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Corporate Compliance and Ethics Plan

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Corporate Compliance and Ethics Plan

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# Overview

## {Facility}’s (the “Facility”) obligations to comply with all federal and state laws, rules, and regulations are paramount. This corporate compliance and ethics plan is designed to help the Facility comply with those rules in accordance with existing guidance from the U.S. Department of Health and Human Services, Office of Inspector General, the statutory requirements of the Patient Protection and Affordable Care Act, as well as any state specific laws.

In response to laws requiring an effective corporate compliance and ethics program, the Governing Body and senior management have adopted this corporate compliance and ethics plan and a Code of Conduct which are designed to emphasize to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) the importance placed on maintaining high ethical standards and compliance with all applicable laws. In addition to containing generally applicable standards and procedures, the goal of the corporate compliance and ethics program is to ensure that the Facility 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, employee and independent contractor credentialing, and the prevention, prompt detection, and appropriate corrective action to detect, address, and prevent fraud, waste, and abuse.

Additionally, the corporate compliance and ethics program is designed to help Associates understand and meet the legal and ethical standards that govern the Facility’s business; to emphasize the Facility’s commitment to accurate and lawful documentation and submission of all claims for services to Medicare, Medicaid and other third-party payers; promote the prevention, detection, and resolution of any acts that do not conform to applicable federal and/or state laws, rules, and regulations; and minimize, through early detection and reporting, any potential loss to the government from erroneous claims as well as reduce the Facility’s potential exposure to damages and civil and criminal penalties that may result from noncompliance.

The corporate compliance and ethics plan is tailored to address specific issues of particular importance to the Facility, and has been designed to establish the framework by which the Facility will use reasonable efforts to ensure compliance with all such laws. It is emphasized, however, that an effective compliance and ethics program is a dynamic process and, accordingly, this compliance and ethics plan may be updated from time to time to meet the unique challenges facing the Facility.

* 1. **COMPLIANCE WITH THE PLAN** 
     1. ***Compliance and Ethics is a key component of the Facility’s day-to-day operations and it is the responsibility of all Associates to use reasonable efforts to comply with all applicable laws, rules, and regulations as well as this Compliance and Ethics Plan, Code of Conduct, and any the Facility’s policies and procedures. Associates who fail to comply with the elements of this Plan may face disciplinary action, up to and including termination.***
     2. Included within the corporate compliance and ethics plan are standards of conduct for all Associates. These standards of conduct shall be made available to all applicable Associates and periodically updated, as necessary. Associates are expected to sign an acknowledgment verifying that they have received a summary of the plan, including the Code of Conduct (see attachment A), and are familiar with the contents and requirements.

## **SCREENING FOR EXCLUDED INDIVIDUALS AND ENTITIES**

No payment may be made by a Federal health care program for items or services furnished by an excluded individual. Companies that violate this ban may be assessed civil money penalties if the company knew or should have known an employee or contractor was excluded from Federal health care program participation.

The federal government strongly advises nursing facilities to screen all owners, officers, directors, employees, agents, and contractors (including, but not limited to, medical directors, physicians and other clinical professionals, vendors and suppliers) against the list of excluded individuals maintained by the OIG as well as the list prepared by the U.S. General Services Administration. Additionally, certain state laws require monthly exclusion checks these individuals as well. As part of its compliance and ethics program, the Facility will screen as recommended by the government including all new employee hires and agent and contractor engagements. Furthermore, the Facility will perform appropriate background checks on all potential the Facility Staff and on all Contractors who have compliance and ethics-related duties, in accordance with the policies set forth in the Compliance and Ethics Policies and Procedures, the Facility’s human resources policies, and the Facility’s credentialing policies.

The Facility will also undertake screening of its Contractors with compliance and ethics related responsibilities, as determined by the Compliance and Ethics Officer or his or her designee, and require an affirmative statement in each such contract that the Contractor has not been excluded from participation in federal or state health care programs, and that the contract will terminate if such exclusion occurs. The Facility will provide all such contractors with a copy of its Code of Conduct and applicable sections of the Compliance and Ethics Policies and Procedures, and require compliance with the documents.

1. **OVERVIEW OF COMPLIANCE PLAN**

An overview of the corporate compliance and ethics plan is set forth below:

## **PROCEDURES, DIRECTIVES, POLICIES, AND GUIDANCE**

To assist healthcare providers in establishing effective corporate compliance and ethics programs, the federal government (and state government) has recommended that such plans include the following eight elements:

* + 1. Designating a Compliance and Ethics Officer  
       The Compliance and Ethics Officer is responsible to oversee the corporate compliance and ethics program. The Compliance and Ethics Officer functions independently and objectively reviews and evaluates compliance and ethics issues/concerns within the facility. The Compliance and Ethics Officer ensures that the owners, management, and employees are in compliance with the rules and regulations of regulatory agencies, that the Facility policies and procedures are being followed, and that all Associates’ behavior meets the Facility’s Standards of Conduct.
    2. The Compliance and Ethics Officer’s duties and responsibilities include:
       1. Developing, initiating, maintaining, and revising policies and procedures for the general operation of the corporate compliance and ethics program and its related activities to prevent illegal, unethical, or improper conduct. The Compliance and Ethics Officer manages day-to-day operation of the program.
       2. Developing policies that encourages the reporting of suspected fraud and other improprieties without fear of retaliation;
       3. Developing and periodically reviewing and updating the Code of Conduct to ensure continuing currency and relevance in providing guidance to management and employees.
       4. Monitoring developments and changes in relevant state and federal law, regulations, government agency guidance, and court rulings, which may affect the Corporate Compliance and Ethics Program, and revising the program when appropriate to reflect any changes in expectations and/or requirements.
       5. Periodically reporting directly to the governing body on the activities of the compliance and ethics program.
       6. Collaborating with different departments to direct compliance and ethics issues to appropriate existing channels for investigation and resolution, and consulting with the Facility’s corporate attorneys as needed to resolve legal compliance and ethics issues.
       7. Responding to alleged violations of rules, regulations, policies, procedures, and standards of conduct by evaluating or recommending the initiation of investigative procedures, as well as developing and overseeing a system for uniform handling of such violations.
       8. Working with individuals responsible for personnel decisions to ensure that the Facility does not delegate substantial discretionary authority to individuals whom the Facility knows or has reason to know has the propensity to engage in criminal, civil, and/or administrative violations;
       9. Acting as an independent review and evaluation body to ensure that compliance and ethics issues/concerns within the Facility are being appropriately evaluated, investigated, and resolved.
       10. Monitoring, and as necessary, coordinating compliance and ethics activities of other departments to remain abreast of the status of all compliance and ethics activities and to identify trends.
       11. Identifying potential areas of compliance and ethics vulnerability and risk; developing/implementing corrective action plans for resolution of problematic issues; and providing general guidance on how to avoid or deal with similar situations in the future.
       12. Providing reports on a regular basis, and as directed or requested, to the Corporate Compliance and Ethics Committee and senior management to keep them informed of the operation and progress of compliance and ethics efforts.
       13. Ensuring proper reporting of violations or potential violations to duly authorized enforcement agencies as appropriate and/or required.
       14. Establishing and providing direction and management of the compliance and ethics Hotline.
       15. Instituting and maintaining an effective compliance and ethics communication program for the Facility, including promoting (a) use of the compliance and ethics Hotline; (b) heightened awareness of the Code of Conduct; and (c) understanding of new and existing compliance and ethics issues and related policies and procedures.
       16. Ensuring that all Associates have read the Code of Conduct and signed a statement acknowledging their understanding of its requirements;
       17. Maintaining documentation and tracking all issues referred to the Compliance and Ethics Officer and/or the Compliance and Ethics Committee.
       18. Working with the Facility’s compliance and ethics attorneys, compliance and ethics consultants, and others as appropriate to develop an effective compliance and ethics training program, including appropriate introductory training for new employees as well as ongoing training for all employees and managers.
       19. Monitoring the performance of the corporate compliance and ethics program and taking appropriate steps as necessary to improve its effectiveness.
       20. **\_\_\_\_\_\_\_\_\_\_\_\_** is hereby appointed as the Facility’s Compliance and Ethics Officer.
       21. Compliance and Ethics Committee
       22. The Facility has appointed a Compliance and Ethics Committee (the Committee), which will oversee and have overall responsibility for all compliance and ethics activities. The Committee will meet no less than quarterly to review reports on the Facility’s compliance and ethics activities.
       23. The Committee’s duties consist of assessing the Facility’s implementation of the Compliance and Ethics Program elements, including:

Staying up to date on current issues and standards specific to the Facility’s business;

* + - * 1. Ensuring that the program to reflects the latest state, national, and industry standards;
        2. Ensuring the Compliance and Ethics Officer’s direct access to senior management and the allocation of sufficient funding, resources, and staff to fully perform his or her responsibilities;
        3. Ensuring that the Facility’s Code of Conduct and written compliance and ethics policies and procedures that guide the Facility and the conduct of its staff in day-to-day operations is revised as necessary, and ensuring the relevant education and training for Associates;
        4. Reviewing reports on the Facility’s compliance and ethics activities;
        5. Ensuring the implementation of appropriate mechanisms for Associates to seek guidance and to report concerns;
        6. Overseeing the Facility’s systems and processes that are designed to: (a) Periodically assess the Facility’s compliance and ethics obligations and associated risks; (b) Monitor and audit the Facility’s systems, processes and transactions; (c) Investigate alleged misconduct; and (d) Promote and enforce standards through incentive and disciplinary actions;
      1. Making necessary modifications to the Compliance and Ethics Program;
      2. Advising and assisting the Compliance and Ethics Officer in his/her responsibilities; and
      3. Ensuring that the Facility meets the highest standards of compliance and ethics.
  1. **IMPLEMENTING WRITTEN POLICIES, PROCEDURES, AND STANDARDS OF CONDUCT**

The Facility is committed to conducting business with honesty and integrity and in compliance with the requirements of applicable laws and sound business practices. The Facility has written policies and procedures that (1) describe compliance and ethics expectations as embodied in the Facility’s Code of Conduct, (2) implement the operation of the compliance and ethics program to ensure compliance with state and federal regulatory agency standards and applicable laws and regulations, (3) provide guidance to Associates on dealing with potential compliance and/or ethics issues, (4) identify how to communicate compliance and/or ethics issues to appropriate compliance and ethics personnel, and (5) describe how potential compliance and ethics problems are investigated and resolved.  
The Facility has implemented policies and procedures in a number of areas, including such areas as:

* + 1. The Deficit Reduction Act of 2005
    2. Fraud, Waste, and Abuse and False Claims Laws
    3. Stark Self-Referral Prohibitions
    4. Federal and State Anti-Kickback laws
    5. Privacy/Security (the Health Insurance Portability and Accountability Act (HIPAA));
    6. Non-Intimidation and Non-Retaliation for good-faith reporting of compliance and/or ethics issues;
    7. Federal and State Employment standards; and
    8. Federal and State standards for resident safety and quality of care.

The Compliance and Ethics Officer is responsible for developing and maintaining all compliance and ethics-related policies and procedures. All written policies and procedures will be reviewed and revised periodically to reflect changes to the Facility’s 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.

The Facility’s policies and procedures also include the adoption of a Code of Conduct designed to assist Associates in avoiding both the appearance and commission of improper activities. The Code of Conduct is distributed to all staff members. The Compliance and Ethics Officer is responsible for ensuring that all Associates have certified that they have received, read, and fully understand the Code of Conduct.

### **EFFECTIVE EDUCATION AND TRAINING PROGRAMS**

To ensure that Associates are effectively educated on specific regulatory compliance and ethics issues and their responsibilities under the compliance and ethics program, the Facility will oversee the training and education of Associates, including executives and governing body members, on compliance and ethics issues, expectations, and the compliance and ethics program operation. These trainings are mandatory for Associates, shall be geared to the level of responsibility and job function of the specific Associates, shall occur periodically throughout the year, and shall be made a part of the orientation for each new employee, associate, executive, and governing body member.

Training sessions may be in person, online, or via other electronic methods (e.g. DVD or videotape) in order to accommodate individual schedules and 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 and ethics 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. Associates that fail to participate in the mandatory trainings will be subject to disciplinary action.

Members of the Governing Body will receive training on the Facility’s Corporate Compliance and Ethics Program, including training on an overview of fraud and abuse laws, the False Claims Act, a summary of the Code of Conduct, and explanation of the elements of the Corporate Compliance and Ethics Plan and Compliance and Ethics Policies and Procedures applicable to their conduct and responsibilities. This training shall include information about the complaint or reporting process, and a statement of the Facility’s commitment to integrity in its business operations and compliance with applicable laws and regulations. The Facility Contractors that have compliance and ethics-related duties, including but not limited to health care professionals, will receive a copy of the Code of Conduct and the elements of the Compliance and Ethics Policies and Procedures that relate to their duties and services to the Facility, and shall also be informed of their duty to report violations of the Facility’s Compliance and Ethics Program and other misconduct under the Code of Conduct and Compliance and Ethics Policies and Procedures.

The Compliance and Ethics Officer will arrange for additional training for Associates involved in specific areas of risk, as necessary. The Compliance and Ethics Officer will coordinate and schedule this training as needed and will supplement the core training with additional or specialty materials. The Compliance and Ethics Officer or the Director of Human Resources will maintain records of all formal training and educational activities.

### **REPORTING SYSTEM AND DEVELOPING OPEN LINES OF COMMUNICATION**

The effectiveness of the corporate compliance and ethics program rests upon the ability of Associates to openly and freely report potential compliance and/or ethics issues to their supervisors, the Compliance and Ethics Officer, and the Compliance and Ethics Committee. All Associates receiving any such reports are required to report such issues to the appropriate compliance and ethics personnel such as the Compliance and Ethics Officer or his/her designee(s). The Facility will take no adverse action or retaliation against any Associate who makes a good faith report of a compliance and/or ethics concern.

The Facility’s methods for maintaining open lines of communication to assist Associates in making good faith reports of potential compliance and/or ethics issues include but are not be limited to:

The ability to make a good-faith report of potential violations or any concerns regarding compliance and/or ethics to the Compliance and Ethics Officer without fear of retaliation. When requested, confidentiality shall be maintained unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.

The option to make an anonymous report via the Facility’s Compliance and Ethics Hotline at 800-610-2544.

The name and contact information for the Compliance and Ethics Officer is posted throughout the Facility, the Facility’s compliance and ethics documents and related policies and procedures are available to associates 24/7 in the administration office and at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. In addition, the name and contact information for the Compliance and Ethics Officer and the Hotline number will be posted throughout the facility, and will be provided to all Associates during compliance and ethics training.

### **ENFORCING DISCIPLINARY STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES**

The Facility has established disciplinary policies and procedures to encourage good faith participation in the compliance and ethics program by all Associates. This includes policies that articulate the Facility’s expectations requiring the reporting of compliance and ethics issues and assisting in their resolution, as well as policies that outline sanctions for:

* + 1. failing to report suspected problems;
    2. participating in non-compliant behavior in violation of the compliance and ethics program or federal or state law and regulations; or
    3. encouraging, directing, facilitating, or permitting non-compliant behavior.
    4. Discipline will be handled on a case-by-case basis, after an investigation of the specific facts presented. The Facility will impose sanctions fairly, uniformly, and firmly in accordance with well-publicized guidelines. Thus, as a general rule similarly situated Associates 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 Associate promptly reported his/her own violation, severity of the offense, previous incidents involving the individual, whether the Associate 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 Associates 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.

The Facility will not take disciplinary action against an Associate for merely reporting what the person reasonably believed to be a violation of the Compliance and Ethics Plan, the Code of Conduct, the Compliance and Ethics Policies and Procedures, or state or federal laws or regulations. However, an Associate will be subject to disciplinary action if, after an investigation into the matter, the Administrator or Compliance and Ethics Officer concludes that the individual knowingly fabricated a report of wrong doing to injure someone else or to protect himself/herself or others. An Associate whose report contains admissions of personal wrongdoing will not be guaranteed protection from discipline or enforcement action.

* 1. **POLICY OF NON-INTIMIDATION AND NON-RETALIATION**

The Facility strictly prohibits intimidation, retaliation, discrimination, harassment, or any other adverse action by management or any other person or group, either directly or indirectly, against any individual or group for good-faith participation in the Facility’s 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;

for reporting a potential violation of the Compliance and Ethics Program; or for other misconduct in good faith No individual may intimidate or threaten to retaliate against another individual for filing such a report or for participating in good faith in an investigation of any compliance and ethics matter, including matters related to resident safety and treatment or resident confidentiality.

* + 1. Prohibited retaliation includes, but is not limited to,
       1. Termination
       2. Suspension
       3. Demotion
       4. Failure to consider for promotion
       5. Harassment
       6. Reduction in compensation
       7. Adverse change in working conditions.

Intimidation and retaliation is prohibited even if it is determined that the allegedly improper conduct covered by a report was proper or did not occur, provided that the report was made in good faith. The Facility reserves the right to take disciplinary action against any employee who maliciously or intentionally files a report he or she knows to be untrue.

### **CONDUCTING INTERNAL AUDITING AND MONITORING**

The Facility shall establish a system for routine identification of compliance and ethics risk areas, for self-evaluation of such risk areas including internal audits or external audits by outside attorneys or consultants, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits. Data will be collected and analyzed on a regular basis to assess the Facility’s compliance with established standards of practice, in particular, documentation, billing, and reimbursement guidelines.

The Compliance and Ethics Officer, in consultation with the Compliance and Ethics Committee and relevant supervisors, should regularly identify priorities for periodic audits or monitoring. Such audits or monitoring will follow the policies set forth in the Compliance and Ethics Policies and Procedures. The Compliance and Ethics Officer will work together with both inside and outside auditors and report the results of audits and monitoring to the Governing Body in writing at least quarterly. Any areas of potential noncompliance shall be kept confidential. Based on these reports, the Compliance and Ethics Officer and Compliance and Ethics Committee shall determine an appropriate response.

The Facility’s compliance and ethics program shall be applicable to:

* + 1. billings;
    2. payments;
    3. medical necessity and quality of care;
    4. governance;
    5. mandatory reporting;
    6. credentialing; and
    7. other risk areas that are or should with due diligence be identified by the Facility.

The Facility will employ a variety of monitoring 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 and ethics 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; and
    5. Exit interviews of departing employees.

The Compliance and Ethics Officer will report the results of audits and monitoring to the Governing Body in writing at least quarterly. Any areas of potential noncompliance shall be kept confidential. Based on these reports, the Compliance and Ethics Officer and Compliance and Ethics Committee shall determine an appropriate response.

Data obtained from the auditing and monitoring processes will be used to identify opportunities for improvement and assess compliance. The Compliance and Ethics Officer and Compliance and Ethics Committee will review monitoring and auditing efforts for their effectiveness, and to identify additional areas of risk, violations of the Compliance and Ethics Documents and applicable federal and state laws, and the Facility’s response to identified problems. The Facility will respond to identified deficiencies through education/training and corrective action plans, an assessment of the obligation to report fraud and abuse to the appropriate agencies, and to repay funds to federal or state health care programs.

### **RESPONDING APPROPRIATELY TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION**

### As discussed above, the Compliance and Ethics Officer, with the assistance of legal counsel as necessary, will coordinate the investigation of all reported compliance and ethics violations as they are raised in a timely manner. The confidentiality of any Associate who requests confidentiality and who makes a report shall be maintained unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.

