or OSHA's injury and illness recording and reporting requirements at 29 CFR Part 1904
   H. Explanation, demonstration and practice of researched and proven methods and techniques that one or more healthcare workers may use for patient handling of a patient who refuses assisted patient handling
   I. Staff will correct improper use as indicated
   J. Human Resources shall maintain training records

3. The Safe Patient Handling Committee shall appoint a person or persons to develop Safe Patient Handling educational materials for residents and their families and include such educational materials in Company’s admissions package.

MECHANICAL LIFTING DEVICES AND OTHER EQUIPMENT/AIDS

1. The Employees Safety Committee and Supervisors will ensure that mechanical lifting devices and other equipment/aids are accessible to staff.
2. Maintenance shall ensure that mechanical lifting devices and other equipment/aids are maintained regularly and kept in proper working order and ensure necessary supplies are available.

Staff is required to inform maintenance of any issues as soon as possible as well as remove the device from further use until it is safe to use.
3. The Employee Safety Committee, Supervisors and staff shall ensure that mechanical lifting devices and other equipment/aids are stored conveniently and safely.

REPORTING OF INJURIES/INCIDENTS

The Administrator and Safe Patient Handling Committee shall:

1. Establish an injury reporting system and encourage all employees to report injuries and near misses in a non-punitive environment.
2. Designate a person or persons to develop procedures for performing injury investigations, preparing investigation reports, and educating staff when an injury or near miss occurs;
3. Appoint an appropriate facility department to receive and analyze injury reports and to generate de-identified, aggregated data reports that take into account, at a minimum, items identified at N.J.A.C. 8:43E-12.8(b); the safe and proper use of assisted patient handling equipment; patient refusals of assisted patient handling associated with injuries to healthcare workers; and the overall efficacy of the safe patient handling program;
4. Establish a system for monthly reporting of generated reports to the safe patient handling committee;
5. Maintain records of work-related musculoskeletal injuries and disorders to help identify problem areas in accordance with the New Jersey Public Employees' Occupational Safety and Health injury and illness recordkeeping requirements (N.J.A.C. 12:110-5), or OSHA's injury and illness recording and reporting requirements at 29 CFR Part 1904.
6. The Safe Patient Handling Committee shall evaluate the de-identified injury incident data in order to: a) identify units and shifts with ongoing injuries related to patient handling; b) track the impact of injuries on employee turnover; and c) determine what measures to take to increase patient acceptance of safe patient handling, including changes to the education of healthcare workers, residents and family members.

DELEGATION OF AUTHORITY AND RESPONSIBILITY

The Administrator, together with the Safe Patient Handling Committee shall:

1. Support the implementation of this policy.
2. Develop a plan and budget for the acquisition of lifting equipment/aids to allow staff to use them when needed for safe patient handling and movement.
3. Furnish acceptable storage locations for lifting equipment/aids.
4. Provide staffing levels sufficient to comply with this policy.

Therapists shall:

1. Ensure high-risk patient handling tasks are assessed prior to completion and are completed safely, using mechanical lifting devices and other approved patient handling aids and appropriate techniques.

2. Ensure employees complete initial and annual training and training as required if employees show noncompliance with safe patient handling and movement.
3. Collaborate with Safe Patient Handling and Movement Committee in evaluating the Safe Patient Handling and Movement policy.
4. Ensure all staff reporting injuries due to patient handling tasks report the incident in a manner consistent with the incidents policy.

Maintenance shall:

1. Ensure mechanical lifting devices and other equipment/aids are maintained regularly, are in proper working order, and are stored conveniently and safely.

Human Resources shall:

1. Provide the staff with due dates and information for training with safe patient handling and movement.
2. Maintain Incident Reports and supplemental injury statistics as required by the facility, OSHA, Worker's Comp. Carrier and as requested by Safe Patient Handling Committee.

Employees shall:

1. Comply with all parameters of this policy.
2. Use proper techniques, mechanical lifting devices, and other approved equipment/aids during performance of high-risk patient handling tasks.
3. Notify supervisor of any injury sustained while performing patient handling tasks.
4. Notify supervisor of need for re-training in use of mechanical lifting devices, other equipment/aids, and lifting/moving techniques.
5. Notify supervisor and/or maintenance of mechanical lifting devices in need of repair.
6. Supply feedback to Supervisor on Safe Patient Handling and Movement components.
7. Have the right to refuse to participate in manually moving a patient if they are concerned for their own or the patient's safety.

Residents shall:

Be encouraged to cooperate fully with the safe patient handling procedures as requested by the nursing staff. However, the resident has the right to refuse.

SAFE PATIENT HANDLING ASSESSMENT FORM
NEW JERSEY

Name: _____ Room #:_____ Date: _____

To be completed within 72 hours of admission, quarterly with MDS, and as needed.

What is the resident's size:	Date	Date	Date	Date
Weight: _____	Wt_____	Wt:_____	Wt:_____	Wt:_____
Height: _____				

What is the level of assistance required by the resident?

- ❑ Partial assistance of the caregiver (requires no more help than standby, cueing, or coaxing, or no more than 50% physical assistance by the caregiver).
- ❑ Dependent (requires more than 50% assistance by the caregiver, or the amount of assistance the resident can offer is unpredictable).

What is the resident's weight-bearing capability?

- ❑ Full weight bearing.
- ❑ Cannot bear own weight.
- ❑ Partial weight bearing.

What is the resident's level of cooperation and comprehension? Is resident cooperative and able to follow instructions?

- ❑ Yes, (resident is cooperative; may need prompting but is able to follow simple commands).
- ❑ No, (resident is either unpredictable, not always cooperative, or is unable to follow simple commands consistently. A resident with frequent behavior changes should be considered "unpredictable.")

What conditions are likely to affect resident handling tasks?

- ❑ Joint replacement
- ❑ LE amputation
- ❑ Severe osteoporosis
- ❑ Paralysis
- ❑ Spinal involvement
- ❑ Pressure Ulcers
- ❑ Impaired balance
- ❑ Presence of tubes (IV, urinary, etc.)
- ❑ Postural hypotension
- ❑ History of falls
- ❑ Urinary or fecal stoma
- ❑ Contractures or spasms
- ❑ Fractures
- ❑ General weakness
- ❑ Obese/or substantial size

Other: _____

What are the resident's safe handling needs? Dependency level:

- ❑ Independent
- ❑ Limited assistance
- ❑ Total dependence
- ❑ Supervision required
- ❑ Extensive assistance

Signature: _____ Title: _____

Intervention

- ❑ Hoyer Lift
- ❑ 2 Person transfer
- ❑ 1 Person transfer with assistive device
- ❑ Gait belt required
- ❑ Supervision with assistive device
- ❑ Supervision without assistive device
- ❑ Independent

Date: _____

Comments: _____

_____

_____

Signature: _____

Date: _____

Comments: _____

_____

_____

Signature: _____

Date: _____

Comments: _____

_____

_____

Signature: _____

OPPORTUNITY TO COMPETE ACT "BAN THE BOX" LAW
New Jersey

*See the New Jersey Department of Labor and Workforce Development for more information.

EMPLOYMENT VERIFICATION FORM
New Jersey

To:

Fold, staple and return

Applicant's Name:
Address:
Position Applied For:
I hereby authorize you to issue any information you have regarding my performance and do unconditionally release you from all liability for any ramifications which might result from providing this information. Signature: Social Security #:

Pursuant to New Jersey's Health Care Professional Responsibility and Reporting Enhancement Act (Nurse Cullen Law):

FOL

Name While Employed: _____ Position _____
Employment Dates: _____ To _____

Have you submitted documentation to the Division of Consumer Affairs or other professional licensing board during the past seven (7) years regarding this employee? Yes ❑ No ❑

If yes, provide the following:

Date of Notification _____

Reason for Notification: _____
(please attach supporting documents)

Is this individual currently employed? Yes ❑ No ❑

If no, what was the reason for leaving?

❑ Voluntary _____ ❑ Involuntary _____
(Reason) *(Reason)*

Is this former employee eligible for re-employment by the healthcare entity? Yes ❑ No ❑

If no, please explain if due to job performance as it relates to patient care: _____

_____

_____

_____

Comments / job performance concerns related to patient care noted in prior evaluative documents:

_____

_____

_____

Reference provided by (please print): _____

Title: _____

Signature _____

Date: _____

FOLD AND STAPLE

FROM:

_____
_____
_____
_____

TO:

_____
_____
_____
_____

NEW YORK REQUIREMENTS

NYS HARASSMENT POLICY

NYS OUR COMPLIANCE AND ETHICS PLAN

NYS DEFICIT REDUCTION ACT OF 2005

NYS 2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN

NYS CHARTER TEMPLATE COMPLIANCE AND ETHICS COMMITTEE

NYS COMPLIANCE HOTLINE POSTER

NYS GOVERNING BODY BYLAWS

NYS GOVERNING BODY TRAINING

HARASSMENT POLICY
New York State

Purpose and Goals

[*Employer Name*] is committed to maintaining a workplace free from harassment and discrimination. Sexual harassment is a form of workplace discrimination that subjects an employee to inferior conditions of employment due to their gender, gender identity, gender expression (perceived or actual), and/or sexual orientation. Sexual harassment is often viewed simply as a form of gender-based discrimination, but *[Employer name]* recognizes that discrimination can be related to or affected by other identities beyond gender. Under the New York State Human Rights Law, it is illegal to discriminate based on sex, sexual orientation, gender identity or expression, age, race, creed, color, national origin, military status, disability, pre-disposing genetic characteristics, familial status, marital status, criminal history, or status as a victim of domestic violence. Our different identities impact our understanding of the world and how others perceive us. For example, an individual's race, ability, or immigration status may impact their experience with gender discrimination in the workplace. While this policy is focused on sexual harassment and gender discrimination, the methods for reporting and investigating discrimination based on other protected identities are the same. The purpose of this policy is to teach employees to recognize discrimination, including discrimination due to an individual's intersecting identities, and provide the tools to take action when it occurs. All employees, managers, and supervisors are required to work in a manner designed to prevent sexual harassment and discrimination in the workplace. This policy is one component of [*Employer Name's*] commitment to a discrimination-free work environment.

Goals of this Policy:

Sexual harassment and discrimination are against the law. After reading this policy, employees will understand their right to a workplace free from harassment. Employees will also learn what harassment and discrimination look like, what actions they can take to prevent and report harassment, and how they are protected from retaliation after taking action. The policy will also explain the investigation process into any claims of harassment. Employees are encouraged to report sexual harassment or discrimination by filing a complaint internally with [*Employer Name*]. Employees can also file a complaint with a government agency or in court under federal, state, or local antidiscrimination laws. To file an employment complaint with the New York State Division of Human Rights, please visit https://dhr.ny.gov/complaint. To file a complaint with the United States Equal Employment Opportunity Commission, please visit https://www.eeoc.gov/filing-charge-discrimination.

Sexual Harassment and Discrimination Prevention Policy:

1. [*Employer Name's*] policy applies to all employees, applicants for employment, and interns, whether paid or unpaid. The policy also applies to additional covered individuals. It applies to anyone who is (or is employed by) a contractor, subcontractor, vendor, consultant, or anyone providing services in our workplace. These individuals include persons commonly referred to as independent contractors, gig workers, and temporary workers. Also included are persons providing equipment repair, cleaning services, or any other services through a contract with [*Employer Name*]. For the remainder of this policy, we will use the term "covered individual" to refer to these individuals who are not direct employees of the company.

2. Sexual harassment is unacceptable. Any employee or covered individual who engages in sexual harassment, discrimination, or retaliation will be subject to action, including appropriate discipline for employees. In New York, harassment does not need to be severe or pervasive to be illegal. Employees and covered individuals should not feel discouraged from reporting harassment because they do not believe it is bad enough, or conversely because they do not want to see a colleague fired over less severe behavior. Just as harassment can happen in different degrees, potential discipline for engaging in sexual harassment will depend on the degree of harassment and might include education and counseling. It may lead to suspension or termination when appropriate.

3. Retaliation is prohibited. Any employee or covered individual that reports an incident of sexual harassment or discrimination, provides information, or otherwise assists in any investigation of a sexual harassment or discrimination complaint is protected from retaliation. No one should fear reporting sexual harassment if they believe it has occurred. So long as a person reasonably believes that they have witnessed or experienced such behavior, they are protected from retaliation. Any employee of [*Employer Name*] who retaliates against anyone involved in a sexual harassment or discrimination investigation will face disciplinary action, up to and including termination. All employees and covered individuals working in the workplace who believe they have been subject to such retaliation should inform a supervisor, manager, or [*name of appropriate person*]. All employees and covered individuals who believe they have been a target of such retaliation may also seek relief from government agencies, as explained below in the section on Legal Protections.

4. Discrimination of any kind, including sexual harassment, is a violation of our policies, is unlawful, and may subject [*Employer Name*] to liability for the harm experienced by targets of discrimination. Harassers may also be individually subject to liability and employers or supervisors who fail to report or act on harassment may be liable for aiding and abetting such behavior. Employees at every level who engage in harassment or discrimination, including managers and supervisors who engage in harassment or discrimination or who allow such behavior to continue, will be penalized for such misconduct.

5. [*Employer Name*] will conduct a prompt and thorough investigation that is fair to all parties. An investigation will happen whenever management receives a complaint about discrimination or sexual harassment, or when it otherwise knows of possible discrimination or sexual harassment occurring. [*Employer Name*] will keep the investigation confidential to the extent possible. If an investigation ends with the finding that discrimination or sexual harassment occurred, [*Employer Name*] will act as required. In addition to any required discipline, [*Employer Name*] will also take steps to ensure a safe work environment for the employee(s) who experienced the discrimination or harassment. All employees, including managers and supervisors, are required to cooperate with any internal investigation of discrimination or sexual harassment.

6. All employees and covered individuals are encouraged to report any harassment or behaviors that violate this policy. All employees will have access to a complaint form to report harassment and file complaints. Use of this form is not required. For anyone who would rather make a complaint verbally, or by email, these complaints will be treated with equal priority. An employee or covered individual who prefers not to report harassment to their manager or employer may instead report harassment to the New York State Division of Human Rights and/or the United States Equal Employment Opportunity Commission. Complaints may be made to both the employer and a government agency.

   Managers and supervisors are **required** to report any complaint that they receive, or any harassment that they observe or become aware of, to [*person or office designated*].

7. This policy applies to all employees and covered individuals, such as contractors, subcontractors, vendors, consultants, or anyone providing services in the workplace, and all must follow and uphold this policy. This policy must be provided to all employees in person or digitally through email upon hiring and will be posted prominently in all work locations. For those offices operating remotely, in addition to sending the policy through email, it will also be available on the organization's shared network.

What Is Sexual Harassment?

Sexual harassment is a form of gender-based discrimination that is unlawful under federal, state, and (where applicable) local law. Sexual harassment includes harassment on the basis of sex, sexual orientation, self-identified or perceived sex, gender expression, gender identity, and the status of being transgender. Sexual harassment is not limited to sexual contact, touching, or expressions of a sexually suggestive nature. Sexual harassment includes all forms of gender discrimination including gender role stereotyping and treating employees differently because of their gender.

Understanding gender diversity is essential to recognizing sexual harassment because discrimination based on sex stereotypes, gender expression and perceived identity are all forms of sexual harassment. The gender spectrum is nuanced, but the three most common ways people identify are cisgender, transgender, and non-binary. A cisgender person is someone whose gender aligns with the sex they were assigned at birth. Generally, this gender will align with the binary of male or female. A transgender person is someone whose gender is different than the sex they were assigned at birth. A non-binary person does not identify exclusively as a man or a woman. They might

identify as both, somewhere in between, or completely outside the gender binary. Some may identify as transgender, but not all do. Respecting an individual's gender identity is a necessary first step in establishing a safe workplace.

Sexual harassment is unlawful when it subjects an individual to inferior terms, conditions, or privileges of employment. Harassment does not need to be severe or pervasive to be illegal. It can be any harassing behavior that rises above petty slights or trivial inconveniences. Every instance of harassment is unique to those experiencing it, and there is no single boundary between petty slights and harassing behavior. However, the Human Rights Law specifies that whether harassing conduct is considered petty or trivial is to be viewed from the standpoint of a reasonable victim of discrimination with the same protected characteristics. Generally, any behavior in which an employee or covered individual is treated worse because of their gender (perceived or actual), sexual orientation, or gender expression is considered a violation of [*Employer Name's*] policy. The intent of the behavior, for example, making a joke, does not neutralize a harassment claim. Not intending to harass is not a defense. The impact of the behavior on a person is what counts. Sexual harassment includes any unwelcome conduct which is either directed at an individual because of that individual's gender identity or expression (perceived or actual), or is of a sexual nature when:

- The purpose or effect of this behavior unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive work environment. The impacted person does not need to be the intended target of the sexual harassment;

- Employment depends implicitly or explicitly on accepting such unwelcome behavior; or

- Decisions regarding an individual's employment are based on an individual's acceptance to or rejection of such behavior. Such decisions can include what shifts and how many hours an employee might work, project assignments, as well as salary and promotion decisions.

There are two main types of sexual harassment:

- Behaviors that contribute to a **hostile work environment** include, but are not limited to, words, signs, jokes, pranks, intimidation, or physical violence which are of a sexual nature, or which are directed at an individual because of that individual's sex, gender identity, or gender expression. Sexual harassment also consists of any unwanted verbal or physical advances, sexually explicit derogatory, or discriminatory statements which an employee finds offensive or objectionable, causes an employee discomfort or humiliation, or interferes with the employee's job performance.