### The Compliance and Ethics Officer will:

* + 1. Document all reports received through either a reporting mechanism or through some other mechanism (e.g., auditing),
       1. 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,
    2. Respond to compliance and ethics problems as identified in the course of self-evaluations and audits in a prompt manner,
       1. all instances of potential noncompliance shall be evaluated carefully to determine whether the allegation appears to be well founded.
    3. Be responsible to conduct a comprehensive investigation of all potential compliance and ethics issues,
    4. The Compliance and Ethics Officer shall promptly begin an investigation in accordance with the following procedure:
       1. The 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 and ethics violation.
       2. The investigation may include:
          1. Interviews of the person(s) involved in or having knowledge of the potential noncompliance;
          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.
       3. The creation of 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 the Facility’s policies and procedures;
          3. Collaboration with the Compliance and Ethics Committee; and
          4. Consultation with legal counsel, auditors, healthcare consultants, etc.
    5. Every effort to investigate potential compliance shall be documented and kept with the original report.
       1. be responsible for establishing a plan – including implementing procedures, policies, and systems as necessary – to correct such problems promptly and thoroughly and to reduce the potential for recurrence.
       2. be available to participate or assist in compliance and ethics investigations by the Facility’ s Contractors, at their request
    6. If allegations made in a report are substantiated, the Compliance and Ethics Officer shall take the following steps:
       1. determine whether the alleged activity violates federal, state, or the Facility’s policies and procedures,
       2. determine whether the allegation warrants reporting
       3. determine what corrective actions, if any, should be taken such as
          1. identifying and reporting the compliance and ethics issues to the appropriate government offices,
          2. refunding overpayments as appropriate,
          3. instituting whatever disciplinary action is necessary,
          4. implementing system changes to prevent a similar violation from recurring in the future,
          5. revising applicable policies and procedures to clarify proper protocols and/or development of new systems to safeguard against future noncompliance of a similar nature,
          6. requiring additional mandatory training for Associates,
          7. increasing auditing and/or monitoring of the affected areas
          8. Focusing a review of records made by Associates for a defined period of time following discovery of noncompliance,
       4. Report the issue to an outside government agency such as the Office of Inspector General (OIG
       5. Other reasonable corrective measures calculated to ensure adherence to applicable federal and state laws, rules, regulations, and the corporate compliance and ethics program.

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.

It is the responsibility of all associated with the Facility to assist in resolving compliance and ethics issues by participating in good faith in the Facility’s response to potential compliance and ethics violations, including cooperating when the Facility is conducting investigations and abiding by corrective action put into place.

As provided for above, the Facility has a policy of non-intimidation and non-retaliation non-intimidation 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.

* 1. **PERIODIC REASSESSMENT OF THE CORPORATE COMPLIANCE PROGRAM**

An effective and efficient compliance and ethics program must remain current – properly reflecting contemporary laws and policies, existing conditions in the facility, and the latest focus trends of regulatory enforcement agencies. Periodic reassessment of the corporate compliance and ethics program is necessary. Thus, the Facility shall undertake to internally monitor and audit the corporate compliance and ethics program as appropriate. The Compliance and Ethics Officer and the Compliance and Ethics Committee will have applicable federal, state and local rules, laws, alerts and regulations monitored for changes that are relevant to the Facility. The Compliance and Ethics Committee may also manage a reassessment, enlisting the assistance of various staff members to study the latest compliance and ethics developments and identify areas of the corporate compliance and ethics program that require modification. These efforts are in addition to – rather than in place of – reviews of the fundamental effectiveness of the program systems and structures and assessments of the overall success of the program in general, as well as each of its basic elements. The Facility also recognizes the need for ongoing external auditing and monitoring to ensure objectivity in implementing, enforcing and updating a proper compliance and ethics program. As such, the Compliance and Ethics Officer and the Compliance and Ethics Committee may procure the services of independent third-party consultants, as needed. These efforts will help the corporate compliance and ethics program remain relevant and useful in effectively guiding the Facility to achieve full regulatory and ethics compliance.

# CONCLUSION

The Facility’s priority is and should always remain providing the highest level of care practicable to our residents. The Facility appreciates the pivotal role an effective and efficient compliance and ethics program plays in achieving its mission. The Facility counts on all Associates’ full support of the Facility’s compliance and ethics efforts and looks forward to working together in making this corporate compliance and ethics program an enduring success.

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Commitment to Compliance and Ethics Code of Conduct and Compliance and Ethics Program Summary

**Adopted**

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**COMMITMENT TO COMPLIANCE AND ETHICS**

The Facility is engaged in the business of providing high-quality skilled nursing care to its residents in a manner that conforms with the highest standards of ethical behavior and care. The Facility and any and all directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) constantly strive to ensure that all activity by, on behalf of or with the organization complies with all applicable federal, state, and local Laws, Regulations, ordinances, administrative directives, and any other binding governmental directives (“Laws and Regulations”).

The Facility is committed not only to providing residents with the high quality and caring medical services necessary to attain or maintain the resident’s highest practicable physical, mental, and psychological well-being, but also to provide those services pursuant to the highest ethical, business, and legal standards. These high standards apply to our interactions with everyone with whom we deal. This includes our residents, the community, other healthcare providers, companies with whom we do business, government entities to whom we report, and the public and private entities from whom reimbursement for services is sought and received. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid even the appearance of impropriety. While the legal rules are very important, we must hold ourselves up to even higher ethical standards.

The Facility does not, and will not, tolerate any form of unlawful or unethical behavior by anyone associated with the Facility. We expect and require all Associates to be law-abiding, honest, trustworthy, and fair in all of their business dealings. To ensure that these expectations are met, the Facility has prepared a comprehensive Code of Conduct and standards of conduct. The Code of Conduct and standards are designed to assist you in navigating the various compliance and ethics obligations of the highly regulated industry in which we do business. By adhering to the Code of Conduct and standards, you enable the Facility to continue to achieve its goal of providing excellent service to our residents in a legal and ethical fashion.

In addition, as part of the Facility’s commitment to health care fraud and abuse and regulatory compliance, and in an effort to assist the Facility’s personnel in meeting their compliance and ethics obligations, the Facility has established a Compliance and Ethics Program. The Compliance and Ethics Program is designed to implement the Code of Conduct and prevent violations of applicable laws and regulations and, where such violations occur, to promote their early and accurate detection and prompt resolution through education, monitoring, disciplinary action, and other appropriate remedial measures.

Because of the importance of the Compliance and Ethics Program, we require that all Associates cooperate fully. All Associates will be given a copy of this Code of Conduct (“Code”), and will be required to review and become familiar with its contents. In addition to this Code, the Facility will provide its Associates with formal training regarding the Code of Conduct and Compliance and Ethics Program policies. The Compliance and Ethics Program standards and policies will be maintained by the corporate compliance and ethics officer and will be made available to all personnel upon request. All the Facility Associates shall adhere to the high standards of business ethics as set forth in the compliance and ethics program and in its Code, and acknowledge that such compliance and ethics is a condition of employment and is a factor that will be considered in his or her performance evaluation. Any conduct by an Associate that runs contrary to the Facility’s expectations regarding the Compliance and Ethics Program will be considered a violation of the compliance and ethics program and related policies and procedures and the Associate will be subject to a range of disciplinary measures.

1. **CODE OF CONDUCT**

This Code of Conduct is intended to articulate general principles in order to provide guidance to Associates in their obligation to comply with applicable Laws and Regulations. The general principles contained in this Code, however, are neither exclusive nor complete. Associates are therefore expected to refer to the Facility’s compliance and ethics program, manuals, policies and procedures, as well as other relevant Laws and Regulations for further guidance. It is critical for all Associates to recognize that they are required to comply with all applicable Laws and Regulations, as well as the Facility’s compliance and ethics program, manuals, policies and procedures, whether or not specifically addressed in this Code of Conduct. Any questions regarding the existence of, interpretation or application of any law, regulation, rule, standard, policy and/or procedure that arise should be directed to the Facility’s Compliance and Ethics Officer.

The Facility has adopted the following Code as a central part of our compliance and ethics program. Everyone should adhere both to the spirit and the language of the Code, maintain a high level of integrity in their conduct and avoid any actions that could reasonably be expected to adversely affect the Facility’s integrity or reputation. Compliance with the Code is a condition of employment, and violation of the Standards (as defined below) will result in discipline being imposed, up to and including possible termination.

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

* 1. **HONESTY AND LAWFUL CONDUCT.** Associates of the Facility, including all physicians who see residents at our facility, must avoid all illegal conduct, both in business and personal matters. No person should take any action that he or she believes violates any statute, rule, or regulation. In addition, Associates must comply with the Code and departmental compliance and ethics policies and procedures, strive to avoid the appearance of impropriety, and never act in a dishonest or misleading manner.
  2. **COOPERATION WITH THE COMPLIANCE AND ETHICS PROGRAM**. We require everyone to cooperate fully with the compliance and ethics program because the program is effective only if everyone works together to ensure its success and understands the requirements under the law and the Code. In particular, all departments, personnel, and physicians must cooperate with all inquiries concerning improper business, documentation, coding or billing practices, respond to any reviews or inquiries, and actively work to correct any improper practices that are identified.
  3. **QUESTIONS AND CONCERNS**. Neither this Code nor our overall Compliance and Ethics Program can cover every situation that you might face. As a result, if you are unsure of what the proper course of conduct might be in a specific situation, or if you believe that this Code or any compliance and ethics standards or policies (whether set forth in here or elsewhere) may have been violated, then you are expected to contact the corporate compliance and ethics officer, who can be reached at the facility.

You may contact the corporate compliance and ethics officer at any time, either in person, by telephone, or in writing, with any compliance and/or ethics-related question or concern you may have. Questions or concerns may be raised anonymously, if you wish. All reports will be held in the strictest confidence possible, consistent with the need to investigate the matter.

* 1. **NON-RETALIATION** AND NON INTIMIDATION It is absolutely forbidden for any personnel to intimidate, retaliate, punish or conduct reprisals against anyone who has reported a suspected violation of a law or regulation or any the Facility policy. It is also forbidden for any personnel to intimidate, retaliate, punish or conduct reprisals against anyone who has participated or cooperated in an investigation of such matters. Retaliatory actions violate this Code and will not be tolerated.

1. **CODE OF CONDUCT STANDARDS**

The Code provides a high-level overview of the expectations that the Facility has for all its Associates. Because Associates will be responsible for complying with this Code, the Facility has adopted the following standards of conduct (“Standards”) that all Associates are expected to follow. These Standards outline and summarize the basic concepts underlying the Facility’s Code of Conduct and its compliance and ethics program. These Standards must be carefully reviewed and closely followed by all the Facility Associates. Supplemental information relating to these Standards will be provided through periodic formal and informal training and educational programs. Additionally, many Standards are expanded in greater detail in the Facility’s compliance and ethics standards and policies.

* 1. **COMPLIANCE WITH THE LAW AND HIGH ETHICAL BUSINESS STANDARDS**

The Facility operates in a heavily regulated industry and is subject to a large number of federal and state civil and criminal laws and regulations. Violation of these laws and regulations can result in harm to the public, severe financial penalties, exclusion from participation in government health care programs and – in some cases – criminal fines and/or imprisonment. The Facility’s Code of Conduct and compliance and ethics program are designed to prevent and detect such violations. Accordingly, it is critical that all Associates comply with all applicable federal and state laws and regulations and with all policies and procedures that comprise the compliance and ethics program.

While one of the objectives of the Facility’s compliance and ethics program is to educate all the Facility Associates about the basic requirements of these laws and regulations, the Facility does not expect any of its Associates to become experts in these areas. For precisely this reason, where an individual is not sure whether a particular activity or practice violates the law (or any of the compliance and ethics program policies), the individual should not – under any circumstances – “guess” as to the correct answer. Instead, the individual should seek appropriate guidance from his or her supervisor or the corporate compliance and ethics officer. The Facility Associates will not be penalized for asking compliance and/or ethics-related questions. To the contrary, the Facility is intent on creating a culture in which every individual is comfortable asking the questions necessary to ensure that he or she understands and performs his or her tasks and obligations in full.

The following is a list of legal compliance and ethics issues that can pertain to Associates. Specifically, Associates shall refrain from any illegal conduct including, but not limited to:

* + 1. Fraud Waste and Abuse. The Facility expects its Associates to refrain from conduct that may violate any federal and state laws relating to health care fraud and abuse. Each Associate is expected to: (1) maintain honest and accurate records of services provided; (2) follow current and applicable laws, regulations, and guidelines to facilitate proper documentation of services; and (3) take necessary steps to prevent the submission of claims for payment and reimbursement of any kind that are fraudulent, abusive, inaccurate, or medically excessive or unnecessary.
    2. Anti-Trust. Associates 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 geographic markets, or joint action to boycott or coerce certain suppliers or providers.
    3. Licensure/Certification. All Associates that require licenses or certifications from state or federal agencies must comply with all licensure and certification laws applicable to the Facility’s operations. Such Associates are expected to participate in educational “in-services” offered by the Facility and by various professional groups and associations, and to be familiar with the laws that affect their specific job duties.
    4. Tax. The Facility and its Associates will truthfully and accurately report payments to appropriate taxing authorities, and will file all tax returns and other information in a manner consistent with applicable laws.
    5. Discrimination. It is the Facility’s policy to treat residents, employees, vendors, and contractors, etc. without regard to race, color, religion, sex, ethnic origin, age, disability, or any other classification protected by law. The Facility recruits, hires, trains, promotes, assigns, transfers, lays off, recalls, and terminates Associates based on their ability, achievement, experience and conduct without regard to race, color, religion, sex, ethnic origin, age, disability or any other classification protected by law. No form of harassment or discrimination on the basis of sex, race, color, disability, age, religion or ethnic origin or disability or any other classification protected by law will be permitted. All Associates 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. Each allegation of harassment or discrimination should be promptly reported to the compliance and ethics officer so that it can be investigated and appropriate action can be taken.
    6. Lobbying/Political Activity. Associates may personally participate in, and contribute to, political organizations or campaigns as individuals, not as representatives of the Facility. Associates may not make any agreement to contribute any money, property, or services at the Facility’s expense to any political candidate, party, organization, committee, or individual in violation of any applicable law. Any attempt to influence the decision-making process of governmental bodies or officials by an improper offer of any benefit is absolutely and completely prohibited.
    7. Kickbacks, Inducement, and Self-Referrals. The Facility and its Associates shall comply with all laws relating to kickbacks, inducements, and self-referrals. The Facility and its Associates 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 government program including, but not limited to, Medicare and/or Medicaid. All Associates are required to report any gifts or other gratuities, other than those of nominal value, received from any outside source that would stand to benefit from the referral of business to the Facility.
  1. **STANDARDS RELATING TO QUALITY OF CARE AND SERVICES**

The Facility is fully committed to providing the highest quality of resident care in accordance with all applicable laws, rules, and regulations. As part of this commitment, the Facility will ensure that necessary quality assurance systems are in place and functioning effectively*.*

* + 1. Quality of Care Principles and Resident Rights. In keeping with the Facility’s mission and values, the following quality of care and services principals have been incorporated into the Facility’s compliance and ethics program:
       1. All residents will receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
       2. All residents will receive information that is necessary to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
       3. All residents will receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
       4. The Facility will protect and promote the rights of each resident, including, but not limited to, the resident’s right to respect, privacy, a dignified existence, self-determination, and the right to participate in all decisions about their own care, treatment and discharge.
       5. The Facility will conduct background checks pursuant to Federal and State law on all Associates involved in resident care, or who have access to residents’ possessions.
       6. All individuals employed by the Facility will have the proper credentials, experience, and expertise required to discharge their responsibilities, pursuant to the Facility’s Employee and Independent Contractor Credentialing Policy and Procedure.
       7. The Facility will continuously strive toward a culture of resident safety and providing quality medical care to its residents.
    2. Mandatory Reporting. As part of its commitment to providing the highest quality of resident care and services, the Facility complies with all applicable federal and state mandatory reporting laws, rules, and regulations. To this end, the Facility will ensure that all incidents and events that are required to be reported are done so in timely manner, and will monitor compliance with such requirements. The Facility will also comply with and have policies and procedures in place relating to the reporting requirements under the Federal Elder Justice Act.
  1. **STANDARDS RELATING TO BILLING AND CODING**
     1. Billing Generally. The Facility is committed to conducting the coding, billing, and collection process with integrity pursuant to the applicable billing laws, regulations, and guidelines to facilitate the proper documentation, coding, and billing of claims. The Facility will therefore ensure that all billing conforms with all federal and state laws regarding the submission of claims. The Facility will accurately code and bill third party payors based upon medical necessity and supporting documentation. Periodic auditing and monitoring may be necessary to ensure full compliance and ethics by the Facility. All Associates responsible for billing will be trained in the appropriate rules governing billing and documentation and will follow all regulations governing billing procedures. The Facility takes all reasonable steps to ensure that its billing software reliably and accurately codes and bills all services according to the most recent federal and state laws and regulations. Policies and training of coding and billing personnel shall focus particular attention to issues of medical necessity, appropriate diagnosis codes, prospective payment, consolidated billing, and individual Medicare Part B or Medicaid claims.
     2. Compliance with Federal and State Laws Regarding the Submission of Claims. All Associates shall comply with all applicable federal and state laws and regulations governing the submission of billing claims and related statements. A detailed description of (i) the federal False Claims Act; (ii) the federal Program Fraud Civil Remedies Act; (iii) state civil and criminal laws pertaining to false claims; and (iv) the whistleblower protections afforded under such laws is provided in the Facility’s Fraud, Waste, and Abuse Policy and Procedure.
  2. **STANDARDS RELATING TO BUSINESS PRACTICES**

All Associates must conduct their business affairs with integrity, honesty, and fairness to avoid conflict between personal interests and the interest of the Facility, and Associates have a responsibility to obtain clarification from management on questionable issues that may arise. Associates shall forego any transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to induce the use of the Facility’s services. Specifically, Associates shall comply with the following standards:

* + 1. Honest Communication. Associates are expected to be honest and truthful with regard to the performance of their responsibilities and in communications with the Facility’s attorneys, consultants, and auditors. Associates may not make false or misleading statements to any state or federal official, investigator, or person/entity doing business with the Facility. Associates shall not destroy or alter the Facility information or documents in anticipation of, or in response to, a request for documents by any applicable government agency or from any court.
    2. Business Relationships. Associates 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. Associates shall not use confidential or proprietary information about the Facility for their own personal benefit or for the benefit of any other person or entity, except the Facility.
       1. Disclosure of Financial Interest. Associates must disclose to the Compliance and Ethics Officer any financial interest, ownership interest, or any other relationship that they or a member of their immediate family have with any of the Facility's vendors or competitors.
       2. Disclosure of Personal Relationship. Associates must disclose personal relationships and business activities with any vendor or contractor that may be construed by an impartial observer as influencing any of the Associates’ performance or duties.
       3. No Use of Insider Information. The Facility and its Associates will not use insider information for any business activity conducted by or on behalf of the Facility. All business relations with vendors and contractors providing any services to the Facility will be conducted at arm’s length both in fact and in appearance, and in compliance with the Facility’s policies and procedures.
    3. Unfair Competition and Deceptive Trade Practices. The Facility and its Associates shall not engage in unfair competition or deceptive trade practices, including misrepresentation of the Facility’s products or operations. Associates shall not make false or disparaging statements about competitors or their products or attempt to coerce suppliers or providers into purchasing products or services.
    4. Financial Reporting. All financial reports, cost reports, accounting records, research reports, expense accounts, time sheets, and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction.
    5. Travel and Entertainment. It is the Facility’s policy that no Associates should suffer a financial loss or gain because of business travel and entertainment. That said, travel and entertainment expenses must be consistent with the Associate’s job duties, and Associates are expected to exercise reasonable judgment in the use of the Facility’s assets.
    6. Personal Use of Corporate Assets. All the Facility business shall be conducted, and the Facility assets property utilized, in a manner designed to further the Facility’s interest rather than the personal interest of an individual Associate. Associates are prohibited from the unauthorized use or taking of the Facility’s equipment, supplies, materials or services and from converting the Facility assets to personal use.
    7. Gifts from Residents or Others. Associates are prohibited from soliciting or accepting tips, personal gratuities, loans, gifts, or other things of value from the Facility residents, or vendors, contractors, and any others that seek to do business with the Facility. If a resident or another individual wishes to present a monetary gift, he/she should be referred to the Compliance and Ethics Officer.
    8. Gifts Influencing Decision-Making. Associates shall not accept gifts, favors, services, entertainment, or other things of value to the extent that decision-making or actions affecting the Facility 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 Facility is absolutely prohibited.
    9. Gifts from Existing Vendors or Residents. Associates may retain gifts from vendors or residents, which have a nominal value generally less than $50 in aggregate over each year. To the extent possible, these gifts should be shared with the Associates’ co-workers. Gifts of cash and cash equivalents (e.g. gift certificates) are never acceptable.
    10. Vendor or Business Associate Sponsored Entertainment. Occasionally, at a vendor’s or business associate’s invitation, an Associate may accept meals or refreshments, attend a local theater or sporting event, or similar entertainment, at the vendor’s or business associate'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 business associate should be in attendance with the employee or contractor. Associates should advise the Compliance and Ethics Officer of vendors or business associates that offer such invitations on a frequent basis, even if the Associate does not accept such invitations.
    11. Conflicts of Interest. Associates may not use their positions at the Facility to profit personally or to assist others in profiting in any way at the expense of the Facility. Associates shall not engage in any financial, business, or other activity which competes with the Facility’s business which may interfere or appear to interfere with the performance of their duties, or that involve the use of the Facility property, facilities, or resources, except to the extent consistent with the conflict of interest policies.
    12. Services for Competitors or Vendors. No Associate shall perform work or render services for any competitor of the Facility or for any organization with which the Facility does business or which seeks to do business with the Facility, without the approval of a member of the Governing Body. No Associate shall be a director, officer, or consultant of an outside organization, nor permit his/her name to be used in any fashion that would tend to indicate a business connection with such organization without the prior approval of a member of the Governing Body.
  1. **STANDARDS RELATING TO HUMAN RESOURCES**
     1. Controlled Substances. The use, sale, or possession of controlled substances or alcohol on the Facility property is strictly prohibited, except as normal course of business, such as authorized sale of alcoholic beverages through Dining Services.
     2. Criminal Background Checks. The Facility shall comply with provisions of the Elder Justice Act contained within the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 199 (“EJA”). To this end, the Facility shall not hire an applicant, or retain an Associate who has violated the reporting requirements of the EJA.
     3. Occupational Health and Safety Act. The Occupational Safety and Health Act (OSHA) requires employers to provide a work environment that meets certain safety and health standards. The Facility takes this responsibility seriously. We provide periodic education programs addressing the requirements of OSHA. Associates are required to comply with established facility policies and procedures designed to meet these guidelines. An Associate who identifies a known or suspected workplace hazard must report it immediately to his/her supervisor.
     4. Sexual and Other Forms of Harassment. The Facility is committed to maintaining a professional work environment that is free from sexual and other illegal harassment, which can include harassment based on race, color, religion, sex, sexual orientation, national origin, age, disability, or any other classification protected by law. Any illegal harassment of any individual by any Associate(s) is prohibited and will not be tolerated. Sexual harassment consists of both direct and indirect actions that create a hostile work environment.
  2. **STANDARDS RELATING TO CONFIDENTIALITY**

The Facility safeguards confidential information regarding its residents, such as individually identifiable health information, and confidential and proprietary information regarding the Facility’s business, such as resident lists, development plans, marketing strategy, financial data, proprietary research, and information about pending or contemplated business deals. Inappropriate disclosure of the Facility’s confidential business information, whether intentional or accidental, may adversely affect the Facility.

Associates shall not steal information belonging to another person or entity – including information belonging to the Facility – or use any publication, document, computer program, information, or product in violation of a third party’s interest in such product. All Associates 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. Associates 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 Facility.

Associates who learn confidential business information about the Facility or its residents shall not disclose that information to third parties, including family or friends, except with the prior written consent of the Facility, or as required by applicable law.

1. **EDUCATION**

The Facility will develop and implement a regular education and training program for all Associates. All Associates are expected to participate in educational programs and abide by policy requirements. Adherence to the Facility’s Compliance and Ethics Program will be a factor in evaluating the performance of an Associate. The Facility will maintain records of all educational programs presented to Associates.

1. **OVERSIGHT BY COMPLIANCE AND ETHICS OFFICER**

The Facility Compliance and Ethics Officer will report to the Facility’s Governing Body (or an appropriate member of the Governing Body). The Compliance and Ethics Officer shall review all material issues of interpretation of this Code of Conduct with the Governing Body or appropriate committee of the Governing Body.

1. **REPORTING OF VIOLATIONS** 
   1. Illegal acts or improper conduct may subject the Facility to severe civil and criminal penalties, including large fines and being barred from certain types of federally funded insurance programs and businesses. It is, therefore, crucial that any illegal activity or violations of the Code be promptly brought to the attention of the Corporate Compliance and Ethics Officer. In many cases, if the Facility discovers and reports illegal acts to the appropriate governmental authorities, the Facility may be subject to lesser penalties.
   2. Any Associate who believes or becomes aware of any violation of this Code or any illegal activity by any other Associate or person acting on the Facility’s behalf shall promptly report the violation or illegal activity in person, by phone, or in writing, to (i) the appropriate supervisor; (2) the Administrator; (3) the Compliance and Ethics Officer; or (4) the compliance and ethics hotline at 800-610-2544.
   3. Associates who do not report a violation of the Code or any known or suspected illegal activity will have violated this Code. Associates that have questions about whether particular acts or conduct may be illegal or violate the Code, have a duty to contact the Compliance and Ethics Officer to get clarification.
   4. High-level Associates to whom illegal activity or violations of this Code are reported to have a responsibility to ensure that such activity is properly investigated. Neglecting to properly investigate such reports shall be a violation of this Code. All Associates receiving any such reports are required to report such issues to the appropriate compliance and ethics personnel such as the Compliance and Ethics Officer or his/her designee(s).
   5. It is the Facility’s policy to promptly, thoroughly, and comprehensively investigate reports of illegal activity or violations of this Code. Associates must fully cooperate with these investigations and shall not take any action to prevent, hinder, or delay discovery and full investigation of illegal acts or violations of this Code.
   6. Associates may report illegal acts or a violation of this Code anonymously. To the extent permitted by law, reasonable precautions will be taken 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 shall be a violation of this Code.
   7. No reprisals, intimidation, retaliation, or disciplinary action will be taken or permitted against Associates for good faith reporting of, or cooperating with the investigation of, illegal acts or violations of this Code.
2. **DISCIPLINARY ACTION**

Associates who violate this Code or commit illegal acts are subject to discipline up to and including dismissal. Associates who report their own illegal acts or improper conduct, however, will have such self-reporting taken into account when determining the appropriate disciplinary action.

1. **CONCLUSION**

This Code of Conduct reflects standards that the Facility believes to be in the best interest of its residents, employees, contractors, vendors, and others with whom it does business. However, in addition to the specific directives set forth in this Code of Conduct, each Associate’s own individual judgment is critical in determining the correct course of action for a particular situation. As each Associate contemplates a situation, the Associate should consider whether the proposed action or inaction is consistent with the Facility’s practices and whether it conforms to the letter and the spirit of this Code of Conduct. Additionally, whenever an Associate sees a situation in which the purpose of this Code of Conduct does not appear to be served, the Associate should bring the concern to the attention of the Compliance and Ethics Officer.

The Facility thanks you for your cooperation with this Code of Conduct and for upholding the high standards of the Facility.

Dear {Facility} Associates,

“Our Residents Come First” is our standard. These four words guide our choices, behaviors, and our business practices so that we can deliver on our mission to provide excellence in care, healing, and health to the individuals and communities we serve.

Please see the enclosed Corporate Compliance and Ethics Plan and Code of Conduct (“Code”) which guides us in living up to our standard. The Code enables us to honor state and federal laws and exemplifies our core values.

{Facility}’s (the “Facility”) Code is designed to make sense. It provides guidelines to ensure all who work on behalf of our residents – including any and all owners, directors, officers, clinical staff, independent contractors, consultants, and others – know what is expected to provide an honest, safe, and fair workplace. The Code helps us protect the privacy of our residents and coworkers. It also enables us to do our jobs with integrity, and it provides resources when questions arise.

We urge you to review our Code thoroughly and be well-versed in its specific requirements and its overall spirit. If you ever have a question, or if you see a situation that just does not look right, please bring it to the attention of your supervisor, department head, or the Compliance and Ethics officer. What’s more, the Facility’s confidential Compliance and Ethics hotline is always available at 800-610-2544.

Thank you for your commitment to your residents, colleagues, and the Facility.

Sincerely,

**ACKNOWLEDGEMENT OF CODE OF CONDUCT AND COMPLIANCE AND ETHICS PLAN**

I hereby acknowledge that I received a copy of the Facility’s Code of Conduct, Corporate Compliance and Ethics Plan, and compliance and ethics program policies and procedures and that I had the opportunity to review them. I understand that I should report any compliance and/or ethics concerns to either the compliance and ethics officer of any other member of the Governing Body. I hereby agree to abide by the requirements of this Code of Conduct, the Compliance and Ethics Plan, the compliance and ethics policies and procedures, and the compliance and ethics program in general. I further understand that adherence to this policy is a condition of my continued business dealings with the Facility.

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Print Name Signature

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Company Name (If Contractor) Date

**{Facility}**

**Adoption, Amendment, and Modification of the Compliance and Ethics Plan Policy and Procedure**

**PURPOSE**

To assist {Facility} (the “Facility”) in its goal to ensure that the Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) conduct business in compliance with applicable laws, rules, and regulations and other directives of federal, state, and local governments’ departments and agencies.

**POLICY**

It is the policy of the Facility to maintain a compliance and ethics program (the “Compliance and Ethics Program”) designed to ensure that the Facility and its Associates conduct business in compliance with applicable laws, rules, regulations and other directives of federal, state and local governments’ departments and agencies.

The Facility has hereby adopted the Compliance and Ethics Program, which is more fully described and explained in the compliance and ethics policies and procedures that in the aggregate make up the Corporate Compliance and Ethics Plan (the “Plan”). The policies and procedures in the Plan relate to the overall administration of the Compliance and Ethics Program and contain specific compliance and ethics standards that the Facility and all Associates of the Facility are expected to meet. the Facility maintains the overall Compliance and Ethics Program, and specific policies and procedures within the Compliance and Ethics Program and Plan are hereby adopted by the members of the Facility’s Governing Body.

The Facility expects all Associates to make an absolute commitment to carry out their daily business affairs with honesty, integrity, and in compliance with the letter and spirit of applicable laws and the requirements of the Plan. Although honesty and integrity are individual attributes, and each individual ultimately is responsible for his or her own conduct, the Facility is committed to maintaining a working environment that promotes these ideals and permits Associates to demonstrate the highest ethical and compliance and ethics standards in performing their daily tasks.

In order to comply with applicable legal and ethical standards, from time to time it may be necessary to amend or modify the overall structure of the Compliance and Ethics Program, specific standards within the Compliance and Ethics Program, or various procedural and technical components of the Compliance and Ethics Program. Any amendment or modification of the Compliance and Ethics Program or Plan may only be accomplished through strict adherence to the procedures contained herein. Only the Governing Body can amend or modify any portion of the Compliance and Ethics Program in accordance with the procedures set forth herein.

**PROCEDURE**

1. Amendment or Modification of Policies and Procedures and the Compliance and Ethics Program
   1. Ultimate authority to approve any and all changes to the Compliance and Ethics Program rests with the Governing Body. The Governing Body shall act, 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 or the Compliance and Ethics Program as a whole.
   2. Delegation of Authority
      1. Material Changes
         1. The Governing Body may not delegate its authority to approve or reject material changes to policies and procedures or the Compliance and Ethics Program as a whole.
            1. A material change is defined as a change which would substantially affect the integrity of the Compliance and Ethics Program or which 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 which 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.
      2. Technical Changes
         1. The Governing Body may delegate to the Compliance and Ethics Committee or the Compliance and Ethics Officer its authority to approve an amendment or modification if the change is a technical change.
            1. A technical change is defined as a change which 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 reviewed 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. A technical amendment to the Compliance and Ethics Program shall be effective upon approval by the Compliance and Ethics Committee or the Compliance and Ethics Officer.
2. Effective Date of Amendment or Modification of Policies and Procedures and the Compliance and Ethics Program
   1. Material Changes
      1. Any material change shall be effective on the date referenced in the resolution of the Governing Body adopting the change.
   2. Technical Changes
      1. Any technical change shall be effective on either:
         1. the date referenced in the resolution of the Governing Body adopting the change; or
         2. the date the Compliance and Ethics Committee or the Compliance and Ethics Officer implement the change in writing based upon a delegation of authority.
3. In no event may Policies and Procedures or the Compliance and Ethics Program in general be amended, changed, revised, or modified except in the manner provided herein.
4. Application of the Compliance and Ethics Program
   1. the Facility’s compliance and ethics program shall be applicable to:
   2. billings;
   3. payments;
   4. medical necessity and quality of care;
   5. governance;
   6. mandatory reporting;
   7. credentialing; and
   8. other risk areas that are or should with due diligence be identified by the Facility.

**{Facility}**

**Corporate Philosophy Statement**

1. To ensure the provision of quality health care that is in Compliance with constantly evolving and increasingly complex healthcare laws, {Facility} (the “Facility”) has developed a Compliance and Ethics program, of which this corporate Compliance and Ethics manual is an integral part. The Compliance and Ethics program establishes the Facility’s standards, policies, and procedures regarding Compliance and Ethics with applicable law governing financial relationships among health care providers or other potential sources of referrals, relevant statutes and regulations, and is designed to ensure that the business and billing practices of the Facility comply with applicable statutes and regulations. The Compliance and Ethics program applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) and also applies to all relationships between the Facility and other health care providers and/or physicians, and between the Facility and its vendors and suppliers. The Compliance and Ethics program also reaffirms the Facility’s commitment to delivery of quality health care consistent with applicable state and federal health and safety standards.
2. The Facility is dedicated to the provision of quality health care and living accommodations for its residents, and to accomplishing its mission by:
   1. Responding to the needs of residents, healthy, and ill;
   2. Providing excellent care through multiple levels of service in selected locations;
   3. Providing an environment that enhances each resident’s awareness of his or her medical condition, treatment and prognosis, dignity, security, comfort, and peace of mind;
   4. Ensuring that services are provided and that facilities are maintained in a fiscally responsible manner; and
   5. Providing residents with a balance between security and independence to assist them in achieving and maintaining their highest practicable physical, mental, and psychosocial well-being, in accordance with their comprehensive assessment and plan of care.
3. The Facility and its Associates shall act in accordance with the following goals:
   1. To serve the needs of residents in health and illness in a committed and caring environment;
   2. To further a commitment to integrity, quality, excellence, and continuous improvement in all areas of service to residents;
   3. To manage human and material resources ethically, with creativity and vision, always mindful of changing needs and environments and the capacity to serve;
   4. To esteem all personnel, including volunteers, as the providers of service, encouraging their professional development, caring for them, and nurturing their growth as capable and compassionate people; and
   5. To serve through providing multiple levels of care, and to facilitate resident transfers based on a consistently applied resident assessment process that considers the physical, mental, and emotional well-being in providing the highest quality of life for residents.
4. To achieve these goals, the Facility is committed to conducting all of its business activities in Compliance with ethical standards and all applicable laws, rules, and regulations. Associates must recognize their duty to act in accordance with this essential directive.
5. All Associates will be educated to direct all questions and issues regarding the application of this Compliance and Ethics manual to their supervisors, or if their supervisor cannot resolve the issue, to the Compliance and Ethics Officer, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**. Associates should be familiar with the laws governing the matters set forth in the Compliance and Ethics policies and procedures and demonstrated familiarity will be part of every Associate’s job performance evaluation and a regular part of each Associate’s review. As such, Associates should consult the Facility’s established policies and procedures and seek the guidance of their supervisor or Compliance and Ethics Officer with respect to any Compliance and Ethics issues that may arise.
6. Any action taken by an Associate in violation of the Facility’s Compliance and Ethics program will subject the Associate to discipline and sanctions by the Facility including, but not limited to, termination of employment/relationship with the Facility.
7. To ensure Compliance and Ethics with applicable statutes and regulations, the Facility will educate its Associates regarding the Compliance and Ethics program. A toll-free Compliance and Ethics hotline has been made available to provide Associates with a confidential method for raising concerns about violations or suspected violations of the Compliance and Ethics program. The Compliance and Ethics hotline number is 800-610-2544.
8. All violations, suspected violations, questionable conduct, or questionable practices must be reported by Associates to the Facility by:
   1. Reporting to the Associate’s immediate supervisor;
   2. Filing a report through the Compliance and Ethics hotline;
   3. Reporting to the Compliance and Ethics Officer; or
   4. Issuing a verbal or written report to any other supervisors designated to receive such report.
9. The caller may report all information anonymously, and confidentiality will be maintained unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.
10. Any documents, reports, or other products of the Facility’s Compliance and Ethics program shall be protected to the extent allowed by law under the copyright, self-evaluative, ombudsman, attorney-client, work-product, and any other applicable privileges.

**{Facility}**

**Resolution Designating a Compliance and Ethics Officer**

{Facility}’s Governing Body hereby appoints \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to the position of compliance and ethics officer.

Compliance and Ethics officer will receive periodic training in compliance and ethics procedures, have direct access to the Governing Body, and have access to necessary records and documentation, including resident’s records, billing records, and marketing agreements, and records. See our Corporate Compliance and Ethics Plan II. A. b. i-xix for a description of the Compliance and Ethics Officer’s duties.

IN WITNESS WHEREOF, as of this date of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned have duly executed these Resolutions as of this date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Signature

\*See the attached flowchart detailing the Facility’s corporate structure.

**{Facility}**

**Resolution Designating a Compliance and Ethics Committee**

1. {Facility}(the “Facility”) herby appoints a Compliance and Ethics Committee. The Compliance and Ethics Committee shall consist of the following named positions as appointed by the Governing Body.  
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. The Compliance and Ethics Committee shall assist the Compliance and Ethics Officer in the performance of his or her duties, as described in the policies and procedures. In addition to other responsibilities requested or assigned by the Compliance and Ethics Officer, the Compliance and Ethics Committee will:
   1. Assist the Compliance and Ethics Officer in analyzing risk areas that should be addressed in the Facility’s compliance and ethics program, including legal risks, operational issues, and quality of care issues;
   2. Assist in accessing the Facility’spolicies and procedures;
   3. Work with the Facility’s Compliance and Ethics Officer and staff to develop standards of conduct;
   4. Assist the Compliance and Ethics Officer in monitoring internal controls for carrying out the Facility’s policies and procedures; and
   5. Assist the Compliance and Ethics Officer in employee education

**{Facility}**

**Resolution Appointing HIPAA Privacy And Security Officer**

**WHEREAS**, the Secretary of the U.S. Department of Health and Human Services has issued final rules and standards related to administrative simplification, privacy and security of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (”HIPAA”), and

**WHEREAS**, {Facility} (the “Facility”) desires to appoint a Privacy and Security Officer who will be responsible for developing, implementing and managing the Facility’s policies and procedures required to comply with HIPAA.

**NOW THEREFORE LET IT BE:**

**RESOLVED**, that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is hereby appointed as the Facility’s Privacy and Security Officer who will be responsible for developing, implementing, and managing all of the Facility’s HIPAA policies and procedures.

**RESOLVED**, that the Privacy and Security Officer shall monitor the Facility’s practices for HIPAA Compliance and Ethics, including ensuring that patient health information, both in electronic and physical form, is maintained, transmitted, and stored in a confidential and secure manner. The Privacy and Security Officer shall receive complaints about HIPAA privacy violations, provide additional information about matters that are covered in applicable privacy notices and ensure that appropriate personnel is properly trained with respect to HIPAA rules.

**RESOLVED**, that the Privacy and Security Officer is hereby authorized to take any actions required to implement the Company’s HIPAA policies and procedures and to fulfill the duties described herein.

IN WITNESS WHEREOF, the undersigned [directors/managers/members/partners] have duly executed these Resolutions as of this date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**{Facility}**

**Compliance and Ethics Program Checklist**

**PURPOSE**

To implement the compliance and ethics program by ensuring that all necessary program components are in place.