- Sexual harassment also occurs when a person in authority tries to trade job benefits for sexual favors. This can include hiring, promotion, continued employment or any other terms, conditions, or privileges of employment. This is also called **quid pro quo** harassment.

Any employee or covered individual who feels harassed is encouraged to report the behavior so that any violation of this policy can be corrected promptly. Any harassing conduct, even a single incident, can be discrimination and is covered by this policy.

Examples of Sexual Harassment

The following describes some of the types of acts that may be unlawful sexual harassment and that are strictly prohibited. **This list is just a sample of behaviors and should not be considered exhaustive**. Any employee who believes they have experienced sexual harassment, even if it does not appear on this list, should feel encouraged to report it:

- Physical acts of a sexual nature, such as:
  - Touching, pinching, patting, kissing, hugging, grabbing, brushing against another employee's body, or poking another employee's body; or
  - Rape, sexual battery, molestation, or attempts to commit these assaults, which may be considered criminal conduct outside the scope of this policy (please contact local law enforcement if you wish to pursue criminal charges).

- Unwanted sexual comments, advances, or propositions, such as:
  - Requests for sexual favors accompanied by implied or overt threats concerning the target's job performance evaluation, a promotion, or other job benefits;
    - This can include sexual advances/pressure placed on a service industry employee by customers or clients, especially those industries where hospitality and tips are essential to the customer/employee relationship;
  - Subtle or obvious pressure for unwelcome sexual activities; or
  - Repeated requests for dates or romantic gestures, including gift-giving.

- Sexually oriented gestures, noises, remarks or jokes, or questions and comments about a person's sexuality, sexual experience, or romantic history which create a hostile work environment. This is not limited to interactions in person. Remarks made over virtual platforms and in messaging apps when employees are working remotely can create a similarly hostile work environment.

- Sex stereotyping, which occurs when someone's conduct or personality traits are judged based on other people's ideas or perceptions about how individuals of a particular sex should act or look:
  - Remarks regarding an employee's gender expression, such as wearing a garment typically associated with a different gender identity; or
  - Asking employees to take on traditionally gendered roles, such as asking a woman to serve meeting refreshments when it is not part of, or appropriate to, her job duties.

- Sexual or discriminatory displays or publications anywhere in the workplace, such as:
  - Displaying pictures, posters, calendars, graffiti, objects, promotional material, reading materials, or other materials that are sexually demeaning or pornographic. This includes such sexual displays on workplace computers or cell phones and sharing such displays while in the workplace;
  - This also extends to the virtual or remote workspace and can include having such materials visible in the background of one's home during a virtual meeting.

- Hostile actions taken against an individual because of that individual's sex, sexual orientation, gender identity, or gender expression, such as:
  - Interfering with, destroying, or damaging a person's workstation, tools or equipment, or otherwise interfering with the individual's ability to perform the job;
  - Sabotaging an individual's work;
  - Bullying, yelling, or name-calling;
  - Intentional misuse of an individual's preferred pronouns; or
  - Creating different expectations for individuals based on their perceived identities:
    - Dress codes that place more emphasis on women's attire;
    - Leaving parents/caregivers out of meetings.

Who Can be a Target of Sexual Harassment?

Sexual harassment can occur between any individuals, regardless of their sex or gender. Harassment does not have to be between members of the opposite sex or gender. New York Law protects employees and all covered individuals described earlier in the policy. **Harassers can be anyone in the workplace**. A supervisor, a supervisee, or a coworker can all be harassers. Anyone else in the workplace can also be harassers including an independent contractor, contract worker, vendor, client, customer, patient, constituent, or visitor.

Sexual harassment does not happen in a vacuum and discrimination experienced by an employee can be impacted by biases and identities beyond an individual's gender. For example:

- Placing different demands or expectations on black women employees than white women employees can be both racial and gender discrimination;
- An individual's immigration status may lead to perceptions of vulnerability and increased concerns around illegal retaliation for reporting sexual harassment; or
- Past experiences as a survivor of domestic or sexual violence may lead an individual to feel re-traumatized by someone's behaviors in the workplace.

Individuals bring personal history with them to the workplace that might impact how they interact with certain behavior. It is especially important for all employees to be aware of how words or actions might impact someone with a different experience than their own in the interest of creating a safe and equitable workplace.

Where Can Sexual Harassment Occur?

Unlawful sexual harassment is not limited to the physical workplace itself. It can occur while employees are traveling for business or at employer or industry sponsored events or parties. Calls, texts, emails, and social media usage by employees or covered individuals can constitute unlawful workplace harassment, even if they occur away from the workplace premises, on personal devices, or during non-work hours.

Sexual harassment can occur when employees are working remotely from home as well. Any behaviors outlined above that leave an employee feeling uncomfortable, humiliated, or unable to meet their job requirements constitute harassment even if the employee or covered individual is at

home when the harassment occurs. Harassment can happen on virtual meeting platforms, in messaging apps, and after working hours between personal cell phones.

Retaliation

Retaliation is unlawful and is any action by an employer or supervisor that punishes an individual upon learning of a harassment claim, that seeks to discourage a worker or covered individual from making a formal complaint or supporting a sexual harassment or discrimination claim, or that punishes those who have come forward. These actions need not be job-related or occur in the workplace to constitute unlawful retaliation. For example, threats of physical violence outside of work hours or disparaging someone on social media would be covered as retaliation under this policy.

Examples of retaliation may include, but are not limited to:

- Demotion, termination, denying accommodations, reduced hours, or the assignment of less desirable shifts;
- Publicly releasing personnel files;
- Refusing to provide a reference or providing an unwarranted negative reference;
- Labeling an employee as "difficult" and excluding them from projects to avoid "drama";
- Undermining an individual's immigration status; or
- Reducing work responsibilities, passing over for a promotion, or moving an individual's desk to a less desirable office location.

Such retaliation is unlawful under federal, state, and (where applicable) local law. The New York State Human Rights Law protects any individual who has engaged in "protected activity." Protected activity occurs when a person has:

- Made a complaint of sexual harassment or discrimination, either internally or with any government agency;
- Testified or assisted in a proceeding involving sexual harassment or discrimination under the Human Rights Law or any other anti-discrimination law;
- Opposed sexual harassment or discrimination by making a verbal or informal complaint to management, or by simply informing a supervisor or manager of suspected harassment;
- Reported that another employee has been sexually harassed or discriminated against; or
- Encouraged a fellow employee to report harassment.

Even if the alleged harassment does not turn out to rise to the level of a violation of law, the individual is protected from retaliation if the person had a good faith belief that the practices were unlawful. However, the retaliation provision is not intended to protect persons making intentionally false charges of harassment.

Reporting Sexual Harassment

Everyone must work toward preventing sexual harassment, but leadership matters. Supervisors and managers have a special responsibility to make sure employees feel safe at work and that workplaces are free from harassment and discrimination. Any employee or covered

individual is encouraged to report harassing or discriminatory behavior to a supervisor, manager or [*person or office designated*]. Anyone who witnesses or becomes aware of potential instances of sexual harassment should report such behavior to a supervisor, manager, or [*person or office designated*].

Reports of sexual harassment may be made verbally or in writing. A written complaint form is attached to this policy if an employee would like to use it, but the complaint form is not required. Employees who are reporting sexual harassment on behalf of other employees may use the complaint form and should note that it is on another employee's behalf. A verbal or otherwise written complaint (such as an email) on behalf of oneself or another employee is also acceptable.

Employees and covered individuals who believe they have been a target of sexual harassment may at any time seek assistance in additional available forums, as explained below in the section on Legal Protections.

Supervisory Responsibilities

Supervisors and managers have a responsibility to prevent sexual harassment and discrimination. All supervisors and managers who receive a complaint or information about suspected sexual harassment, observe what may be sexually harassing or discriminatory behavior, or for any reason suspect that sexual harassment or discrimination is occurring, are required to report such suspected sexual harassment to [*person or office designated*]. Managers and supervisors should not be passive and wait for an employee to make a claim of harassment. If they observe such behavior, they must act.

Supervisors and managers can be disciplined if they engage in sexually harassing or discriminatory behavior themselves. Supervisors and managers can also be disciplined for failing to report suspected sexual harassment or allowing sexual harassment to continue after they know about it.

Supervisors and managers will also be subject to discipline for engaging in any retaliation.

While supervisors and managers have a responsibility to report harassment and discrimination, supervisors and managers must be mindful of the impact that harassment and a subsequent investigation has on victims. Being identified as a possible victim of harassment and questioned about harassment and discrimination can be intimidating, uncomfortable and re-traumatizing for individuals. Supervisors and managers must accommodate the needs of individuals who have experienced harassment to ensure the workplace is safe, supportive, and free from retaliation for them during and after any investigation.

Bystander Intervention

Any employee witnessing harassment as a bystander is encouraged to report it. A supervisor or manager that is a bystander to harassment is **required** to report it. There are five standard methods of bystander intervention that can be used when anyone witnesses harassment or discrimination and wants to help.

1. A bystander can interrupt the harassment by engaging with the individual being harassed and distracting them from the harassing behavior;
2. A bystander who feels unsafe interrupting on their own can ask a third party to help intervene in the harassment;
3. A bystander can record or take notes on the harassment incident to benefit a future investigation;
4. A bystander might check in with the person who has been harassed after the incident, see how they are feeling and let them know the behavior was not ok; and
5. If a bystander feels safe, they can confront the harassers and name the behavior as inappropriate. When confronting harassment, physically assaulting an individual is never an appropriate response.

Though not exhaustive, and dependent on the circumstances, the guidelines above can serve as a brief guide of how to react when witnessing harassment in the workplace. Any employee witnessing harassment as a bystander is encouraged to report it. A supervisor or manager that is a bystander to harassment is required to report it.

Complaints and Investigations of Sexual Harassment

All complaints or information about sexual harassment will be investigated, whether that information was reported in verbal or written form. An investigation of any complaint, information, or knowledge of suspected sexual harassment will be prompt, thorough, and started and completed as soon as possible. The investigation will be kept confidential to the extent possible. All individuals involved, including those making a harassment claim, witnesses, and alleged harassers deserve a fair and impartial investigation.

Any employee may be required to cooperate as needed in an investigation of suspected sexual harassment. [*Employer Name*] will take disciplinary action against anyone engaging in retaliation against employees who file complaints, support another's complaint, or participate in harassment investigations.

[*Employer Name*] recognizes that participating in a harassment investigation can be uncomfortable and has the potential to retraumatize an employee. Those receiving claims and leading investigations will handle complaints and questions with sensitivity toward those participating.

While the process may vary from case to case, investigations will be done in accordance with the following steps. Upon receipt of a complaint, [*person or office designated*]:

1. Will conduct a prompt review of the allegations, assess the appropriate scope of the investigation, and take any interim actions (for example, instructing the individual(s) about whom the complaint was made to refrain from communications with the individual(s) who reported the harassment), as appropriate. If complaint is verbal, request that the individual completes the complaint form in writing. If the person reporting prefers not to fill out the form, [*person or office designated*] will prepare a complaint form or equivalent documentation based on the verbal reporting;

2. Will take steps to obtain, review, and preserve documents sufficient to assess the allegations, including documents, emails or phone records that may be relevant to the investigation. [*Person or office delegated*] will consider and implement appropriate document request, review, and preservation measures, including for electronic communications;

3. Will seek to interview all parties involved, including any relevant witnesses;

4. Will create a written documentation of the investigation (such as a letter, memo or email), which contains the following:
   a. A list of all documents reviewed, along with a detailed summary of relevant documents;
   b. A list of names of those interviewed, along with a detailed summary of their statements;
   c. A timeline of events;
   d. A summary of any prior relevant incidents disclosed in the investigation, reported or unreported; and
   e. The basis for the decision and final resolution of the complaint, together with any corrective action(s).

5. Will keep the written documentation and associated documents in a secure and confidential location;

6. Will promptly notify the individual(s) who reported the harassment and the individual(s) about whom the complaint was made that the investigation has been completed and implement any corrective actions identified in the written document; and

7. Will inform the individual(s) who reported of the right to file a complaint or charge externally as outlined in the next section.

Legal Protections and External Remedies

Sexual harassment is not only prohibited by [*Employer Name*], but it is also prohibited by state, federal, and, where applicable, local law.

The internal process outlined in the policy above is one way for employees to report sexual harassment. Employees and covered individuals may also choose to pursue legal remedies with the following governmental entities. While a private attorney is not required to file a complaint with a governmental agency, you may also seek the legal advice of an attorney.

New York State Division of Human Rights:

The New York State Human Rights Law (HRL), N.Y. Executive Law, art. 15, § 290 *et seq.*, applies to all employers in New York State and protects employees and covered individuals, regardless of immigration status. A complaint alleging violation of the Human Rights Law may be filed either with the New York State Division of Human Rights (DHR) or in New York State Supreme Court.

Complaints of sexual harassment filed with DHR may be submitted any time **within three years** of the harassment. If an individual does not file a complaint with DHR, they can bring a lawsuit

directly in state court under the Human Rights Law, **within three years** of the alleged sexual harassment. An individual may not file with DHR if they have already filed a HRL complaint in state court.

Complaining internally to [*Employer Name*] does not extend your time to file with DHR or in court. The three years are counted from the date of the most recent incident of harassment.

You do not need an attorney to file a complaint with DHR, and there is no cost to file with DHR.

DHR will investigate your complaint and determine whether there is probable cause to believe that sexual harassment has occurred. Probable cause cases receive a public hearing before an administrative law judge. If sexual harassment is found at the hearing, DHR has the power to award relief. Relief varies but it may include requiring your employer to take action to stop the harassment, or repair the damage caused by the harassment, including paying of monetary damages, punitive damages, attorney's fees, and civil fines.

DHR's main office contact information is: NYS Division of Human Rights, One Fordham Plaza, Fourth Floor, Bronx, New York 10458. You may call (718) 741-8400 or visit: www.dhr.ny.gov.

Go to dhr.ny.gov/complaint for more information about filing a complaint with DHR. The website has a digital complaint process that can be completed on your computer or mobile device from start to finish. The website has a complaint form that can be downloaded, filled out, and mailed to DHR as well as a form that can be submitted online. The website also contains contact information for DHR's regional offices across New York State.

Call the DHR sexual harassment hotline at **1(800) HARASS3** for more information about filing a sexual harassment complaint. This hotline can also provide you with a referral to a volunteer attorney experienced in sexual harassment matters who can provide you with limited free assistance and counsel over the phone.

The United States Equal Employment Opportunity Commission:

The United States Equal Employment Opportunity Commission (EEOC) enforces federal anti-discrimination laws, including Title VII of the 1964 federal Civil Rights Act, 42 U.S.C. § 2000e *et seq.* An individual can file a complaint with the EEOC anytime within 300 days from the most recent incident of harassment. There is no cost to file a complaint with the EEOC. The EEOC will investigate the complaint and determine whether there is reasonable cause to believe that discrimination has occurred. If the EEOC determines that the law may have been violated, the EEOC will try to reach a voluntary settlement with the employer. If the EEOC cannot reach a settlement, the EEOC (or the Department of Justice in certain cases) will decide whether to file a lawsuit. The EEOC will issue a Notice of Right to Sue permitting workers to file a lawsuit in federal court if the EEOC closes the charge, is unable to determine if federal employment discrimination laws may have been violated, or believes that unlawful discrimination occurred by does not file a lawsuit.

Individuals may obtain relief in mediation, settlement or conciliation. In addition, federal courts may award remedies if discrimination is found to have occurred. In general, private employers must have at least 15 employees to come within the jurisdiction of the EEOC.

An employee alleging discrimination at work can file a "Charge of Discrimination." The EEOC has district, area, and field offices where complaints can be filed. Contact the EEOC by calling 1-800-669-4000 (TTY: 1-800-669-6820), visiting their website at www.eeoc.gov or via email at info@eeoc.gov.

If an individual filed an administrative complaint with the New York State Division of Human Rights, DHR will automatically file the complaint with the EEOC to preserve the right to proceed in federal court.

Local Protections

Many localities enforce laws protecting individuals from sexual harassment and discrimination. An individual should contact the county, city or town in which they live to find out if such a law exists. For example, employees who work in New York City may file complaints of sexual harassment or discrimination with the New York City Commission on Human Rights. Contact their main office at Law Enforcement Bureau of the NYC Commission on Human Rights, 22 Reade Street, 1st Floor, New York, New York; call 311 or (212) 306-7450; or visit www.nyc.gov/html/cchr/html/home/home.shtml.

Contact the Local Police Department

If the harassment involves unwanted physical touching, coerced physical confinement, or coerced sex acts, the conduct may constitute a crime. Those wishing to pursue criminal charges are encouraged to contact their local police department.

Conclusion

The policy outlined above is aimed at providing employees at [*Employer Name*] and covered individuals an understanding of their right to a discrimination and harassment free workplace. All employees should feel safe at work. Though the focus of this policy is on sexual harassment and gender discrimination, the New York State Human Rights law protects against discrimination in several protected classes including sex, sexual orientation, gender identity or expression, age, race, creed, color, national origin, military status, disability, pre-disposing genetic characteristics, familial status, marital status, criminal history, or domestic violence survivor status. The prevention policies outlined above should be considered applicable to all protected classes.

COMPANYNAME
OUR COMPLIANCE AND ETHICS PLAN

INTRODUCTION TO OUR COMPLIANCE AND ETHICS PROGRAM

CompanyName has always strived to maintain a good faith effort to comply with all applicable laws, rules, and regulations. In accordance with existing guidance from the U.S. Department of Health and Human Services, Office of Inspector General, as well as the statutory requirements of the Patient Protection and Affordable Care Act, CompanyName has adopted a Compliance and Ethics Program.