**POLICY**

To establish a checklist to support the administration of the compliance and ethics program.

**PROCEDURE**

The checklist is divided into initial activities and ongoing activities.

1. Initial Activities
   1. To develop a written corporate compliance and ethics program consisting of substantive policies and procedures that will guide the {Facility}’s (the “Facility”) daily operations, such as policies on inducements for referrals, vendor contracts, etc.; and the mechanical operation of the facility’s compliance and ethics program, including methods for reporting suspected violations and employee compliance and ethics training.
   2. To develop a set of Employee Standards and Code of Conduct consisting of a clearly written document, which includes the general legal principles to which the Facility’s employees must adhere, stated in simple language, and a description of how the process works mechanically, including how the Facility’s employees report, a reminder that participation in the compliance and ethics program is mandatory, and related issues.
   3. To establish a compliance and ethics committee.
   4. To train the compliance and ethics committee and provide committee members with clear guidance regarding their roles.
   5. To distribute the Employee Code of Conduct.
   6. To conduct, or arrange for, Governing Body training on the compliance and ethics program.
   7. To conduct initial compliance and ethics program training of all employees.
   8. To remind employees and supervisors that all employees must sign an affirmation statement.
   9. To conduct special training for supervisors, stressing their roles in the compliance and ethics program.
   10. To establish systems for monitoring compliance (including the audit functions), and for ongoing training of employees.
   11. To ensure that the entire written compliance and ethics program is housed at the employment site where all employees can access it, and advise employees where and how to access the written compliance and ethics program.
   12. To ensure that compliance and ethics-related files are established and maintained.
2. On-going Activities
   1. To periodically review and revise the written compliance and ethics program and the Employee Code of Conduct as appropriate.
   2. To ensure that on-going training of existing employees is conducted and documented, and to make sure that training is frequent enough so that new employees receive training promptly.
   3. To manage and monitor the employee reporting process.
      1. To 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.
   4. To provide ongoing training, as needed, for the Governing Body on all aspects of the compliance and ethics program, including quality of care performance.
   5. To ensure that systems for routine auditing of billing practices, quality of care, contracts and related areas are in place and are working.
   6. To make routine, periodic compliance and ethics reports to the Governing Body, Owners, or other management (including an annual report) regarding compliance and ethics activities, even if no violations are detected.

**{Facility}**

**Auditing and Monitoring of Compliance and Ethics Issues**

**Policy and Procedure**

**PURPOSE**

To ensure effectiveness of the Compliance and Ethics Program through ongoing evaluation of various aspects of the Compliance and Ethics Program by establishing and implementing an effective system for routine monitoring and identification of compliance and ethics risks, and to ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) are complying with all Compliance and Ethics Policies as well as applicable laws, rules and regulations.

**POLICY**

The Facility will develop and implement, under the guidance and responsibility of the Compliance and Ethics Officer, appropriate monitoring and auditing processes to provide an assessment of the effectiveness of the Compliance and Ethics Program, to evaluate compliance with applicable laws, regulations, and policies, and to rapidly detect potential issues, problems, or violations. The Facility will provide proactive, targeted efforts to prevent, detect, and respond to fraud, waste, and abuse issues. Monitoring and auditing of first tier, downstream, and related entities will be conducted and may result in certain actions. To the extent that the Facility's monitoring activities reveal conduct which could potentially constitute violations of the Compliance and Ethics Program, applicable federal or state laws, or any other type of misconduct, the Compliance and Ethics Officer has an obligation to investigate the conduct in question immediately 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.

For purposes of this policy, monitoring is defined as an ongoing check and measurement of performance directed by management to ensure processes are working as intended. Although auditing techniques may be employed, monitoring is often less structured than auditing. Monitoring efforts are generally more frequent and closer to real time than audit activities. Auditing is a more formal, systematic review of past performance against applicable internal and external standards, using structured methodology and evaluation tools. Audits are typically performed by individuals outside of the department under review.

**PROCEDURE**

1. Compliance and Ethics Officer
   1. Monitoring and Auditing plans will be developed and approved by the Compliance and Ethics Officer in consultation with the Compliance and Ethics Committee.
   2. The Compliance and Ethics Officer will develop a schedule for periodic Auditing and Monitoring.
   3. All Monitoring and Auditing findings will be reported to the Compliance and Ethics Committee.
   4. The Compliance and Ethics Officer may employ a variety of monitoring and auditing techniques, including but not limited to:
      1. Audits designed and performed by internal and/or external auditors,
      2. Investigations of alleged non-compliance reported through the Compliance and Ethics Program Procedure or other means,
      3. Reevaluation of past audit results,
      4. Trend analysis, and
      5. On-site visits.
2. The Facility’s compliance and ethics program shall be applicable to:
   1. billings;
   2. payments;
   3. medical necessity and quality of care;
   4. governance;
   5. mandatory reporting;
   6. credentialing; and
   7. other risk areas that are or should with due diligence be identified by the Facility.
3. Identifying Risks and Internal Risk Assessment
   1. An effective monitoring and auditing program begins with an internal risk assessment. The Facility will conduct a formal baseline assessment of its major compliance and ethics and fraud, waste, and abuse areas. Some of the factors that the Facility will consider in determining the risks associated with each area include, but are not limited to,
      1. Size of department
      2. Complexity of work
      3. Amount of training that has taken place
      4. Past compliance and ethics issues
      5. Budget Considerations
      6. High-risk areas as identified by the OIG
      7. Risk areas as identified by the annual CMS Workplan such as
      8. The Facility's Specific Business Operations
   2. The Facility will, on an annual basis, review all management letters issued by the Facility’s outside CPA firm to the Facility’s Governing Board to identify any potential recurring compliance and ethics issues.
   3. Risks identified by the risk assessment will be ranked to determine which risk areas will have the greatest impact on the Facility and the Facility will prioritize the monitoring and auditing plan accordingly.
   4. The Compliance and Ethics Officer will conduct, at least annually, a comprehensive risk assessment, as well as an assessment of the effectiveness of the overall Compliance and Ethics Program. Additionally, there will be an ongoing review of potential risks of non-compliance and fraud, waste, and abuse. The Compliance and Ethics Officer will provide the results to the Compliance and Ethics Committee.
   5. The Compliance and Ethics Officer will revise and issue modifications or updates to the Compliance and Ethics Program based upon results of such evaluations and/or changes in applicable laws, rules, and regulations.
4. Performance Indicators
   1. Each department will identify appropriate performance benchmarks or indicators to assess compliance with applicable laws, regulations, and the Facility policies.
   2. For processes that involve more than one department, performance indicators must be developed to measure each department’s compliance with requirements for its portion of the rocess.
5. Monitoring Plan
   1. Monitoring plans will be developed and approved by the Compliance and Ethics Officer in consultation with the Compliance and Ethics Committee.
   2. Monitoring activities will assess baseline regulatory compliance and ethics performance by comparing specific OIG high-risk areas with associated the Facility policies and procedures.
   3. Information obtained through monitoring efforts should be retained in written form and provided to the Compliance and Ethics Officer upon request.
   4. The Facility will employ suitable monitoring methods including, but not limited to, the following:
      1. conducing risk assessments
      2. data review
      3. charts and graphs
      4. spot checks
      5. random sample reviews
      6. staff interviews
   5. Monitoring shall be performed by department heads, supervisors, and Compliance and Ethics Committee members on an ongoing basis, as appropriate to the nature of the risk involved.
6. Audit Plan
   1. The Compliance and Ethics Officer, with input and approval of the Compliance and Ethics Committee, will develop an Annual Audit Plan. The Audit Plan is subject to review and revision throughout the year as new indicators for focused audit may emerge. The Audit Plan includes:
      1. Audits to be performed
      2. Audit schedules, including start and end dates
      3. Announced and/or unannounced audits
      4. Audit methodology
      5. Types of operational areas to be audited
      6. Necessary resources
      7. Types of audit (desk or onsite)
      8. Person(s) responsible
      9. Final audit report due date
      10. Follow up activities from findings
7. Conducting the Audit
   1. The auditor shall be knowledgeable about the legal and operational requirements for areas under review.
   2. The auditor shall have access to all relevant personnel, information, records, and areas of operation under review.
   3. The auditor shall select a sample audit population that appropriately reflects the matter/area in question. The sample size should be no less than five (5) records.
   4. The auditor shall determine if the sample audit reveals a potential problem and whether a larger sample should be reviewed.
   5. The auditor shall determine if the larger sample confirms the problem and the nature, scope, frequency of the problem.
   6. If needed, the auditor shall apply specialized targeted techniques or stratified sampling methods driven by data mining, complaint monitoring, and aberrant behavior.
   7. The auditor shall qualify the impact of the problem (i.e. legal, internal policy, etc.).
   8. The auditor shall determine the cause of the problem (i.e. human error, computer error, lack of education, fraud, malice, etc.), and assess and calculate compliance with internal processes and procedures.
8. Follow-up and Corrective Action
   1. Any monitoring or auditing result indicative of a potential issue, problem, or noncompliance will be adequately addressed.
   2. If necessary, the Compliance and Ethics Officer will conduct a more thorough review to determine whether the monitoring result accurately reflects reality.
   3. The Compliance and Ethics Officer will determine appropriate next steps, such as conducting a more focused audit.
   4. Confirmed problems or cases of noncompliance will be remediated with appropriate corrective action (see Response to Detected Issues and Remediation Policy and Procedure CCG 00117).

{Facility}

Compliance and Ethics Committee Policy and Procedure

# Purpose

The purpose of the Corporate Compliance and Ethics Committee is to provide guidance to the compliance and ethics officer in the development and implementation of the corporate compliance and ethics plan, to be an extension of the compliance and ethics officer, and to provide {Facility} (the “Facility”) with increased oversight of the implementation and operation of the Compliance and Ethics Program.

**POLICY**

It is the Facility’s policy to maintain a committee with appropriate responsibility for developing, operating, and monitoring the Compliance and Ethics Program. The Committee will report directly to the Governing Body and be responsible for advising the Facility on conducting business affairs in compliance with applicable laws, rules, regulations, and other directives of the federal, state, and local governments’ departments and agencies. This policy and procedure applies to the Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”).

**PROCEDURE**

# Duties of the Corporate Compliance and Ethics Committee

* 1. Key duties of the Corporate Compliance and Ethics Committee under this Charter include, but are not limited to the following:
  2. Assist the Compliance and Ethics Officer in the development and implementation of the Corporate Compliance and Ethics Plan
  3. Assist in the development of the Code of Conduct
  4. Oversee the implementation and operation of the Compliance and Ethics Program
  5. Work with appropriate departments to develop standards of conduct and policies and procedures to promote compliance with legal and ethical requirements
  6. Work in connection with the Compliance and Ethics Officer to develop appropriate compliance and ethics policies and procedures based on evolving guidance from the US DHHS Office of the Inspector General and other federal and state agencies
  7. Meet on at least a quarterly basis (or more often as necessary) to review Compliance and Ethics Program related activities
  8. Oversee the development and coordination of compliance and ethics educational and training sessions that focus on the essential elements of regulatory compliance.
  9. Recommend and monitor, in conjunction with the relevant departments, the development of internal systems and controls to carry out the Facility’s policies
  10. Determine the appropriate strategies and approaches to promote compliance with program requirements and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms
  11. Report to the Governing Body on all matters relating to the Compliance and Ethics Program on a periodic basis as necessary
  12. Develop a system to solicit, evaluate, and respond to complaints and problems; and
  13. Monitor internal and external audits and investigations for the purpose of identifying deficiencies, and implementing corrective action
  14. Act as a liaison to employees who may wish to report compliance and ethics concerns without fear of retribution or retaliation
  15. Receive and act upon reports and recommendations from the Compliance and Ethics Officer
  16. Participate in employee annual compliance and ethics training as well as new employee training as requested
  17. Review compliance and ethics quarterly reports regarding quarterly audit topics, monitoring activities, and results of investigations
  18. Recommend policy changes that may be indicated as a result of compliance and ethics investigations
  19. Participate in compliance and ethics investigations as requested by the Compliance and Ethics Officer
  20. Participate in an annual assessment of the effectiveness of the Corporate Compliance and Ethics Program
  21. Evaluate the performance of the Compliance and Ethics Program and make recommendations accordingly
  22. Perform other duties and responsibilities that may be requested by the Compliance and Ethics Officer
  23. Analyze the industry environment, applicable laws, and regulations and specific areas of compliance and ethics risk and disseminating relevant information, as necessary
  24. Analyze the legal requirements with which the Facility must comply, and specific risk areas
      1. Assess existing policies and procedures that address the risk areas for possible incorporation into the compliance and ethics program

# Committee Membership

* 1. The Corporate Compliance and Ethics Committee is chaired by the Compliance and Ethics Officer. Standing members of the Corporate Compliance and Ethics Committee are:
     1. Facility administrator
     2. Compliance and Ethics Officer
     3. Chief Executive Officer
     4. Chief Financial Officer
     5. Principal

From time to time, other managers or supervisors may be called upon to participate in the Corporate Compliance and Ethics Committee based on risk assessment, audit findings, or other concerns that have been addressed.

1. Attendance and Voting
   1. All Compliance and Ethics Committee members are expected to regularly attend the scheduled and called meetings; and
   2. A simple majority of members present at a meeting shall constitute a quorum for voting purposes.
2. Investigations and Reviews of Compliance and Ethics Matters
   1. Notwithstanding the foregoing, upon the advice of, and where necessary at the direction of, in-house or outside counsel, the Compliance and Ethics Committee and through its delegate, the Compliance and Ethics Officer, shall have the ultimate authority to undertake and/or direct any and all investigations and reviews of any compliance and ethics 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.

**{Facility}**

**Associate and Other Affected Individuals Education and Training Policy and Procedure**

**PURPOSE**

To ensure that all {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and other affected individuals working for the Facility (“Associates”) are properly trained in the relevant Compliance and Ethics policies and procedures applicable to the particular Associates’ job duties.

**POLICY**

To ensure that all the Facility’s Associates and other affected individuals receive proper Compliance and Ethics training in areas relevant to the Associate’s job duties. The Compliance and Ethics Officer shall periodically provide an assessment of the effectiveness of the education and indicate areas where the Compliance and Ethics Program training and testing may need to be revised or improved.

**PROCEDURE**

1. Training Topics
   1. {Facility} provides mandatory Associate trainings in the following areas:
      1. Compliance and Ethics policies and procedures for implementing the policies, focusing on the policies and procedures applicable to each Associate’s job responsibilities, including but not limited to,
         1. Fraud, Waste, and Abuse laws
         2. Anti-Kickback statute
         3. False Claims Act
         4. Billing
         5. Payments
         6. Governance
         7. Medical necessity and quality of care
         8. Credentialing
         9. Physician Self-Referral statutes
         10. Investigation and resolution of Compliance and Ethics reports
         11. Non-intimidation and non-retaliation for reporting Compliance and Ethics concerns
         12. Other risk areas as identified by the Facility
      2. procedures for reporting Compliance and Ethics violations, including the use of the Compliance and Ethics hotline or other available reporting mechanisms; and
      3. the disciplinary system;
2. Documentation
   1. All Compliance and Ethics program training documents including, but not limited to, lists of attendees, dates of training, and agendas or program descriptions will be filed and retained pursuant to the Compliance and Ethics Filing System Policy and Procedure CCG 00118.
3. Additional Training Methods
   1. The Facility may, at its discretion, provide to Associates all relevant fraud alerts and advisory bulletins issued by the OIG or state agencies, or summaries, or relevant points from fraud alerts,

The Facility shall post a notice detailing its commitment to ethical standards and Compliance and Ethics with all applicable laws and regulations in the conduct of its business,

* 1. The Facility shall use reasonable communications to inform Associates of changes in applicable federal and state laws and regulations, and
  2. Associates shall be told that they can obtain additional Compliance and Ethics information from the Compliance and Ethics officer. Any questions that the Associate’s immediate supervisor or the Compliance and Ethics officer cannot answer shall be referred to legal counsel, as applicable.

1. New Associate Training
   1. To emphasize commitment to lawful and ethical business practices, all new Associates must be educated about the Compliance and Ethics Program as soon as possible. To meet this requirement the following guidelines will be adhered to:
      1. Compliance and Ethics Program training must be conducted within thirty (30) days after a new Associate starts work.
      2. The training will emphasize basic concepts of the Compliance and Ethics program.
      3. Have Associates sign a document to acknowledge the Compliance and Ethics training. Such documents shall be maintained as part of the Associate’s personnel file.
2. Quarterly Compliance and Ethics Review Training
   1. The importance of adhering to Compliance and Ethics policies and practicing ethical behavior will be reinforced by quarterly Compliance and Ethics training.
   2. Quarterly Compliance and Ethics training shall be conducted during a time frame as determined by the Compliance and Ethics Officer.
   3. The following elements will be addressed in the quarterly training sessions:
      1. Reinforcement of the importance of integrity in all business activities with emphasis on each Associate’s commitment to the Compliance and Ethics Program.
      2. Provisions of illustrations and real-life examples of Compliance and Ethics issues that may confront Associates.
      3. Explanation of how to report concerns or suspected violations of the Compliance and Ethics Program or laws, rules, and regulations.
      4. Identification and review of any new developments in high-risk areas or new risk areas.
3. “Make-up” Trainings
   1. The Compliance and Ethics Officer shall ensure that all Associates that miss the quarterly Compliance and Ethics trainings attend “make-up” sessions within a reasonable amount of time.
   2. Associates who consistently fail to attend the mandatory Compliance and Ethics trainings will be subject to disciplinary measures.
4. Testing
   1. After a Compliance and Ethics training, the Facility may test Associates’ knowledge of the topic covered in the training with a multiple-choice test after the session. The Facility shall immediately review and discuss the questions and the correct answers with the Associates.
5. See CCG 00514 Effective Training for Associates and Facility Assessment Policy and Procedure for additional training requirements.

**{Facility}**

**Role of the Compliance and Ethics Officer and Compliance and Ethics Committee**

**Policy and Procedure**

To delineate the role and duties of the Compliance and Ethics Officer and Compliance and Ethics Committee.

**Policy**

It is{Facility}’s (the “Facility”) policy to ensure that the duties and responsibilities of the Compliance and Ethics Officer and Compliance and Ethics Committee duties are clearly outlined to enable the Compliance and Ethics Officer and Compliance and Ethics Committee to carry out their duties in an exemplary fashion.

**Procedure**

1. The Compliance and Ethics Officer shall an employee of the Facility.
2. Compliance and Ethics Officer and the Governing Body.
   1. The Compliance and Ethics Officer shall have direct access and shall provide timely reports with regard to reported concerns, findings, remediation efforts, etc., to the Facility’s Governing Body.
   2. The Compliance and Ethics Officer shall keep a detailed documentation record, in the form of minutes or another similar format, of all meetings and conferences.
   3. The Compliance and Ethics Officer shall provide the documentation to the Governing Body when reporting to the Governing Body.
3. Compliance and Ethics Officer Responsibilities:  
   The following is a non-exhaustive list of the Compliance and Ethics Officer’s responsibilities. The Compliance and Ethics Officer will ensure that:
   1. He/she recommends to the Compliance and Ethics Committee any and all appropriate revisions to Policies and Procedures or the Compliance and Ethics Program in general.
   2. He/she provides any and all proposed changes to the Compliance and Ethics Program to the Governing Body and legal counsel for the Facility, as necessary, for review.
   3. The appropriate authority approves or rejects in writing any and all amendments or modifications of Policies and Procedures or the Compliance and Ethics Program in general.
   4. The Code of Conduct is distributed to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”);
   5. The Corporate Compliance and Ethics Plan and Code of Conduct are revised as needed to reflect changes in state or federal law, private payor requirements, or changes in the Facility’s operations;
   6. A background check is conducted for all prospective Associates (as appropriate to the individual Associate), including a criminal background check where applicable, and a determination made of whether the prospective Associate is subject to sanctions under or exclusion from the Medicare and/or Medicaid programs;
   7. Associates are given appropriate compliance and ethics program training, including information regarding the duty to report suspected violations or questionable conduct and the mechanism for such reporting;
   8. Hotline calls, correspondence, and other reports of suspected violations or questionable conduct are treated confidentially (unless circumstances dictate to the contrary);
   9. An appropriate inquiry or investigation is initiated with respect to any report of a suspected violation or questionable conduct, and corrective and/or disciplinary action is taken, where appropriate;
   10. Reports are periodically made directly to the Governing Body on the activities of the compliance and ethics program in general, regarding material matters involving suspected violations or questionable conduct, and on as needed basis;
   11. Periodic reviews of vulnerable areas are conducted and the findings reported to the Governing Body;
   12. A report at least annually regarding the operation of the compliance and ethics is provided to the Governing Body;
   13. Compliance and Ethics Assessments and Work/Audit Plans are established with the collaboration of the Governing Body.
   14. A compliance and ethics filing system is maintained, including a log of all employee compliance and ethics trainings, compliance and ethics issues raised, the resolution of such issues, and action taken in response, if any;
   15. Specific compliance and ethics issues are assigned to individuals outside the organization for review, as appropriate, such as legal counsel, accountants, quality consultants, etc.;
   16. Activities of the compliance and ethics committee are coordinated to assure that all duties are fully performed; and
   17. The Facility’s compliance and ethics program is explained to the Facility’s vendors, suppliers, and other contractors.
4. Compliance and Ethics Committee Responsibilities
   1. The compliance and ethics committee shall be responsible for making recommendations to the Governing Body with respect to any amendments or modifications of Policies and Procedures and the Compliance and Ethics Program in general.