The goal of our Compliance and Ethics Program (our Program) is to ensure that CompanyName adheres to all applicable Medicare and Medicaid laws, rules, and regulations related to the submission of claims. This includes, among other things, to ensure proper documentation of services, billing, coding, and claims submission, and the prevention, prompt detection, and appropriate corrective action to detect, address, and prevent fraud, waste, and abuse.

All persons and entities who are affected by CompanyName's risk areas including CompanyName's employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors/contractors and subcontractors, agents, Chief Executive and other senior administrators, managers, executives, Governing Body Members, corporate officers, 1099 employees, and service contractors, hereinafter referred to collectively as "affected individuals", are subject to Our Compliance and Ethics Plan. Any reference in our Compliance and Ethics Plan or policies to affected individuals is intended to cover "all affected individuals" as noted above for the purpose of compliance with the elements of our Compliance and Ethics Program.

The purpose of our Program is to:

1. Outline and emphasize our commitment to accurate and lawful documentation and submission of all claims for services to Medicare, Medicaid, and other third-party payers.

2. Help our affected individuals understand and meet legal and ethical standards that govern our business.

3. Promote the prevention, detection, and resolution of any acts that do not conform to applicable federal and/or state laws, rules, and regulations,

4. Minimize, through early detection and reporting, any potential loss to the government from erroneous claims as well as reduce CompanyName's potential exposure to damages and civil and criminal penalties that may result from noncompliance.

Compliance is a key component to our day-to-day operations. Thus, all affected individuals are expected to comply with all applicable laws, rules, and regulations as well as Company-Name's policies and procedures. Those who fail to comply with the elements of this Plan may face disciplinary action, up to and including termination.

COMPLIANCE AND ETHICS PROGRAM COMPONENTS

Compliance and Ethics Officer

CompanyName has appointed a Compliance and Ethics Officer, who is responsible for day-to-day operations of our Program. The designated Compliance and Ethics Officer should be someone within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited, to the chief executive officer (CEO), members of the Governing Body, and/or directors of major divisions in the operating organization.

Our Compliance and Ethics Officer is well integrated into and knowledgeable about the operations of the organization and is explicitly responsible for overseeing the implementation of our Program, investigating and independently acting on matters related to the compliance program, including, but not limited to: a) designing, coordinating, and documenting internal investigations and pursuing any resulting corrective actions; b) providing a confidential means of reporting compliance concerns; c) making recommendations to CompanyName regarding changes that must be made to enhance compliance, and updating our Program, as necessary, including drafting, reviewing, revising and adopting policies and procedures to reflect updates in expectations enumerated in applicable laws, rules, and regulations. Pursuant to 42 CFR § 483.85(c)(2), our Compliance and Ethics Officer is someone who has substantial control over the operating organization or who has a substantial role in the making of policy within our organization.

Our Compliance and Ethics Officer has the following specific responsibilities:

1. Coordinates resources, in coordination with the Compliance Committee, to ensure the ongoing effectiveness of our Program.

2. Participates in the development of compliance policies and standards.

3. Reports to governing body (i.e. a board of directors), CEO, and compliance committee on the progress of adopting, implementing, and maintaining the compliance program on a quarterly basis, at a minimum..

4. Monitors developments and changes in relevant state and federal law, regulations, government agency guidance, and court rulings, which may affect our Program. Revises our Program when appropriate to reflect any changes in expectations and/or requirements.

5. Assists CompanyName in establishing methods to improve efficiency, quality of services and reducing vulnerability to fraud, waste, and abuse.

6. Ensures that all affected individuals have read the Code of Conduct and signed a statement acknowledging their understanding of its requirements.

7. Oversees the development, presentation, and the documentation of educational programs through the annual education workplan for all affected individuals with focus on the elements of our Program and risk areas specific to CompanyName.

8. Oversees the development, presentation, and the documentation of the annual compliance workplan for all affected individuals with focus on the elements of our Program and risk areas specific to CompanyName.

9. Responsible for the implementation and management of policies that support and encourage confidential and anonymous reporting, by all affected individuals and residents/family members including, but not limited to, Medicaid recipients and their family members, of suspected fraud, waste, abuse, and other improprieties without fear of retaliation or intimidation.

10. In collaboration with Human Resource, the Compliance Officer will take due care to ensure that CompanyName does not delegate substantial discretionary authority to individuals whom CompanyName knows, or has reason to know, have or had the propensity to engage in criminal, civil, and/or administrative violations.

11. Conducts or oversees appropriate internal compliance reviews and audits.

12. Receives and maintains confidentiality of reports of potential compliance issues.

13. Conducts and oversees investigations of matters that merit investigation under our Program.

14. Brings to the Compliance and Ethics Committee and senior management's attention all compliance issues for appropriate response and disciplinary action, if necessary.

15. Maintains documentation and tracks all issues referred to the Compliance and Ethics Officer and/or Compliance and Ethics Committee.

16. Reports regularly, on a quarterly basis, at a minimum, to the Governing Board on the operation of our Program and any significant developments.

Annual Reporting

On at least an annual basis, the Compliance and Ethics Officer will issue a report to the Senior Administration, the Governing Board, and the Board of Directors, that discusses the effectiveness of the compliance and ethics program using an annual assessment and audit and monitoring tool results of the prior year that identifies any changes to the Compliance and Ethics Program that need to be made to improve compliance. The report shall include the following:

1. Copy of Audit Plan

2. Copy of Education Workplan and list of who has and who has not completed all mandatory compliance education

3. Copy of Annual Compliance Workplan

4. Compliance Meeting Attendance

5. All Audit, Monitoring and Risk Assessment results including annual Self-Assessment of Compliance Program Effectiveness including:
   a. A report on the annual self-assessment review of the effectiveness of the compliance plan includes:
   b. A report on the design, implementation, and results of the annual compliance program effectiveness review, and any corrective action implemented;
   c. Date completed;
   d. Who was in attendance at the review by the compliance committee;
   e. Summary of updates or modifications to the compliance program as a result of the annual review, including implementation dates, if applicable;
   f. Evidence that the results of the annual compliance program review were shared with the chief executive, senior management, compliance committee, and governing body;
   g. Any documentation to evidence that other staff have the necessary knowledge and expertise to evaluate the effectiveness of the components of the compliance program they are reviewing and are independent from the functions being reviewed.

6. All Reports of noncompliance (whether made by hotline call, telephone call, e-mail, face-to-face communication, etc.)

7. All Investigations into alleged noncompliance and results of the investigations

8. All disciplinary action including response and corrective action, addressing identified and substantiated noncompliance

As necessary, and as specific compliance issues arise that require immediate attention, the Compliance and Ethics Officer will make a report on a more frequent basis.

Compliance and Ethics Committee

CompanyName has appointed a Compliance and Ethics Committee (the Committee), which will have overall responsibility for oversight of compliance activities.

The Committee will meet no less than quarterly to review reports on CompanyName's compliance activities.

Our Compliance and Ethics Committee has the following specific responsibilities:

1. Ensure sufficient resources and authority are delegated to the Compliance and Ethics Officer to reasonably ensure compliance with our Program..

2. Exercise due care and due diligence not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known, through exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act..

3. To stay up to date on current issues and standards specific to our business.

4. Ensure that we maintain and improve our Program to reflect the latest state, national, and industry standards.

5. Make recommendations to management regarding recommended revisions to existing policies and new policies that may be necessary.

6. Review reports on CompanyName's compliance activities.

7. Assist Compliance and Ethics Officer and senior management in putting into place appropriate responses to compliance issues as well as appropriate disciplinary actions.

8. Oversee the development and implementation of systems for communicating compliance questions and concerns and reports of wrongdoing.

9. Advise and assist the Compliance and Ethics Officer in his/her responsibilities.

10. Report regularly and at least quarterly to the Governing Board on the operation of our Program and any significant developments.

11. Ensure the company is meeting the highest standards of compliance.

12. Establish and maintain a Compliance Committee Charter that is reviewed annually and updated as needed.

13. The Compliance Committee reports directly to the Chief Executive and Governing Body.

14. All Compliance and Ethics Committee members shall sign a Confidentiality Statement.

Policies and Procedures

CompanyName has written policies and procedures, with a record of implementation and revision dates, that describe compliance expectations, identify how to communicate compliance issues with affected individuals, and describe how potential compliance problems should be investigated and resolved.

Our policies and procedures establish CompanyName's expectations for the conduct of all affected individuals in order to reduce the possibility of fraud, waste, and abuse. Our policies include the adoption of a Code of Conduct (Attachment A), which assists our affected individuals in avoiding

both the appearance and commission of improper activities. The Code of Conduct is distributed to all affected individuals. The Compliance and Ethics Officer is responsible for ensuring that all affected individuals have certified that they have received, read, and fully understand the Code of Conduct. Such policies must be accessible and applicable to all affected individuals. Company-Name's policies on Reporting/Lines of Communication, Confidentiality, and Non-Retaliation and Non-Intimidation must be accessible and applicable to all residents/representatives, including Medicaid beneficiaries.

CompanyName's policies establish compliance with governing laws and regulations applicable to their risk areas, including any relevant Medicaid program policies and procedures.

CompanyName's written policies set forth CompanyName's fundamental principles/values and commitment to conduct its business in an ethical manner, in addition to its compliance expectations.

Training and Education

All affected individuals are responsible for compliance.

CompanyName mandates all affected individuals, as defined again below, to be trained at orientation and annually thereafter on our Compliance and Ethics program, specific regulatory compliance issues, and the responsibilities of the affected individual.

1. Employees and 1099 employees
2. Chief Executive, Executives, and other senior administrators
3. Corporate Officers
4. Managers
5. Volunteers and Interns
6. Appointees
7. Associates
8. Consultants
9. Vendors and Service Contractors, Contractors, Subcontractors, and Independent contractors
10. Agents
11. Governing Body Members
12. All other persons affected by CompanyName's risk areas.

CompanyName maintains an ongoing compliance training program, which includes the following:

1. Our Compliance and Ethics Plan, including, but not limited to, the Code of Conduct and the Deficit Reduction Act policy and all related material from NYS OMIG, OIG, CMS, and Med-Net Compliance monthly bundle documents.

CompanyName's compliance training and education program is designed to communicate our Program's standards and procedures to affected individuals in a meaningful and effective manner, and to ensure consistent application of our Program's policies. In order to best accomplish this, our training program is geared to the level of responsibility and job function.

Training sessions will utilize classroom, lecture, recorded instruction, and/or other means of communication, as appropriate to accommodate the skills, experience, and knowledge of the trainees. Other forms of education will be employed, such as the use of posters, bulletin boards, paycheck stuffers, etc., to inform employees of new compliance issues or to reinforce various aspects of past training. No matter how the information is presented, that training occurred must be thoroughly documented, including the date, attendees, and agenda.

During new hire orientation, all affected individuals, regardless of position and seniority, will be trained on the Compliance and Ethics Program and specific requirements and expectations under the program.

It is the Compliance and Ethics Officer's responsibility to coordinate training activities and maintain a library of compliance-related information and training materials.

All compliance training is mandatory.

Reporting System

Our Program rests upon the ability of our personnel to openly and freely communicate issues of concern to their supervisors, the Compliance and Ethics Officer, and the Compliance and Ethics Committee. We are committed to developing and supporting any and all lines of communication to support our efforts to detect, address, and prevent compliance issues, including a method of anonymous reporting.

CompanyName has established reporting procedures that are readily accessible to all affected individuals, including Medicaid recipients and their families, as well as members of the general public.

CompanyName's Compliance and Ethics Officer should be contacted with questions about compliance or to report potential violations or any concerns regarding compliance. The Compliance and Ethics Officer will maintain open lines of communication and may be reached by telephone, by inter-office mail, or by face-to-face communication. Even if an individual merely has a general question about the propriety of conduct, he/she should still reach out to the Compliance and Ethics Officer. All reports of compliance issues and violations to the Compliance and Ethics Officer will

be kept confidential unless the matter is subject to a disciplinary proceeding; referred to, or under investigation by, MFCU, OMIG, or law enforcement; or disclosure is required during a legal proceeding; and such persons shall be protected under a policy for non-intimidation and non-retaliation.. All reports of compliance issues and violations to the Compliance and Ethics Officer are taken seriously and investigated accordingly.

Should any individual feel uncomfortable making a report to the Compliance and Ethics Officer or wish to remain anonymous and make a good faith report of potential compliance issues, he/she has the option of making a report to our Compliance Hotline (800-557-1066), which allows for anonymous and confidential good faith reporting of potential compliance issues as they are identified without fear of retribution. Signs with information for contacting the Compliance Hotline are visible throughout our facility.

All reports must be made in good faith. There will be no adverse action or retaliation against any affected individual/person who makes a good faith report of a compliance concern. Likewise, there will be no retaliation for other actions of good faith participation in the Compliance and Ethics Program including, but not limited to, reporting potential issues; cooperating or participating in the investigation of issues; participating in self-evaluations, audits, and remedial action; and/or making reports of inappropriate conduct to appropriate officials."

Auditing and Monitoring

CompanyName has established a system for routine identification of compliance risk areas set forth below and self-evaluation of risk areas including auditing and monitoring, designed to detect criminal, civil, and administrative violations in compliance with CompanyName's Deficit Reduction Act policy, attached hereto as "Attachment B" and in compliance with the below referenced risk areas, laws, regulations, and NYS Medicaid program policies and procedures:

- RISK AREAS
  - Billings
  - Payments
  - Ordered services
  - Medical necessity
  - Quality of care
  - Governance
  - Mandatory reporting
  - Credentialing
  - Contractor, subcontractor, agent, or Independent Contract oversight
  - Other risk areas that are or should reasonably be identified through organizational experience

- 10 NYCRR Parts 400 and 415
- NY Public Health Law Article 28
- NYS Social Services Law § 363-d
- NYS Social Services Law § 366-b
- NYS Penal Law Article 155

- NYS Penal Law Article 175
- NYS Penal Law Article 176
- 18 NYCRR SubPart 521-1 et seq.
- 18 NYCRR Part 504, Medical Care – Enrollment of Providers
- 18 NYCRR Part 515, Provider Sanctions
- 18 NYCRR Part 516, Monetary Penalties
- 18 NYCRR Part 519, Provider Hearings
- https://www.health.ny.gov/health_care/medicaid/program/update/main.htm
- https://www.emedny.org/

Internal auditing standards are integral to the Compliance and Ethics Program. Data will be collected and analyzed on a regular basis to assess CompanyName's compliance with established standards of practice, in particular: quality, documentation, billing, and reimbursement guidelines.

CompanyName will employ a variety of techniques including, but not limited to, the following:

1. Periodic interviews with management personnel regarding their perceived levels of compliance within their departments or areas of responsibility.

2. Questionnaires developed to poll personnel regarding compliance matters as well as the effectiveness of individual training techniques.

3. Periodic written reports of department managers, utilizing assessment tools developed to track specific areas of compliance.

4. Audits designed and performed by internal and/or external auditors using auditing guidelines.

5. Exit interviews of departing employees.

The Compliance and Ethics Officer will ultimately be responsible for coordinating formal audits; however, the audits may be performed by internal or external auditors or another designee. The auditors should: possess the qualifications and experience necessary to adequately identify potential compliance issues; be objective and independent of management; and have access to relevant personnel, records, and areas of operation; present a written evaluation concerning compliance activities to the Compliance and Ethics Officer; and specifically identify areas where corrective actions are needed.

Auditing and monitoring should be conducted regularly, and written reports must be presented to the Compliance and Ethics Officer and Compliance and Ethics Committee at least quarterly. Any areas of potential noncompliance shall be kept confidential.

The Compliance and Ethics Officer shall analyze the results of the auditing and monitoring to determine the root cause. On the basis of these reports, the Compliance and Ethics Officer and Compliance and Ethics Committee shall determine an appropriate response.

Response

When potential compliance issues arise, CompanyName will take reasonable steps to respond appropriately to the offense and prevent future similar offenses. As such, CompanyName has established a system for responding to compliance issues as they arise including investigating, retaining legal consultation, updating policies and procedures, implementing corrective action plans, and, when appropriate, remitting payment and/or reporting misconduct to appropriate authorities. It is the responsibility of all associated with CompanyName to assist in resolving compliance issues by participating in good faith in CompanyName's response to potential compliance violations, including cooperating when CompanyName is conducting investigations and abiding by corrective action put into place.

Reports received through either a reporting mechanism or through some other mechanism (e.g., auditing), shall be documented and assessed initially by the Compliance and Ethics Officer. If the initial assessment indicates that there is a basis for believing that the conduct reported constitutes noncompliance, the matter shall be reported to the Compliance and Ethics Committee for review.

All instances of potential noncompliance shall be investigated carefully to determine whether the allegation appears to be well-founded. The Compliance and Ethics Officer shall promptly begin an investigation in accordance with the following procedure:

1. Compliance and Ethics Officer shall commence an investigation as soon as reasonably possible, but in no event more than thirty (30) days following reasonable suspicion of a compliance violation.

2. The investigation may include:

    A. Interviews of the person(s) involved in or having knowledge of the potential noncompliance.
    B. Interviewees with relevant information may be required to submit a signed, dated, written statement.
    C. If the Compliance and Ethics Officer does not request a written statement from Interviewee, the Compliance and Ethics Officer shall document the interview and he/she should sign and date the record.
    D. The creation of a timeline of events.
    E. Review of related documents, if appropriate.
    F. Review of applicable federal and state laws, rules, and regulations as well as CompanyName's policies and procedures.
    G. Collaboration with the Compliance and Ethics Committee.
    H. Consultation with Compliance and Ethics Attorney, auditors, healthcare consultants, etc.

Every effort to investigate potential noncompliance shall be documented and kept with the original report.