**{Facility}**

**Individual Reporting Of Compliance and Ethics Concerns**

**Policy And Procedure**

**PURPOSE**

To facilitate {Facility}'s (the “Facility”) goal to ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) promptly report any actual or suspected violations of the Compliance and Ethics Program.

**POLICY**

It is the policy and expectation of the Facility that any and all Associates have the duty to report any questionable conduct, questionable practices, and actual or suspected violations of the Compliance and Ethics Program. All Associates receiving any such reports are required to report such issues to the appropriate Compliance and Ethics personnel such as the Compliance and Ethics Officer or his/her designee(s). An Associate who fails to promptly report any such activity will be subject to disciplinary action, which may include termination of employment or contract.

**PROCEDURE**

1. Associates can utilize any of the following channels of communication to internally report a suspected violation of law or the Compliance and Ethics Program:
   1. Supervisor
   2. Compliance and Ethics Hotline
   3. Compliance and Ethics Officer
2. The Facility prohibits any intimidation or retaliatory action against any individual for making any verbal or written communication regarding any violations or suspected violations of the Compliance and Ethics Program, Code of Conduct, laws, rules or regulations.
3. Compliance and Ethics Hotline
   1. The Facility will provide a telephone number to all Associates to be used as the Confidential Compliance and Ethics Hotline.
   2. Associates will be able to make their reports anonymously and/or confidentially via the Confidential Compliance and Ethics Hotline.
   3. The Compliance and Ethics Hotline will be managed by an external source for the purposes of ensuring anonymity if requested by the individual making the report.
   4. The Compliance and Ethics Hotline is 800-610-2544.
   5. All calls received will routinely be logged.
   6. A report will be created for each call received including, but not limited to the following information:
      1. a list of the individuals involved in the reported issue and their roles;
      2. information about the caller if the caller has chosen to reveal his or her identity;
      3. a summary of the nature of the call;
      4. a detailed narrative of the caller’s concerns;
      5. additional comments as needed.
   7. All reports will be communicated directly to the Compliance and Ethics Officer for review. When a reporter requests confidentiality, the report will be provided solely to the Compliance and Ethics Officer or his/her designee(s).
   8. The Compliance and Ethics Officer will confer with the Administrator and/or other Compliance and Ethics Committee members, while maintaining the reporter’s confidentiality when so requested, to investigate the complaint and develop an action plan for resolution of the stated problem.
   9. The Compliance and Ethics Officer shall have direct access, and shall provide timely reports with regard to reported concerns, findings, remediation efforts, etc., to the Facility’s Governing Board.
      1. The Compliance and Ethics Officer shall keep a detailed documentation record, in the form of minutes or another similar format, of all meetings and conferences.
      2. The Compliance and Ethics Officer shall provide the documentation to the Governing Board when reporting to the Governing Board.
   10. All Compliance and Ethics Hotline calls will be analyzed, investigated, and followed as they are received.
   11. The Compliance and Ethics Officer will document the investigation process including the completion of the investigation.
   12. If requested, the individual making the call will receive a direct response from the investigation and resolution.

Failure by Associates to Report suspected Compliance and Ethics issues will result in the Facility taking disciplinary action pursuant to the Facility’s Discipline Policy and Procedure (see CCG 00303).

**Compliance and Ethics Reporting Form[[1]](#footnote-2)**

*Confidential*

Non-Intimidation and Non-Retaliation Policy

The facility protects employees who report suspected violations, and will ensure confidentiality of Compliance and Ethics reporting and Compliance and Ethics investigations unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.

Date reported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parties Involved in the Incident:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date(s) of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) Name of Person Reporting Concern\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does not wish to give name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requests identity to be kept in confidence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**{Facility}**

**Internal Compliance and Ethics Investigation Policy and Procedure**

**PURPOSE**

The early detection of possible wrongdoing in the workplace is an essential part of {Facility}’s (the “Facility”) Compliance and Ethics Program. Reporting of suspected wrongdoing is an important means of detecting such possible wrongdoing. This policy establishes the procedures to facilitate the Facility’s goal to ensure that all possible violations of applicable laws, rules, regulations or the Compliance and Ethics program by the Facility or any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) are thoroughly investigated to determine if there is any actual wrongdoing. An effective Compliance and Ethics Program requires the prompt investigation of complaints so that Compliance and Ethics issues can be properly identified and resolved.

**POLICY**

The Compliance and Ethics Officer will, in consultation with legal counsel, initiate investigations to ascertain if an allegation of non-Compliance received through a Compliance and Ethics reporting channel represents a possible violation of applicable laws, rules, regulations or the Compliance and Ethics program. Additionally, the Facility shall review its past and continuing relationship with any entity identified in fraud alerts. The extent of the investigation will vary depending upon the nature of the concern.

**PROCEDURE**

1. Investigation Generally
   1. The Compliance and Ethics Officer, in consultation with the Compliance and Ethics Committee and legal counsel, shall establish clear internal investigatory guidelines defining what may be investigated, what should be investigated, clarify internal reporting structure, and provide procedures for conducting investigations.
   2. The Compliance and Ethics Officer will review every report and any related documentation of potential non-compliant behavior and will, in consultation with outside legal counsel, as necessary, determine an appropriate course of action, including assignments and/or referrals for investigation, reporting of findings, and proposals for corrective actions.
   3. Investigations shall be designed to clear the matter at hand and to identify trends and patterns with an eye toward performance improvement.
   4. All Associates are required to assist in the resolution of the investigation in the appropriate manner. Employees who willfully hinder the investigation will themselves be subject to disciplinary action pursuant to the Facility’s Discipline Policy and Procedure.
   5. Examples of individuals who may serve as investigators include, but are not limited to:
      1. Compliance and Ethics Committee members;
      2. Compliance and Ethics Officer; or
      3. Legal counsel.
2. Scope of an Investigation
   1. An investigator, upon initiation of an investigation, will:
      1. Review the complaint;
      2. Review applicable laws, rules and regulations, policies and procedures governing the complaint;
      3. Determine whether the complaint, if true, violates the applicable standard;
      4. Determine the scope and time-frame of the investigation, including necessary Associate interviews, documentation collection, audit and the identity of outside resources (if needed) to complete the investigation; and
      5. Identify rights of an Associate under investigation (i.e. are they entitled to counsel).
3. Conducting an Investigation
   1. If an investigation is warranted, the Compliance and Ethics Officer shall notify the Compliance and Ethics Committee as to the nature of the issue.
   2. The Compliance and Ethics Officer will assign an investigator to begin investigating all Compliance and Ethics related concerns within 7 days (or sooner if required by law) following receipt of the report or complaint.
   3. The investigation shall be concluded within a reasonable time after the non-Compliance is reported or discovered.
   4. In instances where the concern was previously investigated, the investigator will review the details of the previous investigation and the action taken.
   5. The investigator shall develop a written plan of the investigation. The plan should be revised as the investigation proceeds. The investigation may include, but is not limited to:
      1. Reviewing documents;
      2. Interviewing appropriate individuals;
      3. Reviewing policies and procedures;
      4. Collaborating with an external oversight authority; and
      5. Contracting with an external investigative agency.
   6. All investigative methods and findings, whether or not they substantiate the reports, shall be documented and provided to the Compliance and Ethics Officer, with originals of the supporting documentation attached.
4. Results of an Investigation
   1. If a significant Compliance and Ethics violation exists, the investigator will immediately report the issue to the Compliance and Ethics Officer and work with the Compliance and Ethics Officer to resolve the issue and develop a remediation plan pursuant to the Facility’s Response to Detected Issues and Remediation Policy and Procedure.
      1. All documentation related to the investigation shall be kept in an open investigation file until the remediation plan and any related monitoring are completed.
   2. The investigator and the Compliance and Ethics Officer will prepare a Corrective Action Plan, including disciplinary measures to be taken. The Compliance and Ethics Officer will present a summary report to the Compliance and Ethics Committee.
   3. If the investigation finds that no violation occurred, then the Compliance and Ethics Officer shall file a report on the steps taken in the course of the investigation.
   4. The Compliance and Ethics Officer shall report all Compliance and Ethics related matters to senior management and/or the Board of Directors, as deemed necessary and appropriate.
5. Compliance and Ethics Officer and the Governing Board
   1. The Compliance and Ethics Officer shall have direct access, and shall provide timely reports with regard to reported concerns, findings, remediation efforts, etc., to the Facility’s Governing Board.
   2. The Compliance and Ethics Officer shall keep a detailed documentation record, in the form of minutes or another similar format, of all meetings and conferences.
   3. The Compliance and Ethics Officer shall provide the documentation to the Governing Board when reporting to the Governing Board.
6. Documentation
   1. All documentation shall be filed for a period of six (6) years and in accordance with the Compliance and Ethics Program’s Compliance and Ethics Filing Systems Policy and Procedure.
   2. A copy of a report involving any Associate shall be filed in the individual’s personnel file, pursuant to the Facility’s records retention policy.
7. Confidentiality
   1. All information received through an Associate’s report should be treated in as strictly confidential manner as practicable.
8. Reporting
   1. To the extent that the investigation concludes that an issue requires reporting to a government agency, the Compliance and Ethics Officer will consult with the Compliance and Ethics Committee and legal counsel prior to any such report.
9. Follow-up
   1. The investigator will provide feedback, if feasible, on the investigation to the person who reported the suspected violation. Responses and feedback should be general in nature and not reveal information of a confidential nature such as an individual’s name or corrective action taken as a result of the investigation.
   2. The Compliance and Ethics Officer will check that the recommended Corrective Action Plan and associated disciplinary measures have been completed.
10. Non-Intimidation and Non-Retaliation
    1. The Facility strictly prohibits intimidation, retaliation, discrimination, harassment, or any other adverse action by management or any other person or group, either directly or indirectly, against any individual or group for good-faith participation in the Facility’s 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; for reporting a potential violation of the Compliance and Ethics Program; or for other misconduct in good faith No individual may intimidate or threaten to retaliate against another individual for filing such a report or for participating in good faith in an investigation of any Compliance and Ethics matter, including matters related to resident safety and treatment or resident confidentiality.
       1. Prohibited retaliation includes, but is not limited to,
          1. Termination
          2. Suspension
          3. Demotion
          4. Failure to consider for promotion
          5. Harassment
          6. Reduction in compensation
          7. Adverse change in working conditions.

Retaliation is prohibited even if it is determined that the allegedly improper conduct covered by a report was proper or did not occur, provided that the report was made in good faith. The Facility reserves the right to take disciplinary action against any employee who maliciously or intentionally files a report he or she knows to be untrue.

**{Facility}**

**Internal Investigation of Violations Checklist**

{Facility} (the “Facility”) believes it is important to investigate internal allegations of misconduct in a thorough and consistent manner. While the guidelines outlined below should be followed whenever possible, flexibility is important. Investigations may vary from one case to the next and deviations from these guidelines may be appropriate, based on the type and nature of incident being investigated and other factors. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and any others working for the facility. (“Associates”)

1. Investigators often must ask detailed and difficult questions. The very nature of interviews may cause some Associates to feel uncomfortable and upset. While the investigatory process can be intense, investigators should be guided by the following principles to ensure that investigations are conducted in a manner consistent with our corporate values of integrity and respect:
   1. All interviewees, witnesses, and other parties, including anyone accused of wrongdoing, should be treated with courtesy and dignity.
   2. As much as feasible, complainants should be kept informed about the progress of the investigation.
      1. However, due to the confidential and often complex nature of handling investigations, it is not always possible to provide feedback on referrals. Associates are advised not to let that be a deterrent for continuing to refer suspicious situations.
   3. Investigators should not use methods or techniques that are coercive, intimidating, unethical, or of questionable legality.
   4. Investigators should bear in mind that they are acting on behalf of the company, and Associates will judge the ethics of the company by how the investigators treat people and conduct investigations.
2. Investigators generally should follow the steps listed below in conducting investigations:
   1. The investigator should review relevant corporate policies and guidelines before beginning the investigation.
   2. The investigator should contact the Facility’s designated legal counsel if the investigation involves potential litigation; violations of laws, regulations, or rules promulgated by a governmental entity or agency; improprieties or wrongdoing by the Facility’s senior managers, directors or officers; or issues that require legal counsel to handle or be informed about.
   3. The investigator should review other relevant documents, which may include personnel files and historical files concerning other investigations involving the same Associates.
   4. The investigator should develop an investigation plan considering:
      1. The issues,
      2. Applicable policies, guidelines, and practices,
      3. The witnesses to be interviewed, including the purpose for each interview and facts the investigator believes the witness will address, and
      4. Documents to be gathered in advance and documents to be requested from witnesses,
   5. During the course of the investigation, the investigator should obtain any documents identified by the parties involved in the matter.
   6. Decide upon the order in which investigation interviews will be conducted.
      1. Complainant
      2. Alleged offender
      3. Coworkers and other witnesses
      4. Supervisors of the complainant and alleged offender
      5. Second interview with the alleged offender to discuss any factual questions as a result of the investigation
3. Witness Interview
   1. Interview each witness separately in an office or room where the discussion will not be overheard by other witnesses, the alleged offender, or any other unauthorized persons.
   2. Two uninvolved supervisors should participate in the interview process. At least one of the investigating supervisors should be thoroughly familiar with the laws and the policies and procedures dealing with the issue at hand. One supervisor should be designated as the interviewer, and the other should act primarily as a witness and take notes of the discussion.
   3. Emphasize that the Facility takes these charges very seriously and that the Facility is investigating these charges by interviewing all potential witnesses in Compliance with the Facility policy.
   4. Explain that upon completion of the investigation, the Facility will attempt to determine what occurred, and will take appropriate action based on its determination.
      1. Both the complainant and the alleged offender should be advised that each will be apprised of the results of the investigation and any action taken.
   5. Instruct each witness interviewed not to discuss the matters covered during the interview with any other Associate or the alleged offender.
      1. Explain to the witness that confidentiality is necessary to protect the integrity of the investigation and to ensure that the Facility receives trustworthy information in an atmosphere free from coercion.
      2. Explain to the witness that, however, the Facility may need to disseminate or discuss information obtained during the investigation as appropriate and on a “need to know” basis only (e.g., to allow the person who is alleged to have violated the Facility policy to respond to the allegations; to allow the Facility to defend itself in an arbitration or lawsuit, or to respond to an investigation by a government agency).
      3. Explain to the witness that the Facility policy prohibits intimidation and retaliation against anyone who reports a complaint or participates in an investigation, and that any acts of intimidation and retaliation should be reported immediately.
4. During the interviews:
   * 1. Avoid leading questions.
     2. Ask open ended, nonjudgmental questions.
     3. Use investigation interview forms where appropriate.
     4. Avoid the appearance of impropriety or favoritism in conducting interviews.
     5. Observe and record all physical and verbal reactions of witnesses.
     6. Do not record conclusions regarding credibility.
     7. Avoid judgmental statements or furthering of myths or stereotypes.
   1. The investigator should take accurate, detailed notes of all interviews.
      1. The notes of an interview should document all of the key facts surrounding the incident being investigated and should answer the key questions of what, where, when, how, and why, to the extent such matters were covered during the interview.
      2. The interviewee’s responses should be captured in narrative form, where possible, and should reflect the actual language used by the interviewee, any hesitation to respond to certain questions, any conflicting responses to similar questions, and other pertinent observations.
   2. Discuss investigation results and proposed action with the investigation team and outside counsel where appropriate. This discussion should be limited to those with a need to know the results of the investigation, such as the complainant’s supervisor, the alleged offender’s supervisor, and the Compliance and Ethics Officer.
   3. Consider credibility determinations.
      1. Factors include memory, perception, truthfulness, corroboration or lack of it, bias of witnesses, consistency, plausibility of accounts and prior misconduct.
5. After the Interview
   1. Review all evidence collected.
   2. Consult outside counsel if necessary
   3. Make a decision.
   4. Consider appropriate remedial action:
      1. a verbal warning,
      2. written warning,
      3. denial of bonus or pay raise,
      4. suspension,
      5. demotion,
      6. termination or some combination.
   5. Also, consider providing training to the offender and to all employees.
   6. Consider the following factors in determining the appropriate remedial action:
      1. credibility of the complainant, alleged offender and other witnesses;
      2. prior conduct, if any (e.g., the alleged offender);
      3. prior discipline of the alleged offender;
      4. level of harassment, including the type and frequency of conduct;
      5. alleged offender’s knowledge of company rules of conduct;
      6. prior disciplinary “precedent” for identical, similar or analogous misconduct; and
      7. public and employee relations issues.

**Compliance and Ethics Reporting Form[[2]](#footnote-3)**

*Confidential*

Non-Intimidation and Non-Retaliation Policy

The facility protects employees who report suspected violations, and will ensure confidentiality of Compliance and Ethics reporting and Compliance and Ethics investigations unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.

Date reported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parties Involved in the Incident:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date(s) of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) Name of Person Reporting Concern\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does not wish to give name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requests identity to be kept in confidence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**{Facility}**

**Compliance and Ethics Hotline Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others ("Associates") have the ability to report suspected violations of laws, rules, and regulations.

**POLICY**

The Facility will maintain an anonymous Compliance and Ethics Hotline (“Hotline”) 800-610-2544 to enable Associates to report any suspected violations of the law, federal healthcare regulations, policies or procedures, or the Facility’s Standards of Conduct. Associates will be able to leave a voice mail message 24/7. The Facility will commence an investigation of any and all reports made via the Hotline within one business day after the report. The Facility will publicize the existence of the Hotline and display information regarding the Hotline in an employee area.

**PROCEDURE**

1. Operation. The Facility has hereby engaged the services of Compliance Consulting Group, LLC (“CCG”) to maintain the operation and integrity of the Hotline. CCG shall:
   1. Ensure the proper functioning of the Hotline;
   2. Follow-up with the Compliance and Ethics Officer appropriately in response to all Hotline calls to:
      1. Provide feedback to callers as necessary;
      2. Report Hotline activity to the Facility’s governing board on a consistent/regular basis.
   3. Assist the Compliance and Ethics Officer in conducting appropriate investigations of all credible allegations; and
2. Confidentiality. CCG will promote confidentiality by:
   1. Refraining from requiring the caller to disclose his/her identity;
   2. Assuring anonymity and/or confidentiality, if requested;
   3. Refraining from identifying the number/location of the call;
   4. Keeping the Compliance and Ethics Hotline Report as the only record of Compliance and Ethics Hotline calls;
   5. Maintaining the Compliance and Ethics Hotline Report in a secure area; and
   6. If/when a caller chooses to disclose his/her identity and requests confidentiality, CCG shall safeguard confidentiality by providing the report to the Compliance and Ethics Officer or his/her designee(s) only unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.
3. Retaliation. No retaliatory actions will be taken against any individual who reports Compliance and Ethics violations in good faith through the Hotline.
4. Communication. The Facility will communicate to all Associates the existence of the Compliance and Ethics Hotline by:
   1. Posting a Hotline Poster that states the Hotline number;
   2. Displaying the Poster in a prominent location within the facility frequented by Associates; and
   3. Providing Compliance and Ethics Hotline information/instructions to all Associates during orientation and annual Compliance and Ethics training.
5. Tracking. The Compliance and Ethics Officer will track all Compliance and Ethics Hotline calls by creating case files for each complaint and keep in a secure area.