If the allegation is substantiated, Compliance and Ethics Officer shall determine:

1. Whether the alleged activity violates state, federal, or CompanyName's policies and procedures.

2. What corrective action, if any, should be taken.

3. Whether the allegation warrants reporting.

CompanyName shall respond to compliance problems promptly and thoroughly by putting into place corrective action. Corrective action shall be imposed as a means of facilitating the overall goal of full compliance. Corrective action plans should assist affected individuals including, but not limited to, CompanyName employees, vendors, or business associates, to understand specific issues and reduce the likelihood of future noncompliance. Corrective action shall be sufficient to effectively address the particular instance of noncompliance and should reflect the severity of the noncompliance and the past adherence to compliance standards. All associated with CompanyName are responsible for actively participating in the corrective action.

The corrective action plan should identify the nature of the noncompliance and immediate correction of any harm resulting from the violation as well as the resolution of specific problems identified. The plan may include:

1. A recommendation to revise applicable policies and procedures to clarify proper protocols and/or development of new systems to safeguard against future noncompliance of a similar nature.
2. Additional mandatory training for employees, contractors, vendors, and/or business associates.
3. Increased auditing and/or monitoring.
4. Focused review of records made by employees, contractors, vendors, or business associates for a defined period of time following discovery of noncompliance.
5. A recommendation to not bill inappropriate claims.
6. A recommendation to report identified noncompliance to the appropriate government authorities after consultation with Legal Counsel.

    a. **Report shall be filed as soon as possible but no later than sixty (60) days of the discovery of the credible evidence of fraud**:

        i. The Office of Inspector General (OIG) Provider Self-Disclosure Protocol is available at https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp
        ii. Report to the State Medicaid Office
            1. In New York, call the Office of the New York State Attorney General's Medicaid Fraud Control Unit at (800) 771-7755 or file a complaint on-line at https://ag.ny.gov/nursinghomes.
        iii. Reporting should also be made to the State Department of Health
            1. In New York, call the New York State Department of Health at (888) 201-4563 or file a complaint on-line at https://ag.ny.gov/nursinghomes,

7. A recommendation to report to appropriate authorities within sixty (60) days of discovery and repay any overpayments uncovered during the investigation, with interest, if appropriate, after

the Compliance and Ethics Officer has conducted an investigation and considered the following:

A. Identification of the exact issue

B. The amount involved

C. Any patterns or trends that the problem may demonstrate within the provider's billing system

D. The extent of the period affected

E. The circumstances that led to the overpayment

F. Whether or not the organization has a corporate integrity agreement in place which requires self-disclosure

Report shall be filed and repayment shall be made to payor, with interest if appropriate, as soon as possible, but no later than sixty (60) days of discovery.

i. The Office of Inspector General (OIG) Provider Self-Disclosure Protocol is available at https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp
ii. Report to State Medicaid Office
    a. In New York, CompanyName shall report, return, and explain overpayments to the New York State Medicaid Office in accordance with the 18 NYCRR SubPart 521-3

8. Enforcement of disciplinary standards.
9. Other reasonable corrective measures calculated to ensure adherence to applicable federal and state laws, rules, regulations, and our Program.

For a defined period of time following the implementation of a corrective action plan, the Compliance and Ethics Officer shall follow up and audit the corrective action to determine whether it is being followed as well as its effectiveness in preventing the recurrence of similar violations.

If an allegation is not substantiated, the Compliance and Ethics Officer shall keep a clear record of the investigation's conclusion as well as what factors were considered in making that determination.

Enforcing Disciplinary Standards

Active participation in the Compliance and Ethics Program is mandatory. Adherence to applicable laws, rules, and regulations as well as CompanyName's Compliance and Ethics Program will be an element in evaluating performance. Failing to report suspected noncompliance; participating in noncompliant behavior; or encouraging, directing, facilitating, or permitting, either actively or passively, noncompliant behavior may result in disciplinary action, up to and including termina-

tion. Also, if CompanyName learns that an individual knowingly fabricated, distorted, exaggerated, or minimized a report of misconduct, either to injure someone else or to protect himself or herself, the individual will be subject to disciplinary action, up to and including termination.

Sometimes an individual who makes a report may also admit to noncompliance on his or her part. Making a report, in itself, does not guarantee protection from disciplinary action related to the underlying noncompliance. However, volunteering information about one's own errors, misconduct, or noncompliance will be taken into account, as long as the admission is complete and truthful, and was not already known to, or about to be discovered by, CompanyName. The weight to be given to the report will depend on all the facts known to CompanyName at the time disciplinary decisions are made.

All disciplinary actions are applied consistently and in accordance with well-publicized guidelines. All compliance-related disciplinary policies are fairly and firmly enforced; as a general rule, similarly situated employees committing similar offenses under similar circumstances shall be subject to the same discipline. However, the form of correction or discipline provided will be case specific and may be based on a variety of factors including whether the employee promptly reported his/her own violation, severity of the offense, previous incidents involving the individual, whether the employee cooperates fully in investigating/correcting the violation, and the individual's commitment to a positive change in behavior.

The range of disciplinary action to which persons may be subject include the following:

1. Verbal Warnings
2. Written Warnings
3. (Paid or Unpaid) Suspension from Employment, or Revocation of Contract
4. Termination

Some acts or omissions of employees and others associated with CompanyName shall result in immediate termination. Also, individuals who commit negligent or reckless violations of laws, rules, regulations, or Company policy shall be terminated immediately.

Non-Intimidation and Non-Retaliation

CompanyName has a policy of non-intimidation and non-retaliation for all affected individuals, including Medicaid recipients and their family members, for good faith participation in the Compliance and Ethics Program including, but not limited to, reporting potential issues; cooperating or participating in the investigating of issues; participating in self-evaluations, audits, and remedial action; and/or making reports to appropriate officials of inappropriate conduct.

Reassessment

CompanyName believes that a thorough and ongoing evaluation of the various aspects of the Compliance and Ethics Program is crucial to its success. Therefore, CompanyName performs a periodic reassessment of the Compliance and Ethics Program to evaluate its effectiveness and to make any necessary adjustments.

In order to evaluate the effectiveness of the Compliance and Ethics Program, CompanyName will employ a variety of techniques including, but not limited to, the following:

1. Periodic interviews with management personnel regarding their perceived levels of compliance within their departments or areas of responsibility.
2. Questionnaires developed to poll personnel regarding compliance matters including the effectiveness of individual training/educational techniques.
3. Periodic written reports of department managers utilizing assessment tools developed to track specific areas of compliance.
4. Exit interviews for departing employees.

CompanyName shall make any necessary adjustments to the Compliance and Ethics Program found to be warranted through the reassessment process.

EXTERNAL COMMUNICATIONS

Contact with Government Agents/Investigators

All contacts with anyone claiming to represent any local, state, or federal agency requesting information or an interview concerning CompanyName should be immediately directed to the Compliance and Ethics Officer. It is CompanyName's policy to cooperate with the authorities. Keep the following in mind:

1. No one is **required** to submit to questioning by government investigators or employees. If someone claiming to represent the government contacts you at work or at your home regarding CompanyName or your employment, follow these steps:

    A. Ask for identification and a business card.
    B. Determine precisely why he or she wishes to speak with you.
    C. Tell the investigator that you wish to make an appointment for a date and time in the future.
    D. Immediately notify the Compliance and Ethics Officer.

Contact with the Media

All contacts concerning CompanyName with anyone from the media shall be referred to the Compliance and Ethics Officer.

Contact with Attorneys

All contacts concerning CompanyName with anyone claiming to be an attorney shall be referred immediately to the Compliance and Ethics Officer.

Contact with Competitors

All contacts with anyone representing a competitor of CompanyName or employed by a competitor shall be reported to your immediate supervisor.

INVESTIGATIONS AND LITIGATION

Subpoenas, Summonses, and Legal Complaints

Other than routine subpoenas for medical or personnel records, subpoenas, summonses, or other legal complaints involving CompanyName shall be given to the Compliance and Ethics Officer immediately. It is important that the Compliance and Ethics Officer and other appropriate individuals respond to subpoenas, summonses, and other legal documents; therefore, it is our policy that staff not turn over documents or discuss the case with any individuals unless directed to do so.

Compliance and Ethics Attorney will be contacted, if appropriate.

Search Warrants

If someone representing a government agency attempts to execute a search warrant at any CompanyName location:

1. CompanyName employees and contractors shall not interfere with the agents.
2. CompanyName employees and/or contractors shall demand a copy of the search warrant and the business card (or name) of the agent in charge.
3. The Administrator or highest-ranking CompanyName employee on the premises shall be informed of the situation immediately.
4. The Compliance and Ethics Officer shall be contacted, also. Any instructions given by the Compliance and Ethics Officer shall be carefully followed.
5. Compliance and Ethics Attorney shall be contacted, if appropriate.
6. CompanyName employees and/or contractors shall assure that:

   A. Only those items referred to in the search warrant are taken,

      i. CompanyName acknowledges that the items taken will be our original documents.
      ii. If the government agents attempt to take actual computers, CompanyName employees and/or contractors shall attempt to detach the computers for the government agents in order to minimize damage to the wiring, etc.

   B. CompanyName documents shall not be photocopied by the government agents on the premises,
   C. A correct and complete inventory of all items taken shall be requested from the government agents before they leave the premises.

While the agents may have the right to be on the premises to execute a warrant, that does not mean CompanyName employees and/or contractors must submit to interviews. Employees and contractors need not explain CompanyName operations, bookkeeping, records, or what any document means; however, employees and contractors will cooperate in locating items called for in the search warrant.

If a government agent makes requests or demands of you inconsistent with these instructions, seek the advice of the Compliance and Ethics Officer.

ATTACHMENT A
CODE OF CONDUCT

CompanyName and its employees, volunteers, interns, appointees, associates, consultants, vendors, agents, executives, and governing board members, hereinafter referred to collectively as "affected individuals", constantly strive to ensure that all activity by, on behalf of, or with the organization is in compliance with all applicable federal, state, and local laws, regulations, ordinances, administrative directives, and any other binding governmental directives ("Laws and Regulations").

The general principles articulated in this Code of Conduct are intended to provide guidance to individuals in their obligation to comply with applicable laws and regulations. However, the general principles contained herein are neither exclusive nor complete. All affected individuals are expected to refer to CompanyName's Compliance and Ethics Program, manuals, policies, and procedures as well as other relevant laws and regulations for further guidance. It is important for all affected individuals to recognize that they are required to comply with all applicable laws and regulations, as well as CompanyName's Compliance and Ethics Program, manuals, policies, and procedures, whether or not specifically addressed in this Code of Conduct. If questions regarding the existence of, interpretation, or application of any law, regulation, rule, standard, policy, and/or procedure arise, they should be directed to CompanyName's Compliance and Ethics Officer.

CompanyName expects each individual to whom this Code of Conduct applies to abide by the principles in this Code of Conduct and to conduct the business and affairs of the organization in a manner consistent with the general policies set forth herein.

Nothing in this Code of Conduct is intended to, nor shall be construed as, providing any additional employment or contractual rights to employees and contractors or other persons.

ETHICAL BUSINESS PRACTICES

1. Achieving business results by illegal acts or unethical conduct is not acceptable. It is expected that all affected individuals shall act in compliance with the requirements of applicable law and this Code, and in a sound ethical manner when rendering services to our residents and when conducting business and operational functions.
2. Affected individuals shall perform their duties in good faith and to the best of their ability, and shall not obtain any improper personal benefit by virtue of their relationship with CompanyName.
3. Other than compensation from CompanyName, and as consistent with the conflict of interest policies, personnel shall not have a financial or other personal interest in a transaction between CompanyName and a vendor, supplier, provider, or customer.
4. Each supervisor and manager is responsible for ensuring that the personnel within their supervision are acting ethically and in compliance with applicable law and the Code. All personnel are responsible for acquiring sufficient knowledge to recognize potential compliance issues applicable to their duties, and for appropriately seeking advice regarding such issues.
5. Honest Communication. CompanyName requires honesty from individuals in the performance of their responsibilities and in communication with CompanyName's attorneys and auditors.

No employee or contractor shall make false or misleading statements to any state or federal official, investigator, or person/entity doing business with CompanyName. Employees and contractors shall not destroy or alter CompanyName information or documents in anticipation of, or in response to, a request for documents by any applicable government agency or from any court.

6. Duty to Report. It is the ongoing and continuous obligation of all affected individuals including, but not limited to, employees of CompanyName, to alert the Human Resources Department of any conviction, exclusion from participating in a state or federal healthcare program, or a finding that would disqualify them from providing services.
7. Financial Reporting. All of CompanyName's business transactions shall be carried out in accordance with management's general or specific directives. All of the books and records shall be kept in accordance with generally accepted accounting standards or other applicable standards. All transactions, payments, receipts, accounts, and assets shall be completely and accurately recorded on CompanyName's books and records on a consistent basis. All information including financial reports, cost reports, accounting records, expense accounts, time sheets, and other documents recorded and submitted to other persons, must accurately and clearly represent the relevant facts or the true nature of the transaction, and must not be used to mislead those who receive the information or to conceal anything that is improper.
8. Proprietary Information. CompanyName's employees and contractors shall not steal information belonging to another person or entity, including from CompanyName, or use any publication, document, computer program, information, or product in violation of a third party's interest in such product. All employees and contractors are responsible for ensuring that they do not improperly copy documents or computer programs in violation of applicable copyright laws or licensing agreements for their own use. Employees and contractors shall not use confidential business information obtained from competitors or pre-employment agreements in violation of a covenant not to compete, or in any other manner likely to provide an unfair competitive advantage to CompanyName.
9. Business Relationships. Affected individuals including, but not limited to, employees and contractors, shall not engage in any business practice intended to unlawfully obtain favorable treatment or business from any government entity or any other party in a position to provide such treatment or business. Employees and contractors shall not use confidential or proprietary information about CompanyName for their own personal benefit or for the benefit of any other person or entity, except CompanyName.

    A. *Disclosure of Financial Interest*. Affected individuals including, but not limited to, employees and contractors, shall disclose to the Compliance and Ethics Officer any financial interest, ownership interest, or any other relationship they (or a member of their immediate family) have with CompanyName's vendors or competitors.
    B. *No Use of Insider Information*. Affected individuals including, but not limited to, employees and contractors, may not use "insider" information for any business activity conducted by or on behalf of CompanyName. All business relations with contractors providing any services to CompanyName must be conducted at arm's length both in fact and in appearance, and in compliance with CompanyName's policies and procedures. Employees and contractors must disclose personal relationships and business activities with such contrac-

tor personnel that may be construed by an impartial observer as influencing the employees' and contractors' performance or duties. Employees and contractors have a responsibility to obtain clarification from management on questionable issues that may arise.

10. Affected individuals shall not engage in any financial, business, or other activity that competes with CompanyName's business, that may interfere or appear to interfere with the performance of their duties, or that involves the use of CompanyName property, facilities, or resources, except to the extent consistent with the conflict of interest policies.
11. Affected individuals shall comply with applicable antitrust laws. There shall be no discussions or agreements with competitors regarding price or other terms for product sales, prices paid to suppliers or providers, dividing up customers or geographic markets, or joint action to boycott or coerce certain customers, suppliers, or providers.
12. Affected individuals including, but not limited to, employees and contractors, shall not engage in unfair competition or deceptive trade practices including misrepresentation of CompanyName's products or operations. Personnel shall not make false or disparaging statements about competitors or their products or attempt to coerce suppliers or providers into purchasing products or services.
13. Confidentiality. All personnel shall maintain the confidentiality of CompanyName's business information and of information relating to CompanyName's personnel, vendors, suppliers, providers, and residents. Personnel shall not use any such confidential or proprietary information except as is appropriate for business. Personnel shall not seek to improperly obtain or misuse confidential information of CompanyName's competitors.
14. Personal Use of Corporate Assets. All employees and contractors are expected to refrain from converting assets of CompanyName to personal use. All business of CompanyName shall be conducted, and CompanyName's property utilized, in a manner designed to further CompanyName's interest rather than the personal interest of an individual employee or contractor. Employees and contractors are prohibited from the unauthorized use or taking of CompanyName's equipment, supplies, materials, or services.

LEGAL COMPLIANCE

1. Gifts from Customers or Others. Affected individuals including, but not limited to, employees and contractors, are prohibited from soliciting or accepting tips, personal gratuities, gifts, or other things of value from CompanyName's customers or others who seek to do business with CompanyName. If a customer or another individual wishes to present a monetary gift, he/she should be referred to the Compliance and Ethics Officer.
2. Gifts Influencing Decision-Making. Affected individuals including, but not limited to, employees and contractors, shall not accept gifts, favors, services, entertainment, or other things of value to the extent that decision-making or actions affecting CompanyName might be influenced. Similarly, the offer or giving of money, services, or other things of value with the expectation of influencing the judgment or decision-making process of any purchaser, supplier, government official, or other person by CompanyName is absolutely prohibited.
3. Gifts from Existing Vendors or Customers. Employees and contractors may retain gifts from vendors or customers that have a nominal value generally less than $50 in aggregate over each year. To the extent possible, these gifts should be shared with the employees' and contractors' coworkers. Gifts of cash and cash equivalents (e.g., gift certificates) are never acceptable.