**{Facility}**

**Response to Detected Issues and Remediation**

**Policy and Procedure**

**PURPOSE**

To ensurethe overall success of the Compliance and Ethics Program and provide a means by which to evaluate the effectiveness of the Compliance and Ethics Program.

**POLICY**

It is the policy of {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) to investigate all suspected violations of the Compliance and Ethics Program and take necessary remedial action to the extent it is warranted. Under some circumstances, the Facility may need to consider engaging outside counsel, auditors, or health care experts to assist in an investigation. The investigator, in coordination with the Compliance and Ethics Officer, will develop a remediation plan when a Compliance and Ethics violation is detected. The plan will be designed to prevent a recurrence of the violation and is a key factor in evaluating the success of the overall Compliance and Ethics Program.

**PROCEDURE**

1. Investigation
   1. The investigation shall be concluded within a reasonable time after the non-Compliance is reported or discovered.
   2. The investigative file should contain:
      1. documentation of the alleged violation,
      2. a description of the investigative process (including the objectivity of the investigators and methodologies utilized),
      3. copies of interview notes and key documents,
      4. a log of the witnesses interviewed and the documents reviewed,
      5. the results of the investigation, e.g., any disciplinary action taken, and
      6. the corrective action implemented.
   3. While any action taken as the result of an investigation will necessarily vary depending upon the situation, the Facility shall strive for some consistency by using sound practices and disciplinary protocols.
   4. If the Compliance and Ethics Officer believes the integrity of an investigation may be at stake because of the presence of Associates under investigation, the Facility will remove those individuals from their current responsibilities until the investigation is completed (unless there is an ongoing internal or government-led undercover operation known to the Facility).
   5. The Compliance and Ethics Officer shall take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.
   6. If the Facility determines that disciplinary action is warranted, it shall be promptly imposed in accordance with the Facility’s written standards of disciplinary action.
2. Remediation
   1. Associates are expected to fully cooperate with and assist the Facility in the resolution of reported Compliance and Ethics issues.
   2. Any Associate that committed fraud, waste, or abuse, or non-Compliance in general shall be subject to discipline pursuant to the Facility’s disciplinary policies and procedures, and the Associate may be subject to further discipline and ramification should the Associate fail to satisfactorily implement corrective actions.
   3. A Remediation Plan will be developed on a case-by-case basis. Plans may include:
      1. Additional or modified education
      2. Corrective action plans that are
         1. Designed to correct and prevent future non-compliance, including conducting a root cause analysis
         2. Are tailored to address the particular Compliance and Ethics problem or deficiency identified, and
         3. Include time frames for specific achievements.
      3. The return of any overpayments
      4. Development of new policies and procedures
      5. Revision of existing policies and procedures
      6. Revision of the Compliance and Ethics Program
         1. The Compliance and Ethics Officer shall review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered or modifications of the Compliance and Ethics program are necessary to prevent and detect other inappropriate conduct or violations.
      7. Additional monitoring and/or auditing to ensure that the problem should no reoccur and to ensure the effectiveness of the corrective action.
      8. Reporting to an outside government agency such as the Office of Inspector General (OIG).
      9. A referral to criminal and/or civil law enforcement authorities.
3. Compliance and Ethics Officer and the Governing Board
   1. The Compliance and Ethics Officer shall have direct access, and shall provide timely reports with regard to reported concerns, findings, remediation efforts, etc., to the Facility’s Governing Board.
   2. The Compliance and Ethics Officer shall keep a detailed documentation record, in the form of minutes or another similar format, of all meetings and conferences.
   3. The Compliance and Ethics Officer shall provide the documentation to the Governing Board when reporting to the Governing Board.
4. The Compliance and Ethics Officer shall be involved in the development of all remediation plans that:
   1. Result from significant Compliance and Ethics violations.
   2. Affect multiple departments or service lines.
   3. Involve revisions or additions to the Compliance and Ethics Program or policies and procedures.
5. Reporting to an outside agency shall be coordinated with the Compliance and Ethics Officer and the Facility’s legal counsel prior to reporting. The Compliance and Ethics Officer and legal counsel will monitor settlement of issues reported to outside authorities.
6. All remediation plans will be documented. The Compliance and Ethics Officer will keep all records and documentation relating to any detected issue and/or remediation plan. Plans requiring additional monitoring are left “open” and are not filed until the monitoring period is successfully completed. All filed reports will be kept for a minimum of six (6) years as per the Compliance and Ethics Filing Systems Policy and Procedure, unless applicable state laws and regulations require a longer period.
7. Corrective or remedial action resulting from a Compliance and Ethics investigation must follow the appropriate policy.
8. The Plan of Correction will contain at a minimum:
   1. The area identified for improvement.
   2. Action to be taken.
   3. The individual assigned to complete the Plan of Correction.
   4. The completion date
   5. A follow-up date and the results of the follow-up.
9. The Compliance and Ethics Log will be notated accordingly by the Compliance and Ethics Officer.
10. It is against the policy of the Facility for Associates to be retaliated against for their participation in this process. This includes questions and concerns an Associate discusses with an immediate supervisor, oversight authority, or the Compliance and Ethics Officer

**Corrective Action Plan[[3]](#footnote-4)**

**Sample Format**

1. Issue / Problem Definition (Be Specific – Quantify if Possible)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Root Cause Evaluation

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1. Action Steps

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1. Improvement Benchmark(s) And Timeframe

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1. Certification

The undersigned have read this Corrective Action Plan and agree to its terms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title Date

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Title Date

**{Facility}**

**Compliance and Ethics Filing Systems Policy and Procedure**

**PURPOSE**

To ensure a proper method of filing and retaining Compliance and Ethics related documents.

**POLICY**

It is {Facility}’s policy to establish and maintain a filling system for all Compliance and Ethics-related documents.

**PROCEDURE**

The following files shall be established:

1. Compliance and Ethics Manual, Codes, And Policies
   1. This file shall contain this Compliance and Ethics manual and any amendments, the Employee Standards and Code of Conduct, all conflict of interest statements, any Compliance and Ethics program policy statements issued after the program’s initiation, and all deficiencies identified and corrective actions taken.
2. Oversight
   1. This file shall document the appointment of the Compliance and Ethics officer, all non-privileged communications to the Compliance and Ethics officer, all Compliance and Ethics committee minutes in which Compliance and Ethics issues are discussed, and any other oversight records.
3. Information and Education Campaign
   1. This file shall contain signed affirmation statements, all employee training records including topics discussed and educational materials distributed 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.
   2. Documentation in this file shall be saved for a minimum of ten (10) years.
4. Monitoring and Auditing
   1. This file shall contain all physician contracts, equipment and office leases, loan instruments, joint venture documents, partnership agreements, and other documents relating to financial relationships with physicians. Finally, opinion letters from legal counsel approving physician contracts shall be included.
5. Enforcement
   1. This file shall contain all documents pertaining to the enforcement of the Compliance and Ethics program, such as disciplinary action taken, policies regarding progressive discipline, and informal and formal reprimands issued. 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.
6. Response
   1. 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.
7. Privileged
   1. This file shall include a record of requests for legal assistance or legal opinions in connection with reports received via the hotline, or reported 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 and legal counsel shall have access. All material in this file shall be treated as subject to the attorney-client and/or work product privilege and shall not be disclosed to people outside the privileged relationship.

**{Facility}**

**Human Resources and Compliance and Ethics Officer Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) implements certain human resources requirements to protect against the wrongful use or disclosure of protected health information (“PHI”).

**POLICY**

1. Personnel Designations
   1. The Facility shall designate a Compliance and Ethics Officer who is responsible for the development and implementation of the policies and procedures of the Facility regarding health information Compliance. The Compliance and Ethics Officer shall perform those functions listed in the Facility’s Role of the Compliance and Ethics Officer and Compliance and Ethics Committee Policy and Procedure and shall act as the contact person responsible for receiving complaints. The Compliance and Ethics Officer shall be able to provide further information to workforce members or other individuals about matters covered in the Facility’s Policies and Procedures.
2. Workforce Training
   1. The Facility shall train all members of its workforce on the policies and procedures with respect to PHI to all current employees on a periodic basis and as necessary and appropriate and to each new member of the workforce within a reasonable period of time after the person joins the covered entity's workforce;
   2. Such training shall be performed before any workforce member uses or accesses PHI.
   3. The Facility shall document the training of each workforce member by documenting attendance at the training.
3. Sanctions
   1. The Facility shall apply sanctions against members of its workforce who fail to comply with the Facility's policies and procedures or applicable law regarding PHI.
   2. Nature and Severity of Sanction
      1. The Facility will consider all relevant factors in determining the nature and severity of the sanction, including the type of violation made by the workforce member, the intent of the workforce member at the time of the violation and the number and frequency of any prior violations by the workforce member. The Facility may impose cumulative sanctions on a workforce member who commits more than one violation.
   3. Documentation and Retention
      1. If a sanction is imposed, written documentation of the sanction, including a description of the circumstances leading to the violation, will be given to the workforce member and a copy shall be maintained in the personnel file of the workforce member.
4. Mitigation
   1. The Facility shall mitigate, to the extent practicable, any harmful effect that is known to the Facility of a use or disclosure of PHI in violation of its policies and procedures by the covered entity or its business associate.
5. Refraining from Intimidating or Retaliatory Acts
   1. The Facility shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual or person for the exercise of any right provided by HIPAA, participation in a HIPAA investigation, or opposition to an act or practice in violation of HIPAA.

**{Facility}**

**Interaction with The Government: Inquiries and Investigations Policy and Procedure**

**PURPOSE**

To ensure the appropriate handling of all interaction with Government authorities, and to provide a uniform method for {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) to respond to any government authority (federal or state) who contacts him or her either during office hours or at home, for information regarding the Facility’s business.

**POLICY**

The Facility is likely to be subject to frequent and routine government reviews and/or litigation. The Facility and all Associates must always appropriately and effectively interact with government authorities in an honest and open manner. All interaction with government authorities related to the business of the Facility, whether by inquiry or investigation, whether by inquiry or investigation, or during litigation, MUST be undertaken timely, appropriately, honestly, with the appropriate involvement of the Compliance and Ethics Officer and the Facility’s legal counsel, and in accordance with the procedures listed herein.

*The Compliance and Ethics Officer must not only receive any legal documents (e.g.; subpoenas, summonses, and legal complaints) immediately but will also forward them to appropriate legal counsel in a timely manner in order to ensure that all deadlines are met.*

**PROCEDURE**

1. Government Demand Letters, Subpoenas, and Search Warrants
   1. If an Associate receives an investigative demand letter, subpoena, or search warrant from a government authority relating to the Facility, the Compliance and Ethics Officer shall be immediately notified.
      1. The Associate may not discuss the case with the individual who served the Associate with the subpoena.
      2. The Compliance and Ethics Officer will in turn immediately notify any additional and appropriate senior management or member of the board.
      3. The Compliance and Ethics Officer and legal counsel will coordinate the response to the government. No Associate should release or copy documents without the authorization of the Compliance and Ethics Officer or legal counsel.
      4. Associates may not remove, alter, create, or destroy documents or records including, but not limited to, paper, tape, and computer records.
      5. The Compliance and Ethics Officer will maintain a record of every complaint, subpoena, summons, and court order served on the Facility. The Compliance and Ethics Officer will be responsible for coordinating with legal counsel as needed.
      6. The Compliance and Ethics Officer and legal counsel will be primarily responsible for a timely and appropriate response to the government.
2. Search Warrants
   1. A “search” occurs any time a government representative enters the offices or business premises of the Facility and begins to look for any documents or ask questions. A search generally may not be conducted without a legally valid search warrant.
   2. Associates should check the date and time on the legal documentation to make sure the government representative has a valid document. Government representatives may not search a business at a time other than one within the time period specified in the legal document.
   3. If the warrant is valid, an Associate may not stop the search. It is, however, appropriate for Associates to request that the government representative allow them to contact the Compliance and Ethics Officer and legal counsel to determine the validity of the warrant. Additionally, Associates may ask questions and demand a copy of the warrant.
   4. Once validity of a warrant has been ensured, the Compliance and Ethics Officer or legal counsel will instruct Associates on how to proceed. In general, Associates **must**:
      1. Appoint someone on site to be in charge. That person will be responsible for communicating with the government representative.
      2. Remember that it is a crime to obstruct a government agent in the lawful execution of a valid search warrant.
      3. Remain calm, polite, and observant.
      4. Cooperate with the government representative
      5. Provide accurate information to the government representative.
         1. Providing inaccurate statements to government representatives may result in obstruction of justice charges.
   5. Associates **may not**
      1. alter or destroy documents sought in the investigation;
      2. falsely deny knowledge of information;
      3. corruptly influence another person to exercise the privilege against self-incrimination; or
      4. intimidate a witness with the intent of influencing testimony.
   6. It is critical to keep a thorough list of all documents that the government representative is seizing or copying. An Associate should be assigned to accompany each government representative during his or her search. That Associate should take detailed notes of everything the government representatives seize and those documents that the government representatives inspect but do not seize or copy. The Associate should also take detailed notes of any conversations amongst the government representatives and all conversations between government representatives and other Associates.
   7. An Associate should be assigned to get a detailed receipt from the government representative of all documents/items of which the government has obtained a copy, including the number of pages copied for reimbursement purposes.
      1. If the government representative wishes to take original documents, then those documents should first be copied.
      2. The Compliance and Ethics Officer and legal counsel should be contacted immediately if the government representative will not allow copies to be made.
      3. The Compliance and Ethics Officer and legal counsel should be notified immediately if the government representative seeks to seize documents or items (including computers) whose loss will impede the day-to-day operation of the Facility.
   8. Associates must answer a government representative’s questions concerning the location of documents if the Associate knows the location of the documents in question. Associates are not required to answer other questions and should inform the government representative that they would prefer to wait until the Compliance and Ethics Officer or legal counsel is present before responding to any inquiries.
      1. Associates do not have to explain the Facility operations, bookkeeping, records, or what any document means.
3. If an agent makes requests or demands of an Associate that is inconsistent with these instructions, the Associate should seek the advice of the Compliance and Ethics Officer before responding to any inquiries. If Associates are asked to sign an affidavit of any kind, they should not comment as to the validity of its contents. Rather, they should explain to the government representative that they are not authorized to sign any document prior to review by the Compliance and Ethics Officer or legal counsel.
4. On-Site Investigators/Auditors
   1. If an investigator or other government representative appears in person, Associates should ask to see his or her identification and business card. If these materials are unavailable, Associates should ask for the person’s name and office, address and telephone number, and identification number. An Associate should then call the government representative’s office to confirm his or her authority. If more than one representative appears, determine which representative is in charge of the investigation and ask for his or her identifying information.
   2. If the government representative wants to speak to a particular Associate, that Associate should attempt to find out the reason for the inquiry without getting into specific details.
   3. If the government representative wants to search the offices or business premises or obtain any documents from the Facility, Associates should ask to see a legal document requesting the search, such as a search warrant, and any affidavit supporting the warrant. All documentation set procedures set forth above should be followed.
   4. Associates should check the date and time on the legal documentation to make sure the government representative has a valid document. Government representatives may not search a business at a time other than one within the time period specified in the legal document.
   5. The Associate assisting the government representative should contact the Compliance and Ethics Officer and legal counsel immediately after completing these tasks and relay all information and documentation from the identification and legal documents.
   6. The Compliance and Ethics Officer shall create and maintain a complete listing of all visits by government representatives and all documentation supplied to government representatives.
5. Requests for Interviews
   1. Government representatives may suggest that Associates must speak with them when they first contact the Facility. The representatives may even imply that it is wrong for an Associate to refuse to speak with them during this first encounter.
   2. Associates should be made aware that government representatives may not threaten Associates in any way.
   3. Government representatives may not require an Associate to speak with them immediately.
      1. Associates may schedule an appointment at a later time to speak with the representative.
      2. Associates are entitled to have someone with them during an interview with a government representative. The Facility can arrange to have legal counsel present at no cost, or the Associate may choose to consult with an attorney separately at his or her own expense.
   4. Associates are, of course, free to speak with government representatives at their own discretion. If an Associate speaks with a government representative before notifying the Compliance and Ethics Officer or legal counsel, the Facility does not require, but rather requests that the Associate contact the Compliance and Ethics Officer or legal counsel as soon as possible after the interview. Associates are strongly encouraged to take notes during the interview.
   5. During the interview, Associates should follow these guidelines:
      1. Always tell the truth. If you do not recall something or have no knowledge about the topic being discussed, say so.
      2. Carefully answer questions completely, accurately, and concisely so that there will be no misunderstanding as to what you are saying. Indicate whether the information you are providing is first-hand knowledge, something you have heard, or speculation. It is good practice to avoid speculation, but if you do speculate, it is important to make sure you let the government representative know that you are speculating.
      3. Contact the Compliance and Ethics Officer or legal counsel as soon as possible after the interview.
6. Communications Regarding a Government Inquiry or Investigation.
   1. Except as set forth above in relation to interaction with a government representative directly, Associates should not discuss any government inquiry or investigative matter with anyone without first receiving permission from the Compliance and Ethics Officer or legal counsel.
   2. Innocent parties may be hurt by rumors regarding the government contact and the Facility will not tolerate the spreading of such rumors by any Associate.
7. Administrative Issues
   1. Once a government contact is initiated, the lead Associate involved should establish a file for communications to and from the Compliance and Ethics Officer and legal counsel. The file and all related documentation must be labeled with the words “CONFIDENTIAL ATTORNEY-CLIENT PRIVILEGED COMMUNICATION.”
   2. Associates should NOT make copies other than a file copy, or further distribute any confidential communication with the Compliance and Ethics Officer or legal counsel, as distribution may destroy the privilege of confidentiality.

{Facility}

Deficit Reduction Act Of 2005 Policy and Procedure

PURPOSE

To ensure Compliance with all fraud, waste, and abuse Compliance and Ethics requirements mandated by the Federal Deficit Reduction Act of 2005 (“DRA”), as well as any other federal or state fraud, waste, and abuse statutes or regulations.

POLICY

{Facility} (the “Facility”) is committed to complying with the requirements of the DRA, and preventing and detecting any fraud, waste, or abuse in the facility. To this end, the Facility maintains a Compliance and Ethics program and strives to educate its work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to the federal and state governments. The Facility has instituted various procedures to ensure Compliance with these laws and to assist the Facility in preventing fraud, waste, and abuse in federal health care programs. In furtherance of this policy and to comply with the DRA, the Facility shall disseminate this policy to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) to ensure that such persons are aware of certain relevant federal and state laws, and that submission of a false claim can result in significant administrative and civil penalties under the federal False Claims Act and other state laws. See Appendix A attached here for a summary of the relevant laws and regulations.