4. Vendor or Customer Sponsored Entertainment. Occasionally, at a vendor's or customer's invitation, an employee or contractor may accept meals or refreshments, attend a local theater or sporting event, or similar entertainment, at the vendor's or customer's expense, so long as the cost is of nominal value under the circumstances, generally less than $50 in aggregate over each year. In most circumstances, a regular business representative of the vendor or customer should be in attendance with the employee or contractor. Employees and contractors should advise the Compliance and Ethics Officer of vendors or customers who offer such invitations on a frequent basis, even if the employee or contractor does not accept such invitations.
5. Conflicts of Interest. Neither employees nor contractors may use their positions at CompanyName to profit personally or to assist others in profiting in any way at the expense of CompanyName.
6. Anti-Discrimination/Anti-Harassment. All affected individuals are responsible for ensuring that the work environment is free of discrimination or harassment due to sex, age, race, gender, color, religion, national origin, disability, or any other status protected under state or federal law.
7. Fraud and Abuse. CompanyName expects all affected individuals including, but not limited to, its employees and contractors, to refrain from conduct which may violate any federal and state laws relating to health care fraud and abuse. Every affected individual is expected to: a) maintain honest and accurate records of services provided; b) follow current and applicable laws, regulations, and guidelines to facilitate proper documentation of services; and c) take necessary steps to prevent the submission of claims for payment and reimbursement of any kind that are fraudulent, abusive, inaccurate, or medically unnecessary.
8. Kickbacks, Inducement, and Self-Referrals. All affected individuals including, but not limited to, CompanyName employees and contractors, shall comply with all laws relating to kickbacks, inducements, and self-referrals.

   All affected individuals including, but not limited to, CompanyName employees and contractors, shall not knowingly offer, pay, solicit, or receive bribes, kickbacks, or other improper remuneration in order to induce business reimbursable by any federal or state governmental program including, but not limited to, Medicare and/or Medicaid.

   All affected individuals including, but not limited to, CompanyName employees and contractors, are required to report any gifts or other gratuities, other than those of nominal value, received from any outside source that is in the position to benefit from the referral of business to CompanyName.
9. Lobbying/Political Activity. Affected individuals shall not directly or indirectly authorize, pay, promise, deliver, or solicit any payment, gratuity, or favor for the purpose of influencing any political official or government employee in the discharge of that person's responsibilities. Personnel shall not entertain government personnel in connection with CompanyName business.

EDUCATION

1. CompanyName will develop and implement a regular education and training program for all employees and external agents.

2. All employees are expected to participate in educational programs and abide by policy requirements.
3. Adherence to CompanyName's Compliance and Ethics Program will be a factor in evaluating the performance of an employee.
4. CompanyName will maintain records of all educational programs presented to employees and relevant external agents.

REPORTING OF VIOLATIONS

1. Illegal acts or improper conduct may subject CompanyName to severe civil and criminal penalties including large fines and being excluded from certain types of federally funded insurance programs. It is, therefore, very important that any illegal activity or violations of the Code be promptly brought to CompanyName's attention.
2. All affected individuals including, but not limited to, any director, officer, or employee, who is uncertain of, or believes, or becomes aware of any violation of this Code or any illegal activity by a director, officer, or employee or another person acting on CompanyName's behalf shall promptly report the violation or illegal activity in person, by phone, or in writing, to:

    A. the appropriate supervisor;
    B. the Administrator;
    C. the Compliance and Ethics Officer; or
    D. the Compliance Hotline at (800) 557-1066.
        i. Provides option to report anonymously

3. It is the duty of the Administrator or any supervisor who receives a report of a possible compliance issue to report such issue to the Compliance and Ethics Officer or appropriate compliance personnel immediately.
4. The confidentiality of persons reporting compliance issues shall be maintained unless the matter is subject to a disciplinary proceeding; referred to, or under investigation by, MFCU, OMIG, or law enforcement; or disclosure is required during a legal proceeding; and such persons shall be protected under a policy for non-intimidation and non-retaliation.
5. It is a violation for personnel not to report a violation of the Code or any illegal activity. If you have a question about whether particular acts or conduct may be illegal or violate the Code, you should contact one of the persons listed above. It is a violation of this Code for personnel to whom a potential illegal act or violation of the Code is reported, to not ensure that the illegal act or violation of the Code comes to the attention of those responsible for investigating such reports. If the illegal acts or conduct in violation of the Code involve a person to whom such illegal acts or violations might otherwise be reported, the illegal acts or violation should be reported to another person to whom reporting is appropriate.
6. It is CompanyName's policy to promptly and thoroughly investigate reports of illegal activity or violations of this Code. Personnel must cooperate with these investigations. You must not take any actions to prevent, hinder, or delay discovery and full investigation of illegal acts or violations of this Code. It is a violation of this Code for personnel to prevent, hinder, or delay discovery and full investigation of illegal acts or violations of this Code.

7. Affected individuals may report illegal acts or a violation of this Code anonymously. To the extent permitted by law, CompanyName will take reasonable precautions to maintain the confidentiality of those individuals who report illegal activity or violations of this Code and of those individuals involved in the alleged improper activity, whether or not it turns out that improper acts occurred. Failure to abide by this confidentiality obligation is a violation of this Code.
8. No reprisals or disciplinary action will be taken or permitted against personnel for good faith reporting of, or cooperating in the investigation of, illegal acts or violations of this Code. It is a violation of this Code for personnel to punish or conduct reprisals in regard to personnel who have made a good faith report of, or cooperated in the investigation of, illegal acts or violations of this Code.

DISCIPLINARY ACTION

Affected individuals who violate the Code or commit illegal acts are subject to discipline up to and including dismissal. Affected individuals who report their own illegal acts or improper conduct, however, will have such self-reporting taken into account when determining the appropriate disciplinary action.

ATTACHMENT B
DEFICIT REDUCTION ACT OF 2005
NEW YORK

Policy Statement/Purpose: To ensure CompanyName is consistent with applicable legal requirements and standards of practice.

Policy Interpretation and Implementation: CompanyName is committed to adhering to all fraud and abuse compliance regulations. Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) § 521-1.4(a)(2)(ix) states all Required Providers shall comply with the provisions of 42 USC 1396a(a)(68) also known as the Deficit Reduction Act of 2005, the Deficit Reduction Act or DRA. The Deficit Reduction Act of 2005 requires CompanyName to educate and train all affected individuals on federal and state false claims laws, whistleblower protections and CompanyName's policies and procedures for detecting and preventing fraud, waste, and abuse.

DEFINITIONS

1. Affected Individual(s): Employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors, contractors, subcontractors, agents, Chief Executive and other senior administrators, managers, executives, Governing Body Members, corporate officers, 1099 employees, and service contractors.

2. Contractor: Vendors, contractors, associates, consultants, independent contractors, subcontractors, agents, 1099 employees, and service contractors.

Procedure:

This policy applies to all Affected Individuals.

CompanyName's Compliance and Ethics Officer shall implement this policy and procedure.

CompanyName shall require its Contractors to adopt this policy and disseminate and provide training on this policy to their affected individuals.

EXCLUSION CHECKS

CompanyName shall verify that any current or prospective affected individual who directly or indirectly will be furnishing, ordering, directing, managing, or prescribing items or services in whole or in part is not excluded from participating in a state or federal healthcare program by searching the following databases on a monthly basis:

1. Federal Exclusions Database (mandatory)
   https://exclusions.oig.hhs.gov/ or http://oig.hhs.gov/fraud/exclusions.asp
2. The General Services Administration's System for Award Management (mandatory)
   http://www.sam.gov

3. Office of the NYS Medicaid Inspector General List of Restricted and Excluded Providers Search
   https://www.omig.ny.gov/search-exclusions

Because the Affordable Care Act has proclaimed an individual excluded in one state as excluded in all states, CompanyName shall also verify that no current or prospective affected individual who directly or indirectly will be furnishing, ordering, directing, managing, or prescribing items or services in whole or in part is not excluded from participating in a state or federal healthcare program by searching currently maintained state databases.

AUDIT OF PATIENT CHARTS

CompanyName shall audit residents' charts and other documents relative to quality care and compliance to standards of practice regulated by state and federal agencies. The number of charts to be reviewed will vary depending upon the resident census. Semi-annual audits shall be prepared and a summary of findings shall be presented to the Compliance and Ethics Officer and the Compliance and Ethics Committee.

AUDIT OF MEDICAL AND BILLING RECORDS

CompanyName shall review medical and billing records for a designated semi-annual period, at a minimum under the overall direction of the Compliance and Ethics Officer. Review may be both prospective and retrospective.

The medical records shall be provided at random. The audit shall include at least the number of records equal to five (5) percent of the CompanyName's current census; additional records may be reviewed more frequently at the discretion of the Compliance and Ethics Officer and the Compliance and Ethics Committee.

CompanyName shall examine the records for compliance with the applicable standards of practice, specifically compliance with billing-related statutes, regulations, and guidelines as well as clinical quality of care.

CompanyName shall review a representative sample of billing records for the audit period and compare the charges found in those records with the documentation entered into the medical record. This review shall assess the following:

1. Whether the recognized documentation guidelines have been met;
2. Whether key elements of the service were provided by staff members;
3. Whether the billing codes are supported by the documentation; and
4. Other aspects of billing as outlined by the Office of the Inspector General standards.

CORRECTIVE ACTION PLANS

The Compliance and Ethics Officer and the Compliance and Ethics Committee shall develop a work plan based on the audit findings to address any negative practices. Corrections may include, but are not limited to, the following actions:

1. Review of documentation process and/or forms; changes shall be made, if necessary.
2. In-service to professional staff.
3. Disciplinary actions to individual(s) who may be repeat offenders of improper documentation.

DRA EDUCATION

Written policies, employee handbooks and training to all affected individuals shall cover:

1. The Federal False Claims Act [31 U.S.C. §§ 3729–33]
2. The Federal Program Fraud Civil Remedies Act [31 U.S.C. §§ 3801–12]
3. Any applicable state false claims laws, which in New York include:

    A. New York False Claims Act [N.Y. FIN. LAW § 187–194]

        i. Civil Penalties [N.Y. FIN. LAW § 190]

    B. Social Services Law, False Statements [N.Y. SOC. SERVS. LAW §145-b]

        i. Social Services Law, Civil Sanctions [N.Y. SOC. SERVS. LAW §145-c]
        ii. Social Services Law, Criminal Penalties [N.Y. SOC. SERVS. LAW §145-c

    C. Social Services Law, Penalties for Fraudulent Practices [N.Y. SOC. SERVS. LAW §366-b]
    D. Penal Law, Larceny [N.Y. PENAL LAW § 155]
    E. Penal Law, False Written Statements [N.Y. PENAL LAW § 175]
    F. Penal Law, Insurance Fraud [N.Y. PENAL LAW § 176]
    G. Penal Law, Health Care Fraud [N.Y. PENAL LAW § 177]

4. The right of employees for whistleblower protections under the New York State Whistleblower Law [N.Y. LABOR LAW §§ 740, 741], and some of the Federal and State statutes mentioned above including a policy of non-intimidation and non-retaliation for good faith participation in the Compliance and Ethics Program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits, and remedial actions, and reporting to appropriate officials.
5. The employer's policies and procedures for detecting and preventing fraud, waste, and abuse in Medicaid, Medicare, and other federally funded health care programs, as outlined above.

All affected individuals shall be trained upon initial hire and on an annual basis thereafter.

DISCUSSION OF APPLICABLE LAW

1. Deficit Reduction Act of 2005 [42 U.S.C. § 1396a(a)(68]

   A. Federal law that requires CompanyName, because it receives Medicaid funding, to take the following actions to address fraud, waste, and abuse in health care programs that receive federal funds:

      i. Establish written policies for all affected individuals.

         a. Provide detailed information about the Federal and State False Claims Act; administrative remedies for false claims or statements; and whistleblower protection;
         b. Include provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and;
         c. Provide affected individuals with a specific discussion of their rights to be protected as whistleblowers.

      ii. Under Section 6032, CompanyName must establish and make available to their affected individuals policies that explain:

         a. Federal and state laws dealing with false claims for payment from federally funded programs; and
         b. CompanyName's policies and procedures to detect and prevent fraud, waste, and abuse in these programs.

      iii. Contractors must adopt this policy and disseminate and provide training on this policy to their affected individuals.

2. Federal False Claims Act [31 U.S.C. §§ 3729–33]

   A. Federal law that creates liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment from any federally funded contract or program.

      i. "Knowingly" means that a person, with respect to information:

         a. Has actual knowledge of falsity of information in the claim;
         b. Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
         c. Acts in reckless disregard of the truth or falsity of the information in a claim, and;

      ii. Requires no proof of specific intent to defraud.

   B. Health care providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties ranging from $13,508 to $27,018 for each false claim submitted in accordance with Federal Register Vol. 82, No. 22, Friday, February 3, 2017, pgs 9131-9136 located at https://www.gpo.gov/fdsys/pkg/FR-2017-02-03/pdf/FR-2017-02-03.pdf.

i. Section 701 of the "Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015" (the Act) [28 U.S.C. 2461], amending the "Federal Civil Penalties Inflation Adjustment Act of 1990", requires federal agencies to make subsequent annual adjustments for inflation. Starting in January 2017, federal agencies are required to publish in the Federal Register annual inflation adjustments for civil penalties and must do so no later than January 15 of each year.
ii. PLUS up to three times the amount of damages sustained by the U.S. Government.
iii. PLUS, if convicted, possible exclusion from participation in federal health care programs.

C. Qui Tam "Whistleblower" Provisions

i. Allow any person, also known as the "relator", with actual knowledge of allegedly false claims to file a lawsuit on behalf of the U.S. government.
ii. Relators may receive a percentage of the moneys recovered by the U.S. government.
iii. CompanyName is prohibited from retaliating against Relators for complaining or filing lawsuits. If there is retaliation, Relators are entitled to employment reinstatement, back pay and any other compensation arising from retaliatory conduct against a whistleblower for filing an action, investigating a false claim or providing testimony for or assistance in a False Claims Act action.

D. Examples of Health Care Fraud [31 U.S.C. §§ 3801–12]

i. Billing for services not rendered or goods not provided
ii. Falsifying certificates of medical necessity
iii. Billing for services not medically necessary
iv. Billing separately for services that should be a single service
v. Falsifying treatment plans or medical records to maximize payments
vi. Failing to report overpayments or credit balances
vii. Duplicate billing

3. Federal Program Fraud Civil Remedies Act [31 U.S.C. §§ 3801–12]

A. Federal law that provides federal administrative remedies for false claims and statements to federally funded health care programs.
B. Current civil penalties are $13,508 (in accordance with Federal Register Vol. 82, No. 22, Friday, February 3, 2017, pgs 9131-9136 located at https://www.gpo.gov/fdsys/pkg/FR-2017-02-03/pdf/FR-2017-02-03.pdf) for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the Government makes a payment.
C. Section 701 of the "Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015" (the Act) [28 U.S.C. 2461], amending the "Federal Civil Penalties Inflation Adjustment Act of 1990", requires federal agencies to make subsequent annual adjustments for inflation. Starting in January 2017, federal agencies are required to publish in the Federal

Register annual inflation adjustments for civil penalties and must do so no later than January 15 of each year.

4. New York False Claims Act [N.Y. FIN. LAW § 187–194]

   A. State law creates liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the State of New York for payment from any state funded contract or program.
   B. Health care providers and suppliers who violate the New York False Claims Act can be subject to civil monetary penalties ranging from $6,000 to $12,000 for each false claim submitted, recoverable damages are between two (2) and three (3) times the amount that is falsely received. In addition, the false claim filer may have to pay for the government's legal fees.
   C. No employer shall make, adopt, or enforce any rule, regulation, or policy preventing an employee from disclosing information to a State or law enforcement agency or from acting to further a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed under this act.

      i. In addition, the defendant shall be required to pay litigation costs and reasonable attorney's fees associated with an action brought under this section.

   D. Allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.
   E. Prohibits retaliation by CompanyName against any employee for the disclosure of information regarding this law; thus, CompanyName shall not discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee in the terms and conditions of employment because of the employee's good faith report to the State or law enforcement agency.

      i. If there is retaliation, the employer must make the employee "whole" by reinstating him/her, paying him/her two (2) times the amount of back pay, interest on the back pay, compensation for any special damage sustained as a result of the discrimination and, where appropriate, punitive damages.

5. Social Services Law, False Statements [N.Y. SOC. SERVS. LAW §§ 145, 145-b, 145-c]

   A. It is a violation to knowingly submit false statements in order to obtain or attempt to obtain payment for items or services from any Social Services program, including Medicaid.

      i. The Department of Health may impose civil penalties up to $10,000 per violation. If repeat violations occur within five (5) years, penalties may increase to up to $30,000 per violation.

ii. Any person who submits false statements or deliberately conceals information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.
iii. Any person who obtains or attempts to obtain, for themselves or others, medical assistant by means of a false claim is guilty of a Class A misdemeanor.
iv. Any person who applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months to five years depending on the offense.

6. Social Services Law, Penalties for Fraudulent Practices [N.Y. SOC. SERVS. LAW §366-b]

A. Any person who knowingly makes a false statement or conceals any material fact in order to obtain or attempt to obtain medical assistance to which he is not entitled shall be guilty of a Class A misdemeanor.
B. Any person who, with intent to defraud, presents false or fraudulent claims for the purpose of obtaining compensation to which he or she is not entitled to for furnishing services or merchandise shall be guilty of a Class A misdemeanor.

7. New York Penal Law, Larceny [N.Y. PENAL LAW § 155]

A. Larceny applies to a person who intentionally deprives another of his or her property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, or extortion.
B. Larceny has been applied to Medicaid fraud cases.
C. Larceny definitions and penalties:

i. Petit larceny, Class A Misdemeanor: person steals property
ii. Fourth degree, Class E Felony: person steals property valued over $1,000
iii. Third degree, Class D Felony: person steals property valued over $3,000
iv. Second degree, Class C Felony: person steals property valued over $50,000
v. First degree, Class B Felony: person steals property valued over $1 million

8. New York Penal Law, False Written Statements [N.Y. PENAL LAW § 175]

A. False written statements apply to a person who intentionally files false information or a claim.
B. False written statements have been applied to Medicaid fraud cases.
C. False written statements definitions and penalties:

i. Falsifying Business Records:

a. Second degree, Class A misdemeanor: a person falsifies business records with intent to defraud.
b. First degree, Class E felony: a person falsifies business records in the second degree with the intent to commit another crime or to conceal the commission thereof.

ii. Tampering with Public Records:

a. Second degree, Class A misdemeanor: a person tampers with public records when they knowingly and without authority remove, conceal, or make a false entry in a written instrument filed with a public office or public servant.
b. First degree, Class D felony: a person tampers with public records when they knowingly, with intent to defraud, without authority, remove, conceal, or make false entry in a written instrument filed with a public office or public servant.

iii. Offering False Statements:

a. Second degree, Class A misdemeanor: a person offers a false instrument for filing knowing that the written instrument contains false information, presents it to a public office or public servant with the belief that it will become a part of the records of such public office or public servant.
b. First degree, Class E felony: a person offers a false instrument for filing when they knowingly, with the intent to defraud the state or any subdivision of the state, offer a written instrument containing false information and present it to a public office or public servant with the belief that it will become a part of the records of such public office or public servant.

iv. Issuing False Certificates

a. Class E felony: issuing a false certificate, a person authorized by law to make or issue official certificates, with intent to defraud, issues such an instrument, knowing that it contains a false statement or false information.
b. Class A misdemeanor: issuing a false financial statement, a person issues a false financial statement when, with intent to defraud, knowingly makes a written instrument which describes the financial condition of a person inaccurate.

9. New York Penal Law, Insurance Fraud [N.Y. PENAL LAW Art. 176]

A. Insurance Fraud applies to any person who knowingly, with intent to defraud, presents or prepares, with belief that it will be presented to an insurer or self –insurer for payment,

i. any written statement as part of, or in support of, an application for the issuance of, or the rating of a commercial insurance policy
ii. a certificate or evidence of self-insurance for commercial insurance
iii. a claim for payment or other benefit from an insurance policy or self-insurance program for commercial or personal insurance that he or she knows to;

a. Contain materially false information
b. Conceal information, for the purpose of misleading

iv. any written statement as part of, or in support of, an application for the issuance of a health insurance policy, or a policy that provides coverage for other services of a public or private health plan, or a claim for payment that he or she knows to:

a. Contain materially false information.
b. Conceal information for the purpose of misleading.

B. Insurance fraud has been applied to Medicaid fraud cases.

C. Insurance fraud definitions and penalties;

i. First degree, Class A misdemeanor: intentionally filing a health insurance claim knowing that it is false.
ii. Fourth degree, Class E felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of $1,000.
iii. Third degree, Class D felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of $3,000.
iv. Second degree, Class C felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of $50,000.
v. First degree, Class B felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of 1 million dollars.
vi. Aggravated Insurance Fraud: committing a fraudulent insurance act, where one has been previously convicted, within the preceding five (5) years of any offense, an essential element of which is the commission of a fraudulent insurance act.

10. Penal Law, Health Care Fraud [N.Y. PENAL LAW Art. 177]

A. Knowingly filing a claim for health insurance payment (including Medicaid), with the intent to defraud.
B. Health care fraud definitions and penalties:

i. Fifth degree, Class A misdemeanor: a person with intent to defraud, knowingly provides false information or omits information and as a result of such information or omission, he or she or another person receives payment that they are not entitled to.
ii. Fourth degree, Class E felony: a person, on one or more occasions, commits the crime of health care fraud and the payment wrongfully received, in a period of no more than one year, exceeds $3,000 in total.
iii. Third degree, Class D felony: a person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment wrongfully received, in a period of no more than one year, exceeds $10,000 dollars in total.
iv. Second degree, Class C felony: a person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment wrongfully received, in a period of no more than one year, exceeds $50,000 dollars in total.
v. First degree, Class B felony: a person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment wrongfully received, in a period of no more than one year, exceeds one million dollars in total.

11. New York State Whistleblower Law [N.Y. LABOR LAW §§ 740, 741]

A. State law that prohibits CompanyName from intimidating or taking any retaliatory action against an employee because the employee:

   i. Discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer, or another employer, with whom there is a business relationship, that the employee reasonably believes:

      a. is in violation of a law, or a rule or regulation promulgated pursuant to law and/or
      b. is fraudulent or criminal,

   ii. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation promulgated pursuant to law by the employer, or another employer;
   iii. Objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes:

      a. is in violation of a law, or a rule or regulation promulgated pursuant to law and/or;
      b. is fraudulent or criminal; and/or 3. is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment; or

   iv. In health care, the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official;
   v. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care.

B. Prohibits CompanyName from intimidating or taking any retaliatory action against an employee for good faith participation in the Compliance and Ethics Program, including but not limited to reporting potential issues, investigating issues, self evaluations, audits and remedial actions, and reporting to appropriate officials.
C. If an employer retaliates against an employee, the employee may sue in state court and may be awarded lost back wages and benefits, and attorney's fees. If the employer, is a health care provider, the court may impose a civil penalty of $10,000 on the employer.
D. The employee's disclosure is protected under these statutes only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation before reporting the violation to regulatory, law enforcement or other similar agency or public officials.
E. An affected individual who feels that he/she/they have been retaliated against or intimidated may make a report by contacting any of the following:

   i. Administrator
   ii. Compliance and Ethics Officer

iii. Compliance Hotline: 1-800-557-1066
    a. Provides option to report anonymously
iv. NY State Office of the Medicaid Inspector General: (518) 402-1378 or 1-877-873-7283
v. Centers for Medicare & Medicaid Services: 1-800-447-8477

If any provider or person discovers fraud and/or abuse occurring in any state or federally-funded health benefit program, they should report it to:

A. NY Office of Medicaid Inspector General (NY OMIG) Hotline, 1-877-87 FRAUD (1-877-873-7283) or online at https://omig.ny.gov/medicaid-fraud/file-allegation
B. The New York State Office of Attorney General Hotline, 1-800-771-7755 or file a complaint online at https://ag.ny.gov/nursinghomes

ATTACHMENT C
POLICY AGAINST HARASSMENT

POLICY

CompanyName intends to provide a work environment that is pleasant, healthful, comfortable, and free from intimidation, hostility, or other offenses that might interfere with work performance. Harassment of any sort - verbal, physical, and/or visual - will not be tolerated.

WHAT IS HARASSMENT?

CompanyName is committed to equal opportunity and non-discrimination in all aspects of employment, including hiring, promotions, and the work environment. CompanyName endeavors to foster a congenial work environment in which all individuals are treated with respect and dignity. Each individual has the right to work in an environment that promotes equal opportunity and prohibits discriminatory practices, including sexual and other forms of harassment.

CompanyName expressly prohibits any form of harassment or discrimination against any affected individual based on sex, race, color, religion, national origin, age, disability, sexual orientation, marital status or veteran status, or any other factor illegal under federal, state, or city law (any of which is referred to as an "Unlawful Category"). Improper interference with the ability of an affected individual to perform their expected job duties is not tolerated.

Harassment or discrimination is unacceptable on CompanyName's property, or in other work-related settings.

DEFINITIONS AND EXAMPLES OF HARASSMENT

For purposes of this policy, harassment is defined as unwelcome or unwanted conduct, whether verbal or physical, based upon race, sex, religion, or any other Unlawful Category. Harassment occurs when the unwelcome or unwanted conduct is made a condition of employment, utilized for decisions affecting employment (including, but not limited to, promotions, hiring, and firing), used to create an intimidating or hostile work environment or found to unreasonably interfere with an individual's ability to work.

Examples of the type of conduct that constitutes harassment include, but are not limited to: physical conduct, verbal conduct, display of harassing pictures or materials, name calling and jokes which are based on Unlawful Categories such as race, sex, national origin, sexual orientation, disability, etc.

COVERAGE

This policy covers all CompanyName affected individuals without exception. CompanyName will not tolerate, condone, or allow harassment, whether engaged in by fellow employees, **volunteers, interns, appointees, associates, consultants, independent contractors, vendors/contractors**

and subcontractors, agents, Chief Executive and other senior administrators, supervisors, managers, executives, Governing Body Members, corporate officers, 1099 employees, and service contractors, or other non-employees who conduct business with the company. CompanyName encourages the reporting of all incidents of harassment, regardless of who the offender may be.

COMPLAINT PROCEDURES

While CompanyName encourages individuals who are being harassed, or subject to discrimination, to promptly notify the offender that his or her behavior is unwelcome, CompanyName also recognizes that power and status disparities between an alleged harasser and a target may make such confrontation extremely difficult. Whether or not such informal, direct communication between individuals is effective, CompanyName requires that the complaint be reported in the following manner:

If an individual has been subjected to harassment based on an Unlawful Category, or believes he or she has been treated in an unlawful, discriminatory manner, whether by a coworker, superior, or other non-employee who conducts business with CompanyName, the individual should promptly report the incident, either verbally or in writing, to his or her immediate supervisor. In the event the employee believes it would be inappropriate to discuss the matter with his or her immediate supervisor, the employee should report it to CompanyName's Compliance and Ethics Officer.

All reports of harassment or discrimination will be reduced to writing by the person receiving the complaint and signed by the complainant. If a person other than the Compliance and Ethics Officer receives the complaint from a CompanyName employee or agent, he or she will promptly confer with the Compliance and Ethics Officer who will coordinate and direct an investigation into the allegations.

Where necessary, CompanyName may employ a Compliance and Ethics Attorney, a lawyer or consultant to investigate the complaint and provide guidance in handling the matter.

The complaint will be investigated expeditiously. While CompanyName endeavors to keep the complaint confidential throughout the investigatory process, please be aware that CompanyName will only do so to the extent practical and appropriate under the circumstances.

RESOLVING THE COMPLAINT

Upon completing the investigation of a complaint and conferring with counsel and CompanyName's management, if necessary, the Compliance and Ethics Officer will communicate his or her findings and intended action to the complainant and alleged offender.

If CompanyName determines that an individual is guilty of harassing or discriminating against another individual, appropriate disciplinary action, up to and including termination, will be taken against the offending person. Appropriate sanctions will be determined by the management of the

company in consultation with the person conducting the investigation, Compliance and Ethics Attorney, and/or any outside counsel or consultant so engaged. In addressing confirmed incidents of harassment, CompanyName's response, at a minimum, will include reprimanding the offender and preparing a written record of the offense. Additional action may include, but is not limited to: referral to counseling, withholding of a promotion, reassignment, temporary suspension without pay, financial penalties, or termination.

RETALIATION PROHIBITED

CompanyName will not in any way retaliate against an individual who makes a report of harassment or unlawful discrimination or provides information concerning such actions, nor will it permit any employee to do so. Retaliation is a serious violation of this policy and should be reported immediately. Any person found to have retaliated against another individual for reporting harassment or discrimination will be subject to the same disciplinary action provided for offenders.

FALSE ACCUSATIONS

If, after investigating any complaint of harassment or unlawful discrimination, CompanyName determines that the complainant or purported witness falsely accused another knowingly or in a malicious manner, the complainant or witness, as the case may be, will be subject to appropriate disciplinary action.

COMPANYNAME
ACKNOWLEDGEMENT OF OUR COMPLIANCE AND ETHICS PLAN

I hereby acknowledge by my signature that I have received a copy of CompanyName's document entitled "Our Compliance and Ethics Plan." Further, I understand that:

- Our Compliance and Ethics Program has committed our organization to support each affected individual in our efforts to provide quality of care while adhering to all applicable laws and regulations.
- If I have any concerns that may involve a violation of a law or regulation, I am expected to report such concern. Even if I am unsure it is a violation of any law or regulation, I am encouraged to report the concern without delay.
- I should report concerns to either my manager, the Administrator, or the Compliance and Ethics Officer, by openly or anonymously calling the Compliance Hotline at (800) 557-1066.
- If my concern is reported in good faith, I will not be subjected to retaliation for making the report.
- CompanyName's Compliance and Ethics Program Manual is available for my review should I have any questions or require any clarification.
- If I am a vendor and/or contractor, I agree to abide by the standards contained in CompanyName's Compliance Plan as well as its Compliance and Ethics Program Manual and also agree to participate in CompanyName's mandatory compliance training. A sample of which can be accessed at under the "Monthly Agenda Bundle Tab," Med-Net Compliance, LLC. - Healthcare Compliance Providers (mednetcompliance.com) then under Monthly Bundle Tab and then the Resources Tab in the "Compliance and Ethics Training File." Vendor shall disseminate CompanyName's policies to vendor's managers and employees. (Password: **elements1**)

I hereby agree to abide by all Compliance and Ethics Program requirements and understand that adherence to this document and other policies and procedures in CompanyName's Compliance and Ethics Program Manual is a condition of employment or continued business dealings with CompanyName.

I hereby acknowledge receipt of the following:

CompanyName's Compliance Plan which includes:

1. Code of Conduct
2. Deficit Reduction Act
3. Policy Against Harassment
4. Compliance and Ethics Training Program (For Vendors/Contractors only)

_____ _____
Print Name Signature

_____ _____
Company Name (If Contractor) Date

DEFICIT REDUCTION ACT OF 2005
NEW YORK

PURPOSE

To ensure CompanyName is consistent with applicable legal requirements and standards of practice.

POLICY

DEFINITIONS

1. Affected Individual(s): Employees, volunteers, interns, appointees, associates, consultants, independent contractors, vendors, contractors, subcontractors, agents, Chief Executive and other senior administrators, managers, executives, Governing Body Members, corporate officers, 1099 employees, and service contractors.

2. Contractor: Vendors, contractors, associates, consultants, independent contractors, subcontractors, agents, 1099 employees, and service contractors.

CompanyName is committed to adhering to all fraud and abuse compliance regulations. Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) § 521-1.4(a)(2)(ix) states all Required Providers shall comply with the provisions of 42 USC 1396a(a)(68) also known as the Deficit Reduction Act of 2005, the Deficit Reduction Act or DRA. The Deficit Reduction Act of 2005 requires CompanyName to educate and train all affected individuals on federal and state false claims laws, whistleblower protections and CompanyName's policies and procedures for detecting and preventing fraud, waste, and abuse.

PROCEDURE

This policy applies to all Affected Individuals.

CompanyName's Compliance and Ethics Officer shall implement this policy and procedure.

CompanyName shall require its Contractors to adopt this policy and disseminate and provide training on this policy to their affected individuals.

EXCLUSION CHECKS

CompanyName shall verify that any current or prospective affected individual who directly or indirectly will be furnishing, ordering, directing, managing, or prescribing items or services in whole or in part is not excluded from participating in a state or federal healthcare program by searching the following databases on a monthly basis:

1. Federal Exclusions Database (mandatory)
   https://exclusions.oig.hhs.gov/ or http://oig.hhs.gov/fraud/exclusions.asp

2. The General Services Administration's System for Award Management (mandatory)
   http://www.sam.gov

3. Office of the NYS Medicaid Inspector General List of Restricted and Excluded Providers Search
   https://www.omig.ny.gov/search-exclusions

Because the Affordable Care Act has proclaimed an individual excluded in one state as excluded in all states, CompanyName shall also verify that no current or prospective affected individual who directly or indirectly will be furnishing, ordering, directing, managing, or prescribing items or services in whole or in part is not excluded from participating in a state or federal healthcare program by searching currently maintained state databases.

AUDIT OF PATIENT CHARTS

CompanyName shall audit residents' charts and other documents relative to quality care and compliance to standards of practice regulated by state and federal agencies. The number of charts to be reviewed will vary depending upon the resident census. Semi-annual audits shall be prepared and a summary of findings shall be presented to the Compliance and Ethics Officer and the Compliance and Ethics Committee.

AUDIT OF MEDICAL AND BILLING RECORDS

CompanyName shall review medical and billing records for a designated semi-annual period, at a minimum under the overall direction of the Compliance and Ethics Officer. Review may be both prospective and retrospective.

The medical records shall be provided at random. The audit shall include at least the number of records equal to five (5) percent of the CompanyName's current census; additional records may be reviewed more frequently at the discretion of the Compliance and Ethics Officer and the Compliance and Ethics Committee.

CompanyName shall examine the records for compliance with the applicable standards of practice, specifically compliance with billing-related statutes, regulations, and guidelines as well as clinical quality of care.

CompanyName shall review a representative sample of billing records for the audit period and compare the charges found in those records with the documentation entered into the medical record. This review shall assess the following:

1. Whether the recognized documentation guidelines have been met;
2. Whether key elements of the service were provided by staff members;
3. Whether the billing codes are supported by the documentation; and
4. Other aspects of billing as outlined by the Office of the Inspector General standards.

CORRECTIVE ACTION PLANS

The Compliance and Ethics Officer and the Compliance and Ethics Committee shall develop a work plan based on the audit findings to address any negative practices. Corrections may include, but are not limited to, the following actions:

1. Review of documentation process and/or forms; changes shall be made, if necessary.
2. In-service to professional staff.
3. Disciplinary actions to individual(s) who may be repeat offenders of improper documentation.