PROCEDURE

1. Pursuant to the DRA, the Facility shall educate staff on federal and state false claims laws, whistleblower protections, and the Facility’s policies and procedures for detecting and preventing fraud, waste, and abuse.
   1. Pursuant to its policies, the Facility shall:
      1. Conduct the required background checks on employees;
      2. Audit resident charts and billing records and provide a comprehensive corrective action plan to address any negative findings;
      3. Educate all staff and Associates on applicable federal or state fraud, waste, and abuse laws;
      4. Provide Associates with detailed information about the Federal and State False Claims Act; administrative remedies for false claims or statements; and whistleblower protection;
      5. Provide employees with a specific discussion of employees’ rights to be protected as whistleblowers (see below II B).
2. The Facility’s Compliance and Ethics officer shall implement this policy and procedure with the assistance of the Facility’s legal counsel. The Facility shall require Vendors and Contractors to adopt this policy. The Facility further expects that Vendors and Contractors shall disseminate this policy to their Associates.
   1. To assist the Facility in meeting its legal and ethical obligations, any Associate who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a federally or state funded health care program is required to report such information to his/her supervisor and the Compliance and Ethics Officer. All Associates can make a report either openly or anonymously by calling our Compliance and Ethics Hotline at (800) 610-2544.
   2. Any Associate who reports such information will have the right and opportunity to do so anonymously and will be protected against retaliation for coming forward with such information both under the Facility’s internal Compliance and Ethics policies and procedures (See the Facility’s Anti-Retaliation Policy and Procedure) and federal and state law (See Appendix A for a discussion of the relevant laws).
   3. Failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the Associate’s obligations to the Facility and may result in disciplinary action, up to, and including termination.
3. For additional information related to detecting and reporting suspected fraud, waste, and abuse see the Facility’s Fraud, Waste, and Abuse in Federal Health Care Programs Policy and Procedure.

APPENDIX A: EXPLANATION OF LAWS

1. Deficit Reduction Act of 2005 – 42 U.S.C. § 1396a(a)(68)
   1. Federal law that requires the facility because it receives Medicaid funding, to take the following actions to address fraud, waste, and abuse in health care programs that receive federal funds:
      1. Establish written policies for all employees and contractors or agents.
         1. Provide detailed information about the Federal and
         2. State False Claims Act; administrative remedies for false claims or statements; and whistleblower protection;
         3. Include provisions regarding the facility’s policies and procedures for detecting and preventing fraud, waste, and abuse, and;
         4. Provide employees with a specific discussion of employees’ rights to be protected as whistleblowers.
      2. Pursuant to the DRA, the facility must establish and make available to their employees, contractors, and agents policies that explain:
         1. Federal and state laws dealing with false claims for payment from federally funded programs; and
         2. The facility’s policies and procedures to detect and prevent fraud, waste, and abuse in these programs.
      3. Contractors and agents must also adopt the facility’s policies and make them available to their employees.
2. The Federal Civil False Claims Act – 31 U.S.C. §§ 3729 – 3733
   1. The False Claims Act (“FCA”) imposes liability on any person who “knowingly” submits either a claim to the federal government, or a contractor of the federal government, or a false record in order to obtain payment from the government, that he or she knows, or should have known, is false. To “knowingly” present a false or fraudulent claim means that the person: (1) has actual knowledge that the information on the claim is false; (2) acts in “deliberate ignorance” of the truth or falsity of the information on the claim; or (3) acts in “reckless disregard” of the truth or falsity of the information on the claim. It is important to note that the person does not have to deliberately intend to defraud the federal government in order to be found liable under the FCA. The person need only “knowingly” present a false or fraudulent claim in the manner described above. The FCA also imposes liability for “reverse false claims,” which are instances which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money.
   2. Examples of false claims include, but are not limited to:
      1. A claim for a service or supply that was never provided;
      2. A claim indicating the service was provided for some diagnosis code other than the true diagnosis code in order to obtain reimbursement for the service (which would not be covered if the true diagnosis code were submitted);
      3. A claim indicating a higher level of service than was actually provided;
      4. A claim for a service that the provider knows is not reasonable and necessary;
      5. A claim for services provided by an unlicensed individual;
      6. A claim for services that were performed as a result of a kickback in violation of the Anti-Kickback Statute (42 U.S.C. §1320a-7b); or
      7. A claim resulting in an unreturned overpayment.
3. Penalties
   1. The statutory provisions of the FCA authorizes a range of penalties of from between $5,000 and $10,000 per claim, which have been adjusted for inflation and increased by regulation to not less than $10,781 and not more than $21,563 per claim. 28 CFR §85.3(a)(9).
4. Qui Tam Provisions
   1. In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. These private parties, known as “qui tam relators,” may share in a percentage of the proceeds from an FCA action or settlement.
5. Whistleblower Protection (31 U.S.C. §3730(h))
   1. The FCA provides protection to any employee, contractor, or agent who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their lawful acts in furtherance of other efforts to stop violations of the FCA. Remedies include reinstatement with comparable seniority as the employee, contractor, or agent would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.
6. Federal False Statements Statute – 42 U.S.C. § 1320a-7b(a)
   1. Pursuant to this statute, any “person” that “knowingly” and “willfully” makes false statements in connection with the delivery or payment of health care benefits, items, or services payable in United States government funds is subject to significant fines and imprisonment.
      1. “Person” includes individuals, organizations, agencies, and other entities.
      2. “Knowingly” means that a person has actual knowledge of the false statement; acts in deliberate ignorance of whether the statement is true or false, or acts with reckless disregard as to whether the statement is true or false.
      3. “Willfully” means that a person’s actions were voluntary and intentional.
   2. The statute makes the commission of several acts a felony, including the following:
      1. Knowingly and willfully making or causing to be made any false statement of a material fact in any application for any benefit or payment, or for use in determining rights to such payment, under a federal health care program.
         1. “Federal health care program” means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, that is funded directly, in whole or in part, by the U.S. Government, or any state health care program.
      2. Concealing information from or failing to disclose information to the government, including specifically, information of an event affecting the initial or continued right to a benefit or payment under a federal health care program.
      3. Applying to receive a federal benefit or payment for the use and benefit of another and knowingly and willfully converting such payment to another use.
      4. Presenting or causing to be presented a claim for physician services knowing that the person who furnished the services is not a licensed physician.
         1. Counseling or assisting an individual to dispose of assets in order for the individual to become eligible for medical assistance.
   3. Anyone furnishing health care items or services payable in federal funds who commit any of these violations in connection with the furnishing of those items or services may be found guilty of a felony and subject to fines up to $25,000 and/or imprisonment for up to five (5) years.
   4. Violations by all other persons not furnishing health care items or services are misdemeanors and are subject to fines up to $10,000 and/or imprisonment for up to one (1) year.
7. Federal Health Care Fraud Statute – 18 U.S.C. § 1347
   1. Pursuant to this statute, any “person” or entity that “knowingly” and “willfully” defrauds or attempts to defraud any “health care benefit program,” or obtains through fraud or false pretenses, representations, or promises, any money or property owned or controlled by any health care benefit program in connection with the payment or delivery of health care benefits, items and services shall be subject to significant fines and/or imprisonment for up to ten (10) years.
      1. “Person” includes individuals, organizations, agencies, and other entities.
      2. “Knowingly” means that a person has actual knowledge of the information; or acts with reckless disregard as to whether the information is true or false.
      3. “Health care benefit program” is defined as any public or private plan or contract affecting commerce, under which any medical benefit, item, or service is provided to any individual.
   2. 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.
   3. 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.
   4. Liability under this statute is not limited to federal health care benefit programs such as Medicare and Medicaid. Fraud as to private health insurance providers or any other health care benefit program falls within the scope of this statute as well.
8. Federal Criminal False Claims Act – 18 U.S.C.A. §§ 286-287
   1. Pursuant to this statute, whoever enters into any agreement, combination, or conspiracy to defraud the United States, or any department or agency thereof, by obtaining or aiding to obtain the payment or allowance of any false, fictitious, or fraudulent claim, shall be fined or imprisoned not more than ten years, or both.
   2. Additionally, whoever makes or presents to any person or officer in the civil, military, or naval service of the United States, or to any department or agency thereof, any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be imprisoned not more than five years and shall be subject to a fine.
9. The Program Fraud Civil Remedies Act (“PFCRA”) – 31 U.S.C. 3801-3812
   1. This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 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. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula. For 2019, the adjusted amount is $11,462.00.
   2. Unlike the FCA, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the FCA, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by prosecution in the federal court system.
10. Federal Civil Monetary Penalties Statute – 42 U.S.C. § 1320a-7a
    1. Pursuant to this statute, any “person,” with the exception of beneficiaries of federal health care programs, that “knowingly” engages in a broad range of conduct resulting in false or improper claims payable in United States government funds is liable for significant penalties and fines.
       1. “Person” includes individuals, organizations, agencies, and other entities.
       2. “Knowingly” means that a person has actual knowledge of the information; acts with reckless disregard as to whether the information is true or false, or acts with reckless disregard as to whether the information is true or false.
    2. Specifically, the following are types of activities that will be subject to penalties:
       1. A claim for a medical item or service that the person knows or should know was not provided as claimed, including engaging in a practice of presenting a claim using a Current Procedural Terminology (“CPT”) code that the person knows or should know will result in greater payment than using the CPT code the person knows or should have known was applicable to the item or service actually provided.
          1. The term “should know” means that a person acts in deliberate ignorance of the truth or falsity of the information, or acts with reckless disregard to the truth or falsity of the information.
       2. A claim for a Medicare item or service that the person knows or should know is false or fraudulent.
       3. A claim for a physician’s service by a person who knows or should know that the individual who provided that service was not a licensed physician, or was licensed as a physician but such license was obtained through misrepresentation of a material fact, or who misrepresented that the physician was certified in a medical specialty.
       4. A claim for a medical or other item or service furnished during a period in which the person was excluded.
       5. A pattern of claims for medical or other items or services that a person knows or should know are not medically necessary.
    3. Additionally, the Secretary of Health and Human Services may impose civil monetary penalties for activities such as:
       1. Knowingly providing false or misleading information to any person regarding coverage of inpatient hospital services if the communication could reasonably be expected to influence the person’s decision about when to discharge an individual from the hospital.
       2. Offering and attempting to influence individuals to choose a particular provider if federal or state money will pay for the provider’s services and the offer or attempt to influence funds violates the Anti-Kickback statute.
       3. Contracting with an individual or entity that provides items or services payable by a federal program if the person knows or should know that the individual or entity is excluded from participation in a federal health care program.
    4. Persons or entities can be subject to civil monetary penalties of up to $10,000 for each fraudulent or improper claim. In some cases, the penalties may reach up to $50,000. Additionally, such person or entity is subject to a charge of up to three times the amount claimed for each item or service and may also be excluded from participation in both federal and state health care programs.
    5. The United States Attorney General may authorize the Secretary of Health and Human Services to initiate a proceeding to determine whether to impose a civil monetary penalty. The Secretary must give the person or entity in question written notice and an opportunity for a hearing. In determining the amount or scope of any penalty imposed, the Secretary will take into account the nature of claims and the circumstances under which the claims were presented; the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and such other matters as justice may require.
    6. Any person upon whom the Secretary imposes civil monetary penalties or exclusions has the right to appeal to the United States Court of Appeal within 60 days after the Secretary makes his determination. If an appeal is not filed within this 60-day period, the Secretary’s determination is deemed final.
    7. The Secretary is also required to notify appropriate state licensing agencies, the state Medicaid program, and peer review and professional organizations of the imposition of civil monetary penalties against providers, and to request that action be taken against the provider.
11. Georgia False Medicaid Claims Act (Ga. Code. Ann. §§ 49-4-168 et seq.)
    1. The Georgia False Medicaid Claims Act (the “GA FCA”) prohibits, among other things, knowingly presenting, making, or using (or causing to be presented, made or used) a false or fraudulent claim, record, or statement to the Georgia Medicaid program for payment or approval. In addition, the GA FCA prohibits conspiring to make or receive payments or benefits by filing a false claim, record, or statement.
    2. Penalty for Unlawful Conduct
       1. The civil penalty for violating the GA FCA is consistent with the civil penalties provision of the federal False Claims Act (see above Section II) for each violation. In addition to the penalty, a provider could be found liable for up to three times the amount of damages, including consequential damages that the Georgia Medicaid program sustains because of such violations. The provider also may be liable for the expenses associated for bringing the action, including attorney’s fees.
    3. Qui Tam Provisions
       1. The GA FCA also allows individuals to bring a civil action, called a qui tam action, against a provider in the name of the State for a violation of the GA FCA. When a plaintiff files the action, it remains under seal (not public) for at least 60 days. The Attorney General may choose to join in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the Attorney General chooses not to join the suit, the individual who initiated the lawsuit has the right to conduct the action independent of the Attorney General.
       2. In the event the Attorney General proceeds with the lawsuit, the plaintiff may receive 15%-25% of the proceeds of the action or settlement. If the case is primarily based on disclosures other than those made by the plaintiff, the plaintiff’s award may be reduced to less than 10% of the recovery. If the plaintiff proceeds in the action without the Attorney General, the plaintiff may receive 25%-30% of the recovery. In either case, the plaintiff may also receive an amount for reasonable expenses, including attorney’s fees and costs.
       3. If the plaintiff planned or initiated the violation, the plaintiff’s share of the proceeds may be reduced. If the plaintiff is found guilty of a crime associated with the violation, no share of the recovery will be awarded the plaintiff. If the Attorney General does not proceed with the lawsuit and the court found that the action was clearly frivolous, vexatious, or brought for the sole purpose of harassment, the defendant is entitled to the reasonable costs and attorney’s fees.
    4. Whistleblower Protection
       1. The GA FCA prohibits employers from retaliating against employees, contractors, or agents. Any employee, contractor, or agent who is discharged, demoted, suspended, threatened, harassed or discriminated against because of lawful acts conducted in furtherance of an action under the law may bring an action seeking two times their back pay plus interest; reinstatement at the seniority level he or she would have had except for the discrimination; compensation for any special damages sustained because of the discrimination; and costs and attorney’s fees for the bringing the action.
12. Georgia Criminal Code (Ga. Code. Ann. § 16-10-20)
    1. It is unlawful for a person to knowingly and willfully falsify, conceal, or cover up by any trick, scheme, or device a material fact; make a false, fictitious, or fraudulent statement or representation; or make or use any false writing or document, knowing the same to contain any false, fictitious, or fraudulent statement or entry, in any matter within the jurisdiction of any department or agency of the Georgia government or of the government of any county, city, or other political subdivision of Georgia. Conviction of such an offense is punishable by a fine of not more than $1,000.00 or by imprisonment for not less than one nor more than five years, or both.
13. Georgia Taxpayer Protection False Claims Act (the “GTPFCA”) O.C.G.A. § 23-3-120 et seq.
    1. The GTPFCA broadened liability for state false claims in order to reach non-Medicaid claims involving the money or property of the State or local governments. The GTPFCA grants sweeping governmental authority to recover damages and penalties from private sector contractors and subcontractors who present erroneous claims to government entities. Violations of the GTPFCA can result in a civil penalty of not less than five thousand five hundred dollars ($5,500) and not more than eleven thousand dollars ($11,000) per false claim, plus up to three times the amount of damages sustained by the Georgia Medicaid program or the State or local government.
14. Theft by Deception O.C.G.A. § 16-8-3.
    1. Georgia also imposes the threat of criminal liability to every person who obtains property by any deceitful means or artful practice with the intention of depriving the owner of the property.
    2. A person deceives intentionally if that person (a) creates or confirms another’s impression of an existing fact or past event which is false and which the accused knows or believes to be false; (b) fails to correct a false impression of an existing fact or past event which he has previously created or confirmed; or (c) prevents another from acquiring information pertinent to the disposition of the property involved.

**Acknowledgement of Training and Receipt**

**of Deficit Reduction Act of 2005 Policy and Procedure**

I hereby acknowledge by my signature that I have received and read the Deficit Reduction Act of 2005 Policy and Procedure, agree to comply with it, and understand that:

* This Facility is committed to providing quality care for its residents and submitting reimbursement claims for healthcare services that have been properly provided and that are supported by complete documentation.
* This Facility has a Compliance and Ethics Program that provides support to each employee while providing quality care and adhering to all applicable laws and regulations. I have received a copy of this Facility’s Compliance and Ethics Program Manual and I am aware that additional copies are available through the Facility’s Administrator or Compliance and Ethics Officer.
* If I have any concerns that may involve a violation of a law or regulation, even if I am unsure if the issue is a violation of any law or regulation, I am encouraged and expected to report such concern without delay.
* Concerns related to this policy may be reported to my manager, the Administrator, or the Compliance and Ethics Officer. Calls may also be made anonymously to the Compliance and Ethics Hotline at **(800) 610-2544**.
* I understand that this Facility will not intimidate me from reporting, nor will I face any retaliation, provided my report was made in good faith.
* This Facility is committed to complying with the Deficit Reduction Act of 2005 as outlined in this Policy and Procedure.
* Vendors and Contractors only: I agree to abide by the standards contained in this Policy and Procedure, and also agree to participate in this Facility’s mandatory Compliance and Ethics training as applicable. I agree to disseminate this Facility’s policies to my managers and employees.

Choose one:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❍ Employee

Name of individual (Please print) ❍ Health Care Provider

❍ Vendor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❍ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of company (Please print)

**{Facility}**

**Fraud, Waste, and Abuse in Federal Health Care Programs**

**Policy And Procedure**

**PURPOSE**

To enable {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”), to understand the requirements of the applicable federal and state fraud, waste, and abuse laws, and to comply with certain requirements set forth in the Deficit Reduction Act of 2005 (DRA) with regard to federal false claims laws.

**POLICY**

Section 6032 of the DRA requires entities such as the Facility that receive

Medicaid funds in excess of $5 million annually to establish written policies providing detailed information about fraud, waste, and abuse in Federal health care programs. These policies must be disseminated to all Associates. Additionally, Associates must adopt these policies and procedures in performing work for the Facility.

1. Fraud, waste, and abuse mean the following:
   1. Fraud *-* an intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to himself, herself, or to some other person.
   2. Waste *-* means an over-utilization of services or misuse of resources not caused by criminally negligent actions that nevertheless result in the expenditure of resources in excess of program needs and unnecessary costs.
   3. Abuse *–* practices inconsistent with sound fiscal, business, or medical practices that result in unnecessary cost, the reimbursement for services medically unnecessary, or that fail to meet professionally recognized standards for health care.
2. Fraud, waste, and abuse also includes any act defined as constituting fraud, waste, or abuse under any applicable Federal or State law.
3. Types of behaviors that state and federal government investigators will target during a fraud investigation include illegal payments or remuneration in exchange for the referral of federal health care program business, filing claims with the government for items or services not rendered, filing claims with the government that misrepresent the nature or quality of the goods or services provided.
4. Sanctions for fraud and abuse in federal and state health care programs include both civil and criminal penalties. The Department of Justice and U.S. Attorney’s Office may impose criminal sanctions for health care fraud and abuse. Administrative agencies may impose civil money penalties, may exclude violators from participation in Medicare and Medicaid, and may impose other civil penalties on individuals or entities committing health care fraud and abuse. Both the government and private persons are permitted to bring claims for health care fraud and abuse under the False Claims Act.