DRA EDUCATION

Written policies, employee handbooks and training to all affected individuals shall cover:

1. The Federal False Claims Act [31 U.S.C. §§ 3729–33]
2. The Federal Program Fraud Civil Remedies Act [31 U.S.C. §§ 3801–12]
3. Any applicable state false claims laws, which in New York include:

    a. New York False Claims Act [N.Y. FIN. LAW § 187–194]

        i. Civil Penalties [N.Y. FIN. LAW § 190]

    b. Social Services Law, False Statements [N.Y. SOC. SERVS. LAW §145-b]

        i. Social Services Law, Civil Sanctions [N.Y. SOC. SERVS. LAW §145-c]
        ii. Social Services Law, Criminal Penalties [N.Y. SOC. SERVS. LAW §145-c

    c. Social Services Law, Penalties for Fraudulent Practices [N.Y. SOC. SERVS. LAW §366-b]
    d. Penal Law, Larceny [N.Y. PENAL LAW § 155]
    e. Penal Law, False Written Statements [N.Y. PENAL LAW § 175]
    f. Penal Law, Insurance Fraud [N.Y. PENAL LAW § 176]
    g. Penal Law, Health Care Fraud [N.Y. PENAL LAW § 177]

4. The right of employees for whistleblower protections under the New York State Whistleblower Law [N.Y. LABOR LAW §§ 740, 741], and some of the Federal and State statutes mentioned above including a policy of non-intimidation and non-retaliation for good faith participation in the Compliance and Ethics Program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits, and remedial actions, and reporting to appropriate officials.

5. The employer's policies and procedures for detecting and preventing fraud, waste, and abuse in Medicaid, Medicare and other federally funded health care programs, as outlined above.

All affected individuals shall be trained upon initial hire and on an annual basis thereafter.

DISCUSSION OF APPLICABLE LAW

1. Deficit Reduction Act of 2005 [42 U.S.C. § 1396a(a)(68]

   A. Federal law that requires CompanyName, because it receives Medicaid funding, to take the following actions to address fraud, waste, and abuse in health care programs that receive federal funds:

      i. Establish written policies for all affected individuals.

         a. Provide detailed information about the Federal and State False Claims Act; administrative remedies for false claims or statements; and whistleblower protection;
         b. Include provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and;
         c. Provide affected individuals with a specific discussion of their rights to be protected as whistleblowers.

      ii. Under Section 6032, CompanyName must establish and make available to their affected individuals policies that explain:

         a. Federal and state laws dealing with false claims for payment from federally funded programs; and
         b. CompanyName's policies and procedures to detect and prevent fraud, waste, and abuse in these programs.

      iii. Contractors must adopt this policy and disseminate and provide training on this policy to their affected individuals.

2. Federal False Claims Act [31 U.S.C. §§ 3729–33]

   A. Federal law that creates liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment from any federally funded contract or program.

      i. "Knowingly" means that a person, with respect to information:

         a. Has actual knowledge of falsity of information in the claim;
         b. Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
         c. Acts in reckless disregard of the truth or falsity of the information in a claim, and;

      ii. Requires no proof of specific intent to defraud.

   B. Health care providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties ranging from $13,508 to $27,018 for each false claim submitted in accordance with Federal Register Vol. 82, No. 22, Friday, February 3, 2017, pgs 9131-9136 located at https://www.gpo.gov/fdsys/pkg/FR-2017-02-03/pdf/FR-2017-02-03.pdf.

i. Section 701 of the "Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015" (the Act) [28 U.S.C. 2461], amending the "Federal Civil Penalties Inflation Adjustment Act of 1990", requires federal agencies to make subsequent annual adjustments for inflation. Starting in January 2017, federal agencies are required to publish in the Federal Register annual inflation adjustments for civil penalties and must do so no later than January 15 of each year.
ii. PLUS up to three times the amount of damages sustained by the U.S. Government.
iii. PLUS, if convicted, possible exclusion from participation in federal health care programs.

C. Qui Tam "Whistleblower" Provisions

i. Allow any person, also known as the "relator", with actual knowledge of allegedly false claims to file a lawsuit on behalf of the U.S. government.
ii. Relators may receive a percentage of the moneys recovered by the U.S. government.
iii. CompanyName is prohibited from retaliating against Relators for complaining or filing lawsuits. If there is retaliation, Relators are entitled to employment reinstatement, back pay and any other compensation arising from retaliatory conduct against a whistleblower for filing an action, investigating a false claim or providing testimony for or assistance in a False Claims Act action.

D. Examples of Health Care Fraud [31 U.S.C. §§ 3801–12]

i. Billing for services not rendered or goods not provided
ii. Falsifying certificates of medical necessity
iii. Billing for services not medically necessary
iv. Billing separately for services that should be a single service
v. Falsifying treatment plans or medical records to maximize payments
vi. Failing to report overpayments or credit balances
vii. Duplicate billing

3. Federal Program Fraud Civil Remedies Act [31 U.S.C. §§ 3801–12]

A. Federal law that provides federal administrative remedies for false claims and statements to federally funded health care programs.
B. Current civil penalties are $13,508 (in accordance with Federal Register Vol. 82, No. 22, Friday, February 3, 2017, pgs 9131-9136 located at https://www.gpo.gov/fdsys/pkg/FR-2017-02-03/pdf/FR-2017-02-03.pdf) for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the Government makes a payment.
C. Section 701 of the "Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015" (the Act) [28 U.S.C. 2461], amending the "Federal Civil Penalties Inflation Adjustment Act of 1990", requires federal agencies to make subsequent annual adjustments for inflation. Starting in January 2017, federal agencies are required to publish in the Federal

Register annual inflation adjustments for civil penalties and must do so no later than January 15 of each year.

4. New York False Claims Act [N.Y. FIN. LAW § 187–194]

   A. State law creates liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the State of New York for payment from any state funded contract or program.
   B. Health care providers and suppliers who violate the New York False Claims Act can be subject to civil monetary penalties ranging from $6,000 to $12,000 for each false claim submitted, recoverable damages are between two (2) and three (3) times the amount that is falsely received. In addition, the false claim filer may have to pay for the government's legal fees.
   C. No employer shall make, adopt, or enforce any rule, regulation, or policy preventing an employee from disclosing information to a State or law enforcement agency or from acting to further a false claims action, including investigating, initiating, testifying, or assisting in an action filed or to be filed under this act.

      i. In addition, the defendant shall be required to pay litigation costs and reasonable attorney's fees associated with an action brought under this section.

   D. Allows private individuals to file lawsuits in state court, just as if they were state or local government parties, subject to various possible limitations imposed by the NYS Attorney General or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover twenty-five to thirty percent of the proceeds if the government did not participate in the suit, or fifteen to twenty-five percent if the government did participate in the suit.
   E. Prohibits retaliation by CompanyName against any employee for the disclosure of information regarding this law; thus, CompanyName shall not discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee in the terms and conditions of employment because of the employee's good faith report to the State or law enforcement agency.

      i. If there is retaliation, the employer must make the employee "whole" by reinstating him/her, paying him/her two (2) times the amount of back pay, interest on the back pay, compensation for any special damage sustained as a result of the discrimination and, where appropriate, punitive damages.

5. Social Services Law, False Statements [N.Y. SOC. SERVS. LAW §§ 145, 145-b, 145-c]

   A. It is a violation to knowingly submit false statements in order to obtain or attempt to obtain payment for items or services from any Social Services program, including Medicaid.

      i. The Department of Health may impose civil penalties up to $10,000 per violation. If repeat violations occur within five (5) years, penalties may increase to up to $30,000 per violation.

ii. Any person who submits false statements or deliberately conceals information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.
iii. Any person who obtains or attempts to obtain, for themselves or others, medical assistant by means of a false claim is guilty of a Class A misdemeanor.
iv. Any person who applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months to five years depending on the offense.

6. Social Services Law, Penalties for Fraudulent Practices [N.Y. SOC. SERVS. LAW §366-b]

A. Any person who knowingly makes a false statement or conceals any material fact in order to obtain or attempt to obtain medical assistance to which he is not entitled shall be guilty of a Class A misdemeanor.
B. Any person who, with intent to defraud, presents false or fraudulent claims for the purpose of obtaining compensation to which he or she is not entitled to for furnishing services or merchandise shall be guilty of a Class A misdemeanor.

7. New York Penal Law, Larceny [N.Y. PENAL LAW § 155]

A. Larceny applies to a person who intentionally deprives another of his or her property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, or extortion.
B. Larceny has been applied to Medicaid fraud cases.
C. Larceny definitions and penalties:

i. Petit larceny, Class A Misdemeanor: person steals property
ii. Fourth degree, Class E Felony: person steals property valued over $1,000
iii. Third degree, Class D Felony: person steals property valued over $3,000
iv. Second degree, Class C Felony: person steals property valued over $50,000
v. First degree, Class B Felony: person steals property valued over $1 million

8. New York Penal Law, False Written Statements [N.Y. PENAL LAW § 175]

A. False written statements apply to a person who intentionally files false information or a claim.
B. False written statements have been applied to Medicaid fraud cases.
C. False written statements definitions and penalties:

i. Falsifying Business Records:

a. Second degree, Class A misdemeanor: a person falsifies business records with intent to defraud.
b. First degree, Class E felony: a person falsifies business records in the second degree with the intent to commit another crime or to conceal the commission thereof.

ii. Tampering with Public Records:

a. Second degree, Class A misdemeanor: a person tampers with public records when they knowingly and without authority remove, conceal, or make a false entry in a written instrument filed with a public office or public servant.
b. First degree, Class D felony: a person tampers with public records when they knowingly, with intent to defraud, without authority, remove, conceal, or make false entry in a written instrument filed with a public office or public servant.

iii. Offering False Statements:

a. Second degree, Class A misdemeanor: a person offers a false instrument for filing knowing that the written instrument contains false information, presents it to a public office or public servant with the belief that it will become a part of the records of such public office or public servant.
b. First degree, Class E felony: a person offers a false instrument for filing when they knowingly, with the intent to defraud the state or any subdivision of the state, offer a written instrument containing false information and present it to a public office or public servant with the belief that it will become a part of the records of such public office or public servant.

iv. Issuing False Certificates

a. Class E felony: issuing a false certificate, a person authorized by law to make or issue official certificates, with intent to defraud, issues such an instrument, knowing that it contains a false statement or false information.
b. Class A misdemeanor: issuing a false financial statement, a person issues a false financial statement when, with intent to defraud, knowingly makes a written instrument which describes the financial condition of a person inaccurate.

9. New York Penal Law, Insurance Fraud [N.Y. PENAL LAW Art. 176]

A. Insurance Fraud applies to any person who knowingly, with intent to defraud, presents or prepares, with belief that it will be presented to an insurer or self –insurer for payment,

i. any written statement as part of, or in support of, an application for the issuance of, or the rating of a commercial insurance policy
ii. a certificate or evidence of self-insurance for commercial insurance
iii. a claim for payment or other benefit from an insurance policy or self-insurance program for commercial or personal insurance that he or she knows to;

a. Contain materially false information
b. Conceal information, for the purpose of misleading

iv. any written statement as part of, or in support of, an application for the issuance of a health insurance policy, or a policy that provides coverage for other services of a public or private health plan, or a claim for payment that he or she knows to:

a. Contain materially false information.
b. Conceal information for the purpose of misleading.

B. Insurance fraud has been applied to Medicaid fraud cases.
C. Insurance fraud definitions and penalties;

i. First degree, Class A misdemeanor: intentionally filing a health insurance claim knowing that it is false.
ii. Fourth degree, Class E felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of $1,000.
iii. Third degree, Class D felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of $3,000.
iv. Second degree, Class C felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of $50,000.
v. First degree, Class B felony: a person wrongfully takes, or attempts to obtain or withhold property with a value in excess of 1 million dollars.
vi. Aggravated Insurance Fraud: committing a fraudulent insurance act, where one has been previously convicted, within the preceding five (5) years of any offense, an essential element of which is the commission of a fraudulent insurance act.

10. Penal Law, Health Care Fraud [N.Y. PENAL LAW Art. 177]

A. Knowingly filing a claim for health insurance payment (including Medicaid), with the intent to defraud.
B. Health care fraud definitions and penalties:

i. Fifth degree, Class A misdemeanor: a person with intent to defraud, knowingly provides false information or omits information and as a result of such information or omission, he or she or another person receives payment that they are not entitled to.
ii. Fourth degree, Class E felony: a person, on one or more occasions, commits the crime of health care fraud and the payment wrongfully received, in a period of no more than one year, exceeds $3,000 in total.
iii. Third degree, Class D felony: a person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment wrongfully received, in a period of no more than one year, exceeds $10,000 dollars in total.
iv. Second degree, Class C felony: a person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment wrongfully received, in a period of no more than one year, exceeds $50,000 dollars in total.
v. First degree, Class B felony: a person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the payment wrongfully received, in a period of no more than one year, exceeds one million dollars in total.

11. New York State Whistleblower Law [N.Y. LABOR LAW §§ 740, 741]

A. State law that prohibits CompanyName from intimidating or taking any retaliatory action against an employee because the employee:

   i. Discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer, or another employer, with whom there is a business relationship, that the employee reasonably believes:

      a. is in violation of a law, or a rule or regulation promulgated pursuant to law and/or
      b. is fraudulent or criminal,

   ii. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation promulgated pursuant to law by the employer, or another employer;
   iii. Objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes:

      a. is in violation of a law, or a rule or regulation promulgated pursuant to law and/or;
      b. is fraudulent or criminal; and/or 3. is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment; or

   iv. In health care, the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official;
   v. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care.

B. Prohibits CompanyName from intimidating or taking any retaliatory action against an employee for good faith participation in the Compliance and Ethics Program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials.
C. If an employer retaliates against an employee, the employee may sue in state court and may be awarded lost back wages and benefits, and attorney's fees. If the employer, is a health care provider, the court may impose a civil penalty of $10,000 on the employer.
D. The employee's disclosure is protected under these statutes only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation before reporting the violation to regulatory, law enforcement or other similar agency or public officials.
E. An affected individual who feels that he/she/they have been retaliated against or intimidated may make a report by contacting any of the following:

   i. Administrator
   ii. Compliance and Ethics Officer
   iii. Compliance Hotline: 1-800-557-1066

a. Provides option to report anonymously

iv. NY State Office of the Medicaid Inspector General: (518) 402-1378 or 1-877-873-7283

v. Centers for Medicare & Medicaid Services: 1-800-447-8477

If any provider or person discovers fraud and/or abuse occurring in any state or federally-funded health benefit program, they should report it to:

A. NY Office of Medicaid Inspector General (NY OMIG) Hotline, 1-877-87 FRAUD (1-877-873-7283) or online at https://omig.ny.gov/medicaid-fraud/file-allegation

B. The New York State Office of Attorney General Hotline, 1-800-771-7755 or file a complaint online at https://ag.ny.gov/nursinghomes

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

Annual Training Plan – Our Training Plan demonstrates how this organization has established and implemented an effective compliance training and education program for all Affected Individuals.

TOPIC/SUBJECT AND KEY POINTS	RISK AREA	TRAINING LENGTH	TRAINING FREQUENCY ORIENTATION ANNUAL BOTH ANNUAL AND ORIENTATION	NY OMIG ELEMENT	REQUIRED AFFECTED INDIVIDUALS (EMPLOYEE, CHIEF EXECUTIVE, SENIOR ADMINISTRATOR, MANAGER, CONTRACTOR, AGENT, SUBCONTRACTOR, INDEPENDENT CONTRACTOR, GOVERNING BODY MEMBER, CORPORATE OFFICER)	METHOD FOR ATTENDANCE TRACKING	TRAINING STYLE	HOW TRAINING EFFECTIVENESS IS EVALUATED
How to Prepare for a NY OMIG Audit Eff. 3/28/2023 • Risk areas and organizational experience • New Written policies and procedures • Role of the compliance officer and the compliance committee • How affected individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of affected individuals to report suspected illegal or improper conduct and the procedures for submitting such reports, and the protection from intimidation and retaliation for good faith participation in the compliance program • Disciplinary standards, with an emphasis on those standards related to the provider's compliance program and prevention of fraud, waste and abuse • How the provider responds to compliance issues and implements corrective action plans • Requirements specific to the Medicaid program and the provider's category or categories of service • Coding and billing requirements and best practices • Claim development and the submission process	1,2,3,4,5,6,7,8,9,10	1 Hour	Both Annual and Orientation	1-7	Employee, Chief Executive, Senior Administrator, Manager	Sign in sheet Or Online sign in	Talking Points in group setting or as independent study Or Remote Webinar	Post training Quiz

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

Harassment and Discrimination in the Workplace • What is Harassment • What may be considered offensive conduct • Harassment can occur in a variety of circumstances • Workplace Discrimination • Workplace Harassment • Federal laws: • What is Sexual Harassment • Investigating Harassment and/or Discrimination • Reporting Harassment and/or Discrimination • Harassment and Discrimination are Subjective • Trends in EEOC Annual Discrimination Charges • According to the EEOC • Prevention Is the Best Means of Elimination • How to Report	10	30 min	Both Annual and Orientation	1,3,5	Employee, Chief Executive, Senior Administrator, Manager	Sign in sheet Or Online sign in	Talking Points in group setting or as independent study Remote Webinar	Post training Quiz
Privacy and HIPAA Compliance • HIPAA • What Is PHI • Electronic Protected Health Information • Access to Designated Record Sets • Cures Act Record Release • Privacy Compliance • Privacy Rule • The Security Rule • Breach Notification Rule • Enforcement of HIPAA • Penalties for Categories of Violations • HIPAA Responsibilities • Privacy Officer • The Privacy Committee • The Privacy Rule & Social Media • Protecting Residents and Employees • Privacy and Texting of PHI • CMS Enforcement • All Privacy issues should be reported • Ways to Ask Questions and Report Concerns	10	30 min	Both Annual and Orientation	1,3,4,5,7	Employee, Chief Executive, Senior Administrator, Manager	Sign in sheet Or Online sign in	Talking Points in group setting or as independent study Remote Webinar	Post training Quiz

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

Sexual Harassment
• What is Sexual Harassment
  ○ Quid Pro Quo Harassment
  ○ Hostile Environment Harassment
• The Workplace Is No Place for Sexual Harassment
• Where Does Sexual Harassment Occur
• Sexual Harassment in the Workplace -
• The behavior of a person who engages in sexual harassment can be:
  ○ Physical
  ○ Verbal
  ○ Non-Verbal
• Sex Stereotyping
• Response to Sexual Harassment is Subjective
• How Can a Victim Respond to Sexual Harassment in the Workplace
• Reporting Sexual Harassment
• Leadership Responsibilities
• Mandatory Reporting
• Responding to Reports of Sexual Harassment
• What Is Retaliation
• What Is Not Retaliation
• Protected Activities
• Addressing Sexual Harassment
• Preventing Sexual Harassment
• Reporting Sexual Harassment -
• New York State Information
• New York City Employer Obligations
• New York City Bystander Intervention
• Sexual Harassment/Discrimination Compliance Management:
	10	30 min	Both Annual and Orientation	1,3,5,7	Employee, Chief Executive, Senior Administrator, Manager	Sign in sheet
						Or
						Online sign in
							Talking Points in group setting or as independent study
							
							Remote Webinar
								Post training Quiz

Understanding the Elements and Code of Conduct • The Difference Between a Compliance and Ethics Committee and an Ethics Committee	6, 8, 10	30 min	Both Annual and Orientation	1,2,3,4,5,6,7	Employee, Chief Executive, Senior Administrator, Manager	Sign in sheet Or Online sign in	Talking Points in group setting or as	Post training Quiz

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

• The Difference Between a Compliance and Ethics Program and QAPI Program
• CMS Regulation: F895 Compliance and Ethics Program
• CMS-Identified Common Healthcare Risk Areas
• CMS Compliance and Ethics Program Requirements
• Information Surveyors Will Seek
• CMS and OIG Program Requirements
  ○ Element 1- Standards, Policies, and Procedures:
  ○ Element 2 - Compliance Program Administration
  ▪ Compliance and Ethics Committee
  ▪ Committee Member Responsibilities:
  ○ Element 3 – Screening and Evaluation of Employees, Physicians, Vendors, and other Agents:
  ○ Element 4 – Communication, Education, and Training on Compliance Issues: Participation in education and training
  ○ Element 5 – Monitoring, Auditing, and Internal Reporting Systems:
  ○ Element 6 - Discipline for Non-Compliance:
  ○ Element 7 – Investigations and Remedial Measures:
• Conflict of Interest
• Non-Intimidation / Non-Retaliation:
• Code of Conduct
• Make the Right Decisions
• Internal Reporting Process
							independent study
							
							Remote Webinar	

Governing Body Member Self Study Plan • Governing Body Responsibilities and By Laws	1-10	Approx 1 Hr.	Both Annual and Orientation	1, 2, 3, 4,5,6,7	Governing Body Member, Corporate Officer	Self-Training Module and Attestation of	Self-Study	Attestation of Training

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

• Governing Body Meeting - Compliance and Ethics Reports at provider level • Compliance Officer Responsibilities ○ Reporting to Governing Body • Compliance Committee Charter • Requirements – Office of Civil Rights • How to Prepare for a NY OMIG Audit Eff. 3/28/2023 • Harassment and Discrimination in the Workplace • Privacy and HIPAA Compliance • Sexual Harassment • Understanding the Elements and Code of Conduct						Training Completed		
Vendor/Contractor Self Study Plan • How to Prepare for a NY OMIG Audit Eff. 3/28/2023 • Harassment and Discrimination in the Workplace • Privacy and HIPAA Compliance • Sexual Harassment • Understanding the Elements and Code of Conduct	1-10	Approx 1 Hr.	Both Annual and Orientation	1, 2, 3, 4,5,6,7	Contractor, Agent, Subcontractor, Independent Contractor	Self-Training Module and Attestation of Training Completed	Self-Study	Attestation of Training
Effective Use of the Anonymous Reporting System • Lines of Communication • Anonymous Hotline • Completing an Investigation • Reporting Timelines	7	30 min	Annual	1, 3, 4, 5, 7	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
Potentially Preventable Hospitalization • HHA and OIG Concerns • Related Medical Conditions • Provider Issues • Discussion Points • Decreasing Unplanned Hospitalizations	5	30 min	Annual	1, 3, 6	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

							Healthcare Specialist	
Opioid Use and Drug Diversion • Drug Diversion Defined • High-Risk Medications • Signs and Symptoms of Drug Diversion • What to Report Immediately • Report Immediately for Suspicion • When the Suspected Offender is Confronted	5	30 min	Annual	1, 3 6,	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
Conflict of Interest and Related Declarations • Conflict of Interest Defined • Conflict of Interest for Directors, Officers, and Senior Management • Conflict of Interest Examples • Other Declarations	6	30 min	Annual	1, 3, 6	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
Financial Integrity: Medicare Enrollment and Disenrollment • Medicare in Review • Provider Responsibilities • Who Can Complete an Enrollment/ Disenrollment Form • Best Practices	1, 2, 3	30 min	Annual	1, 3. 6, 7	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
Facility Initiated Discharge (FID) • OIG Provides Recommendations for Facility-Initiated Discharges in Nursing Homes • Top Reasons for Facility-Initiated Discharges	3, 5	30 min	Annual	1,3,6	Compliance Officer	Compliance Committee Meeting Minutes	Monthly Compliance Bundle	Annual Quiz/ attestation of Compliance Officer and

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

• Only 6 Reasons Allowed for Facility-Initiated Discharge • Deficiencies Often Associated with Federal Requirements For FID • Most Common Ombudsman Reported Issues					Compliance Committee Members		emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Compliance Committee Members
Training Preparation for Completion of Annual Compliance and Ethics Program Effectiveness Self-Assessment • Review of Self-Assessment Tool and Categorical Questions • Analysis Review • Action Plan Review	1,2,3,4,5,6,7,8,9,10	30 min	Annual	1, 2, 3, 4,5,6,7	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
Financial Integrity – Triple Check Process Medicare and Medicaid • The Medicare Triple Check Process • Prevent Submission of False Claims • Who Participates • Business Office Representative Responsibilities • Therapy Department Responsibilities • Nursing Department Responsibilities • MDS Coordinator Responsibilities • Administrator, COO, CFO Responsibilities • Documents and Items that Must Agree with Each Other • Steps That Should Happen Before The Meeting • Additional Items for Review • Value of Triple Check	1, 2, 3	30 min	Annual	1, 3, 5, 6, 7	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

Annual Review of The Annual Compliance and Ethics Program Effectiveness Self-Assessment • Analysis if applicable • Action Plan if applicable • Assessment of Time and Resources of Compliance Officer (Freestanding completion for 2023 and Incorporated in this tool as of 2024)	1,2,3,4,5,6,7,8,9,10	45 min	Annual	1, 2, 3, 4,5,6,7	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
THE FOLLOWING TRAINING OCCURRED IN 2023 PRIOR TO THE MARCH 28, 2023 EFFECTIVE DATE								
CMS Compliance and Ethics Regulations Updates F895 and the 2023 Workplan Review • CMS F895 Regulations for Compliance and Ethics • All CMS Regulatory Updates Effective Oct. 24, 2022 • Survey Preparation Documents for Compliance and Ethics • 2023 Compliance and Ethics Annual Workplan	10	30 min	Annual	3	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
Mandatory Core Compliance and Ethics Education • Review of Mandatory Compliance and Ethics Trainings for the 2023 Year • How to Access Training • How to Monitor Attendance • Education Tips	10	30 min	Annual	1, 3, 6	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

Communication with Your Governing Body • Review of Policy • What is the Role of the Governing Body • Who are Members of the Governing Body • Duties and Responsibilities of the Governing Body • Types of Reports, Communication and Notifications That Should be Made to the Governing Body • How the Governing Body Provides Oversight of the Compliance and Ethics Program • Types of Communication to have with the Governing Body • Examples of Types of Communication	6	30 min	Annual	1, 2, 3, 4, 6, 7	Compliance Officer Compliance Committee Members	Compliance Committee Meeting Minutes	Monthly Compliance Bundle emailed to Provider Remote Live Presentation by Med-Net Healthcare Specialist	Annual Quiz/ attestation of Compliance Officer and Compliance Committee Members
ADDITIONAL PROVIDER IDENTIFIED RISK AREAS FOR TRAINING, IF APPLICABLE								
TOPIC/SUBJECT AND KEY POINTS	**RISK AREA**	**TRAINING LENGTH**	**TRAINING FREQUENCY** **ORIENTATION** **ANNUAL** **BOTH ANNUAL AND ORIENTATION**	**NY OMIG ELEMENT**	**REQUIRED AFFECTED INDIVIDUALS** (EMPLOYEE, CHIEF EXECUTIVE, SENIOR ADMINISTRATOR, MANAGER, CONTRACTOR, AGENT, SUBCONTRACTOR, INDEPENDENT CONTRACTOR, GOVERNING BODY MEMBER, CORPORATE OFFICER)	**METHOD FOR ATTENDANCE TRACKING**	**TRAINING STYLE**	**HOW TRAINING EFFECTIVENESS IS EVALUATED**

Effective MARCH 28, 2023

2023 ANNUAL COMPLIANCE AND ETHICS TRAINING WORKPLAN – APPLIES TO ALL AFFECTED INDIVIDUALS
(For New York Medicaid Providers)

PROVIDER NAME:_____

RISK AREA KEY (X= all risk areas covered in this plan)

Risk Areas are defined as those areas affected by the compliance and ethics program:

1. **Billings**
2. **Payments**
3. **Ordered services**
4. **Medical necessity**
5. **Quality of care**
6. **Governance**
7. **Mandatory reporting**
8. **Credentialing**
9. **Contractor, subcontractor, agent, or Independent Contract oversight**
10. **Other risk areas that are or should reasonably be identified through organizational experience**

Effective MARCH 28, 2023

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(For New York Medicaid Providers)

PROVIDER NAME:_____

Reviewed by the Compliance Officer

_____ _____
Signature **Date**

Reviewed by the Compliance Committee

_____ _____
Signature **Date**

Reviewed by the Administrator

_____ _____
Signature **Date**

PROVIDER NOTES AS NEEDED

Effective MARCH 28, 2023

CHARTER TEMPLATE
COMPLIANCE AND ETHICS COMMITTEE
(For Providers accepting New York Medicaid)

PROVIDER NAME_____

I. PURPOSE

Our Compliance and Ethics Program is well-integrated into our company's operations and supported by the highest levels of the organization by ensuring that the Compliance Committee is active and consists of senior managers. The charter outlines the committee's duties and responsibilities, membership, designation of a chair, and frequency of meetings.

II. MEETING FREQUENCY

The Compliance and Ethics Committee meets monthly.

III. ANNUAL REVIEW OF CHARTER

The Compliance and Ethics Committee in coordination with the Compliance Officer reviews the charter no less than annually, documents the review and any updates made.

IV. DUTIES AND RESPONSIBILITIES

1. ***Designation of a Committee Chairperson***
   a. The Committee Chairperson is _____
2. ***Membership - The membership of the Compliance Committee is comprised of, at a minimum, senior managers.***
   a. The committee benefits from the perspectives of individuals with varying responsibilities in the organization, such as senior managers from operations, finance, audit, human resources, utilization review, social work, discharge planning, medicine, coding, and legal, as well as managers of key operating units.
   b. Current committee members are:

Name: _____ **Title:** _____ **Service Dates:** _____
Name: _____ **Title:** _____ **Service Dates:** _____
Name: _____ **Title:** _____ **Service Dates:** _____
Name: _____ **Title:** _____ **Service Dates:** _____
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Name: _____ **Title:** _____ **Service Dates:** _____
Name: _____ **Title:** _____ **Service Dates:** _____

3. Education and Training

The Compliance Committee coordinates with the Compliance Officer to ensure that all affected individuals complete compliance training and education during orientation and annually.

a. The Compliance Committee will regularly review attendance records for training and education from orientation and annually.

4. Access to Available Resources

The Compliance Committee is obligated to advocate for sufficient funding and resources. Staff are allotted to allow the Compliance Officer to fully perform their duties and to allow for the adoption and implementation of any required modifications to the provider's compliance program.

5. Accountability and Reporting Lines

The committee shall report directly and be accountable to the chief executive and Governing Body.

6. Coordination With the Compliance Officer

The Compliance Committee coordinates with the Compliance Officer to:

a. Ensure that the written policies and procedures, and standards of conduct are current, accurate and complete, and that the required training topics are completed in a timely manner.
b. Ensure communication and cooperation by affected individuals on compliance related issues, internal or external audits, or any other function or activity required.
c. Ensure there are effective systems and processes in place to identify compliance program risks, overpayments, and other issues, and effective policies and procedures for correcting and reporting such issues.
d. Ensure that any required modifications in the compliance program are enacted.

7. ***Documentation***

The Compliance Committee will utilize the following program documentation:

A Compliance Committee charter that:

a. Outlines the duties and responsibilities
b. Membership
c. Designation of a chair
d. Frequency of meetings
e. A list of Compliance Committee members
f. Designated chair
g. Including their names, titles
h. From/to service dates
i. Minutes from regular Compliance and Ethics Committee meetings
j. Evidence of annual Compliance Committee charter reviews, including date of review and a description of any updates.
k. Quarterly reports from the Compliance and Ethics Committee to the organization's chief executive and Governing Body.

V. Signatures for approval and annual adoption:

Compliance and Ethics Officer	**Date**
Compliance and Ethics Committee Chairperson	**Date**

NYS COMPLIANCE HOTLINE POSTER

(Next Page)

DO THE RIGHT THING.

HELP MAKE OUR BUILDING A BETTER PLACE.

REPORT TO YOUR COMPLIANCE OFFICER, OR CALL THE MED-NET COMPLIANCE PROGRAM HOTLINE

800.557.1066

OR EMAIL HOTLINE@MEDNETCONCEPTS.COM

What is A Compliance Hotline?

- Callers may make anonymous reports, without fear of retaliation
- 24/7 reporting for staff, contractors, residents, and family members
- Helps identify and resolve potentially unlawful practices
- Bring any issue, big or small, to the attention of the company

CALL 800.557.1066

OR EMAIL HOTLINE@MEDNETCONCEPTS.COM

IF YOU ARE AWARE OF OR SUSPECT ANYTHING ILLEGAL OR IMPROPER TAKING PLACE. WE ARE ALL RESPONSIBLE FOR COMPLIANCE. TOGETHER WE WILL DO THE RIGHT THING.

Posting Date: _____

Posting Location: _____

MED-NET COMPLIANCE, LLC
A Member of Med-Net Concepts' Network of Compliance, Risk, Education and Consulting Companies

GOVERNING BODY BYLAWS
NY OMIG
FOR USE BY PROVIDERS ACCEPTING NY MEDICAID

WHEREAS the Governing Body of [PROVIDER] is required to have bylaws in accordance with Centers for Medicare & Medicaid Services regulations; and

NOW THEREFORE, BE IT RESOLVED, that the Governing Body does hereby adopt the following bylaws as the Governing Body of [PROVIDER]:

(1) [PROVIDER] must have a Governing Body, or designated persons functioning as a Governing Body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

(2) The Governing Body appoints the administrator/director who is
   i. Licensed by the State, where licensing is required;
   ii. Responsible for management of the organization; and
   iii. Reports to and is accountable to the Governing Body.

(3) The Governing Body is responsible and accountable for the QAPI program.

(4) The Governing Body is responsible and accountable for the Compliance and Ethics program.

(5) The Governing Body appoints the Compliance and Ethics Officer.
   i. The Compliance and Ethics Officer reports directly to the Governing Body
   ii. The Compliance and Ethics Officer will provide regular reports regarding the Compliance and Ethics Program to the Governing Body.
   iii. The Compliance and Ethics Officer will provide the results of the Annual Compliance and Ethics Self-Assessment of Effectiveness to the Governing Body.

(6) The Governing Body will take an annual self-training program regarding the compliance and ethics program, code of conduct, and mandatory core compliance training modules.

(7) Disciplinary Actions. Disciplinary standards that encourage good-faith participation in the compliance program for all Affected Individuals including Governing Body Members, are documented in written Policies and include, but are not limited to, the following:
   i. Expectations for reporting compliance issues.
   ii. It is the duty of every Affected Individual to report suspected concerns regarding Fraud, Waste and Abuse.
   iii. Affected Individual are expected to cooperate as requested in any investigation or resolution.
   iv. Sanctions can be applied for any affected individual that fail to report a suspected problem, participates in non-compliant behavior or encourages, directs, facilitates, or permits noncompliance behavior.
   v. Sanctions can include, but are not limited to, disciplinary warning, required education, a probationary period, suspension or termination of a Governing Body Member position.

vi. Depending upon the severity, the affected individual may also be reported to their respective licensing or certifying body, to NY OMIG, the OIG or the state department of health.

BE IT FURTHER RESOLVED that the Governing Body will vigorously carry out the duties as set forth in the Centers for Medicare & Medicaid Services and state Department of Health regulations.

SIGNATURES

Governing Body Member Printed Name	**Signature**	**Date**
Governing Body Member Printed Name	**Signature**	**Date**
Governing Body Member Printed Name	**Signature**	**Date**
Governing Body Member Printed Name	**Signature**	**Date**
Governing Body Member Printed Name	**Signature**	**Date**
Governing Body Member Printed Name	**Signature**	**Date**

Corporate Compliance and Ethics Governing Body Responsibilities

Compliance and Ethics Training Self-Study Packet