**PROCEDURE**

1. The Facility shall disseminate information to its Associates regarding:
   1. the Facility’s policies and procedures for detecting and preventing fraud, waste, and abuse, and related whistleblower protections pertaining to the laws discussed in this policy.
   2. Federal laws and administrative remedies; state laws related to false claims and statements, and whistleblower protections under such laws; and the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs.
2. The Facility employs the following measures in order to prevent fraud, waste, and abuse:
   1. Compliance and Ethics Program: The Facility has a Compliance and Ethics Program, the following aspects of which pertain to the prevention and detection of false claims and statements and impermissible financial transactions that result in health care fraud and abuse and that describe applicable disciplinary action for negligent and intentional violations of federal, state, or local laws and for failure to report conduct that violates such laws:
      1. Code of Conduct,
      2. Corporate Compliance and Ethics Plan,
      3. Conflict of Interest Policy
3. Education
   1. The Facility provides training to Associates including, but not limited to, billing and coding Compliance and Ethics, education, and mandatory quarterly Compliance and Ethics education to all Associates presented by Facility staff and the Facility’s Compliance and Ethics consultants and/or Compliance and Ethics attorneys.
   2. Reporting Concerns Regarding Fraud, Waste, and Abuse and False Claims
      1. The Facility takes seriously issues regarding the filing of false claims and engaging in activities involving fraud and abuse and requires all of its Associates to be aware of the laws regarding fraud and abuse and false claims and to identify and resolve any issues immediately. Associates must report fraud and abuse concerns to their immediate supervisor or the Compliance and Ethics Officer when appropriate. All Associates receiving any such reports are required to report such issues to the appropriate Compliance and Ethics personnel such as the Compliance and Ethics Officer or his/her designee(s). 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 Facility’s confidential Compliance and Ethics Hotline.
   3. Legal Review of Contracts
      1. Business transactions with external parties shall be reviewed by the appropriate legal counsel to ensure Compliance with all federal and state fraud, waste, and abuse laws.
4. Detection Measures
   1. Internal Reviews
      1. The Compliance and Ethics Officer shall perform periodic reviews of medical record documentation to ensure Compliance with the billing requirements of federal health care programs. In addition, the Compliance and Ethics Officer shall perform periodic internal audits designed to detect fraud, waste, and abuse. Many of these audits shall focus on high-risk areas such as those identified in the U.S. Office of Inspector General’s Annual Work Plan, and other areas of special concern identified through applicable regulatory investigative and audit functions.
   2. Investigations
      1. The Compliance and Ethics Officer in collaboration with the Facility’s Compliance and Ethics attorneys and Compliance and Ethics consultants shall perform investigations based upon reports of possible fraud, waste, or abuse associated with federal or state health care programs. When appropriate, the Facility shall involve outside entities to assist in an investigation.
5. Whistleblower Protections: The Facility prohibits retaliation against anyone who reports a concern made in good faith (meaning the individual has reason to believe there is a factual basis for the concern). All reported concerns and claims of retaliation will be investigated and any individual whom the Facility believes has engaged in acts of retaliation will be subject to appropriate disciplinary action.

**ACKNOWLEDGEMENT OF Receipt Of AND training in PREVERNTION OF FRAUD, WASTE, AND ABUSE PolicIES and ProcedureS**

I hereby acknowledge that the Facility has provided me with copy of the Facility’s Fraud, Waste, and Abuse (“FWA”) Policies and Procedures that I have reviewed. I further acknowledge that the Facility has provided me with FWA training in the form of the CMS provided FWA training. I am aware that I must report any Compliance and Ethics concerns to either my manager, the Administrator, the Compliance and Ethics Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or as a last resort by calling our Compliance and Ethics Hotline at (800) 610-2544. I hereby agree to abide by the requirements of the FWA Policies and Procedures.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

***\* Training must be completed within 30 days of initial hiring and annually thereafter.***

**{Facility}**

**Prohibition on Self-Referrals, Kickbacks, and Inducements to Refer Policy and Procedure**

**PURPOSE**

To enable {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) to understand the basic prohibitions of the federal and state Anti-Kickback Statutes (a summary of the federal Anti-Kickback Statute is attached hereto as Attachment A) and the federal and state Physician Self-Referral Laws (a summary of the federal Physician Self-Referral Law is attached hereto as Attachment B) (“fraud, waste, and abuse laws”) and to ensure Compliance with the requirements set forth in these laws.

**POLICY**

1. The Facility will not enter into an arrangement, nor offer, accept or provide anything of value from/to a source of referrals, or an entity to which the Facility patients are referred, unless such arrangement is in Compliance with all applicable federal and state laws, regulations, and the Facility’s legal Compliance and Ethics policies and standards. The Facility also requires that Associates be educated regarding the federal and state fraud, waste, and abuse laws and their roles in preventing improper referral arrangements.
2. The inducement of referrals to either the Facility or the other party to the arrangement shall **never** be a purpose of a referral source arrangement.
3. For purposes of this policy, the following definitions apply:
   1. “Immediate family member” includes spouse; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother or stepsister; father-in law, mother-in-law, son-in-law, daughter-in-law, brother- in-law, or sister-in-law; grandparent or grandchild; and the spouse of a grandparent or grandchild.
   2. “Financial relationship” or “arrangement” means any solicitation, offer, acceptance, receipt, or exchange of anything of value or any benefit, whether money or in-kind, between the Facility and a party in a position to refer business to the Facility or to which the Facility residents may be referred.
   3. “Physician” means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.
   4. “Referral Source” means (a) a physician; (b) a physician’s immediate family member; (c) any entity that is controlled by a physician or a physician’s Immediate Family Member; or (d) any non-physician who may be capable of making referrals to the Facility.

The Facility shall provide its Associates access to this policy, and shall revise this policy as necessary to comply with changes in the fraud, waste, and abuse laws and shall document and implement any changes.

**PROCEDURE**

1. The Facility and its Associates shall structure financial relationships with referral sources in a manner that complies with applicable fraud, waste, and abuse laws.
2. General Prohibition on Non-Compliant Referral Source Financial Arrangements
   1. No Associate shall enter into an arrangement with a physician that refers or has the potential to refer residents to the Facility, unless such arrangement meets an exception to the referral and billing prohibition of the Stark Law as well as any state law exception;
   2. No Associate shall enter into a relationship with any other person in a position to refer residents to the Facility, or to which the Facility resident may be referred, unless the arrangement undergoes legal review and approval and either;
      1. The relationship fits within a regulatory safe harbor of the Federal Anti-kickback statute, or a relevant state law exception;
      2. The arrangement fulfills a legitimate business or clinical need and no purpose of the arrangement is for the inducement of referral of healthcare business.
   3. All arrangements are subject to review and approval under the Facility’s Contract Review and Approval Policy and Procedure.
   4. Approval for an arrangement will be withheld if there exist any documents, or it appears that there have been any discussions, indicating intent to obtain or reward referrals by way of the arrangement.
   5. The Compliance and Ethics Officer, in conjunction with legal counsel is available to assist in the structuring and preparation of documentation reflecting arrangements with referral sources.
3. Prior to entering into a relationship with any individual in a position to refer residents to the Facility, or to which the Facility resident may be referred to, the proposed relationship shall undergo a comprehensive legal review. Proposed relationships will not be approved unless:
   1. The relationship fits within a regulatory safe harbor of the federal Anti-kickback statute, or
   2. The arrangement fulfills a legitimate business or clinical need and no purpose of the arrangement is for the inducement of referral of healthcare business.
   3. All arrangements shall be subject to legal review and approval under the applicable the Facility policies and procedures prior to its execution. The Compliance and Ethics Officer, in conjunction with legal counsel is available to assist in the structuring and preparation of documentation reflecting arrangements with referral sources.
   4. Arrangements with referral sources, generally, should:
      1. Be in writing and signed by the parties before any remuneration can be paid
      2. Specify the services covered
      3. Specify the timeframe for the arrangement
      4. Specify the remuneration (i.e., salary, other compensation, rental rate, purchase price, etc.)
      5. Set the consideration in advance
      6. Be consistent with fair market value for services or items actually provided without taking into account the value or volume of referrals or other business generated by the other party; and
      7. Be “commercially reasonable”, i.e., intended to obtain or provide an item or service that is reasonable and necessary for a legitimate business purpose, without regard to referrals generated between the parties
      8. Additional legal requirements may apply to certain cases depending on the nature of the relationship. The Compliance and Ethics Officer shall examine and assess each case on a case-by-case basis.
4. Reporting concerns regarding suspected fraud, waste, and abuse laws violations:
   1. The Facility takes any matters regarding improper referrals, illegal remuneration, and other activities prohibited by the applicable fraud, waste, and abuse laws seriously and encourages all Associates to be cognizant and aware of the laws regarding improper referrals and illegal remuneration, and to identify and report any issues immediately. All Associates are urged to use caution when engaging in transactions that involve referral sources.
   2. If an Associate believes that an illegal or questionable arrangement has been or may be entered into involving the Facility and a referral source or vendor of goods and services, he or she must report concerns to his or her immediate supervisor or the Compliance and Ethics Officer. 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 and Ethics Hotline.
   3. Associates should be aware of the Facility’s Code of Conduct and elements of the Compliance and Ethics Program that directly relate to the Facility’s detection and prevention of improper referrals and illegal remuneration, and that describe applicable disciplinary action for negligent and intentional violations of federal, state, or local laws and for failure to report conduct that violates such laws. A copy of the Code of Conduct is available from any supervisor as well as from the Compliance and Ethics Officer.
   4. Any arrangement found to be non-compliant shall be immediately terminated or amended to be compliant, and any pending payments suspended until the relevant supervisors as well as legal counsel have approved the plan of correction.

**ATTACHMENT A**

**SUMMARY OF THE ANTI-KICKBACK STATUTE**

Generally, under the Anti-Kickback Statute, persons or entities that knowingly and willfully solicit or receive bribes, kickbacks, or other remuneration in order to induce referrals of business that may be paid under a federal health care program will be subject to significant fines and/or imprisonment. In addition, violations of the Anti-Kickback Statute can result in exclusion from participation in the federal health care programs and civil False Claims Act liability.

A person need not have actual knowledge of the Anti-Kickback Statute prohibitions or specific intent to commit a violation of the Anti-Kickback

Statute. A “federal health care program” means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, that is funded directly, in whole or in part, by the federal government, or any state health care program.

Prohibited conduct includes not only remuneration intended to induce referrals, but also remuneration intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by a federal health care program. The types of remuneration prohibited under the statute include, but are not limited to, kickbacks, bribes, and rebates, and remuneration may be made directly or indirectly, overtly or covertly, in cash or in kind.

Each offense under the Anti-Kickback Statute is punishable by a fine of up to $25,000 and imprisonment for up to five years. Violators may also be excluded from federal health care programs, even in the absence of a criminal conviction. In addition, a violation of the Anti-Kickback Statute.

1. STATUTORY EXCEPTIONS

Congress has recognized a number of exceptions to the Anti-Kickback

Statute, including, but not limited to, the following:

* 1. Discounts that are properly disclosed and reflected in the costs claimed or charges made by the provider;
  2. Payments made by an employer to an employee for a bona fide employment in the provision of covered items and services;
  3. Group purchasing vendor agreements in which there is a written contract specifying the amounts paid to the purchasing agent, compensation is set at a fixed amount or percentage, and the purchasing agent discloses to the provider the amount received from vendors with respect to purchases made on behalf of the provider;
  4. Waivers of coinsurance amounts in connection with certain federally qualified healthcare centers; and
  5. Activities protected by safe harbor regulations.

In determining whether any of the safe harbors apply, the individual or company must seek out competent legal counsel.

1. REGULATORY SAFE HARBORS

Safe harbor regulations exempt certain payment practices from the provisions of the Anti-Kickback Statute. An arrangement must meet all of the elements of a safe harbor in order to be protected from prosecution. Applicable safe harbors may include, but are not limited to, the following types of arrangements, upon meeting certain conditions.

* 1. Space and Equipment Rental Safe Harbors: This safe harbor requires a signed, written agreement between the lessee and the lessor for a term of at least one year that specifies the aggregate payment amounts well as all of the premises and/or equipment covered. Payments must be based on fair market value and may not vary with the volume or value of referrals between the parties. The space or equipment rented must not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.
  2. Personal Services and Management Contracts Safe Harbors: Payments from a principal to an agent as compensation for services are protected by this safe harbor.
  3. Payments to Referral Services Safe Harbor: Exchanges of value between individuals or entities and referral services are protected under this safe harbor. Referral services may qualify participants according to their own criteria, but they must include all participants who meet that criteria and the criteria must be applied equally to all participants.
  4. Warranties Safe Harbors: Payments or exchanges of value under certain manufacturer or supplier warranties are protected under this safe harbor as long as both the buyer (such as a health care provider or beneficiary) and manufacturer/supplier comply with specified reporting standards to disclose price reductions or free items obtained as part of the warranties.
  5. Discounts Safe Harbor: This safe harbor is closely related to statutory exception (1) described above. Discounts on items or services payable by federal health care programs are protected under this safe harbor. There are different standards for buyers, sellers, and offerors of discounts who are not sellers.
  6. Employer/Employee Bona Fide Employment Relationships Safe Harbor: Amounts paid by employers to employees who have a bona fide employment relationship with the employer, for employment in the furnishing of any item or service payable in whole or in part by a federal health care program are protected by this safe harbor. Independent contractor arrangements are not considered employer/employee relationships, and must qualify under the personal services and management contracts safe harbor described in subsection (3) above in order to comply with the Anti-Kickback Statute.
  7. Coinsurance and Deductible Waiver Safe Harbor: This safe harbor applies to waivers of coinsurance and deductible amounts for inpatient services provided by DHS entities paid under the Prospective Payment System.

**ATTACHMENT B**

Summary of the Physician Self-Referral Law (Stark Law): Under Stark, a physician may not refer a patient to an entity for Designated Health Services (“DHS”) payable by Medicare if the physician or one of his or her immediate family members has a financial relationship with that entity unless the financial relationship meets a Stark statutory or regulatory exception. DHS include the following:

* 1. Clinical laboratory services;
  2. Physical therapy services;
  3. Occupational therapy services;
  4. Radiology or other diagnostic services, including MRI, CT scans, ultrasound services, and nuclear medicine;
  5. Radiation therapy services and supplies;
  6. Durable medical equipment and supplies;
  7. Parenteral and enteral nutrients, equipment and supplies;
  8. Prosthetics, orthotics, and prosthetic devices and supplies;
  9. Home health services;
  10. Outpatient prescription drugs;
  11. Inpatient and outpatient hospital services; and
  12. Outpatient speech-language pathology services.

“Financial relationship” means that a physician or physician’s immediate family member has an ownership or investment interest in an entity, or that there is a compensation arrangement between the physician or immediate family member and an entity.

A “referral” includes any request by a physician for an item or service payable under Medicare Part B, including a request by a physician for a consultation with another physician and any test or procedure ordered by, or to be performed by or under the supervision of, that other physician. A “referral” also includes a request or establishment of a plan of care by a physician that includes the provisions of DHS. A referring physician’s personally performed services are excluded from the definition of a “referral.”

Stark is violated when DHS are actually billed, rather than when the referral itself is made. Payment will be denied for the DHS in question and amounts paid for DHS performed in violation of Stark as well as any beneficiary payments must be refunded. A fine of up to $15,000 will be imposed for each service provided by anyone who knew or should have known that the referral of and billing for the service violated Stark. Additionally, any physician or entity that enters into an arrangement whose primary purpose is to induce referrals in violation of Stark is subject to fines up to $100,000 for each arrangement. Such physician or entity may also be fined up to three times the amount of the improperly billed DHS and excluded from participation in federal health care programs.

Under certain circumstances, entities that provide DHS must report their ownership, investment and compensation arrangements information to the

Secretary of Health and Human Services. Anyone who fails to meet the reporting requirements will be subject to a fine of up to $10,000 for each day for which reporting should have been made.

Stark provides for certain exceptions to this rule, and referrals otherwise prohibited under the statute are protected only if one of the exceptions applies. Applicable exceptions include, but are not limited to, the following types of arrangements under various conditions. In determining whether any of the exceptions to Stark apply, the individual or company must seek out competent legal counsel.

1. Rental of Office Space and Equipment – Payments made by a lessee to a lessor for the use of space or equipment are not considered “compensation” under certain conditions.

B. Bona Fide Employment Relationships – Any amount paid by an employer to a physician or immediate family member of a physician who has a ‘bona fide” employment relationship with the employer for the provision of identifiable services is not considered

“compensation” under certain conditions.

1. Personal Services Arrangement – Remuneration from an entity to a physician or to a group practice is not considered a financial relationship under the Personal Services or Management Arrangements exception which are subject to certain conditions.
2. Non-Monetary Compensation up to $300 – An entity may provide non-monetary compensation in the form of items or services, not including cash or cash equivalents, that does not exceed $300 per year as long as the compensation is not based on the volume or value of referrals or other business generated by the referring physician, the physician or physician group did not solicit the compensation, and the arrangement does not violate the Anti-Kickback Statute.
3. Fair Market Value Exception – Compensation paid by a referring physician to a DHS entity and vice versa is protected by the Fair Market Value Exception under certain conditions if no other Stark exception applies. This exception does not apply to office space rental arrangements.
4. Indirect Compensation Arrangements – Remuneration provided by a DHS entity to a physician will not create a financial relationship if the remuneration does not relate, directly or indirectly, to the furnishing of DHS.
5. Professional Courtesy – DHS entities may offer professional courtesy discounts with free or discounted healthcare items.

Temporary Lapses in Compliance– When a financial relationship falls out of Compliance with a Stark exception through events outside the entity’s control or the entity is unable to comply for a temporary period of time, a grace period may apply.

**{Facility}**

**Business Courtesies to Potential Referral Sources**

**Policy and Procedure**

**PURPOSE**

To set forth the parameters of {Facility}’s (the “Facility) standards for ethical business practices with regard to the Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) accepting and giving gifts, gratuities, and business courtesies.

Federal and state laws and regulations (e.g. Anti-Kickback laws, Stark, and civil monetary penalty statutes and regulations and state equivalents) prohibit the acceptance of any item of value (remuneration) made directly or indirectly, in cash or in kind, that may induce or appear to induce the purchase, recommendation to purchase or referral of any kind of healthcare goods, services, or items reimbursed by a federal or state healthcare program such as Medicare and Medicaid. Consequently, the acceptance of any gifts or business courtesies from any third parties with whom the Facility conducts business or who are seeking to do business with the Facility may implicate federal and state prohibitions.

**POLICY**

The Facility and any Associates shall comply with applicable laws, rules, regulations, and other directives of federal, state, and local governments, departments, and agencies governing professional business courtesies. The Facility requires that all Associates be educated in order to lawfully and appropriately receive or extend business courtesies from or to any potential business referral sources, their immediate family members, and office staff.

Associates may not solicit or accept personal gifts, business courtesies, or services from residents, visitors, vendors, or business associates as doing so may be an actual or perceived conflict of interest. Unsolicited gifts of nominal value, as described within this policy, may be permissible under certain circumstances. Gifts that are intended to influence or may be reasonably perceived by anyone as having the potential to influence an Associate in the scope of his or her duties or responsibilities are prohibited regardless of whether the gift is from present or potential interested parties.

Any questions as to whether a particular collaboration, interaction, relationship, gift, or social occasion would be appropriate in a specific circumstance should be directed to the Compliance and Ethics Officer.

**PROCEDURE**

1. Associates may not accept gifts or benefits of anything more than nominal value from either vendors or residents because such gifts or benefits may be viewed to influence or potentially influence Associates in the conduct of their duties or responsibilities. Gifts or benefits that are impermissible to Associates are also impermissible when given to family members or guests of Associates.
2. Generally, a payment, gift, or benefit is considered improper if it is:
   1. made to a person in a position to generate business for the paying party;
   2. is related to the volume of business generated;
   3. is more than nominal in value and/or exceeds the fair market value of any legitimate service rendered to the payer, or is unrelated to any service at all other than referrals;
3. Gifts include, but are not limited to:
   1. cash of any amount,
   2. gift certificates,
   3. loans,
   4. entertainment tickets or entertainment related items,
   5. stocks or other securities, or participation in stock offerings,
   6. raffle prizes, and
   7. use of a vendor’s vehicles or vacation facilities.
4. Examples of prohibited conduct includes, but is not limited to, Associates:
   1. Soliciting, receiving, or accepting from any person or entity, or offering or giving to any person or entity, anything of material value of that person or entity that is in a position to refer business to the Facility, or if the Facility is in a position to refer business to that person or entity, except as permitted by law;
   2. Accepting any hospitality or entertainment in any amount from or on behalf of a resident of the Facility;
   3. Accepting from any other person any gift of cash or cash equivalents of more than $50.00 individually or in the aggregate per year from that person or entity, or any hospitality or entertainment that because of its source or value might influence the Associate’s independent judgment in transactions involving the Facility.
   4. Providing any gifts or gratuities to any government or public agency representatives except as permitted by law;
   5. Making payments for a physician’s travel to or to participation in conferences unless the subject matter of the conference is of direct benefit to the Facility. 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 specially allowed as part of a permissible physician agreement;
   6. Getting their travel expenses reimbursed by outside organizations when:
      1. The reimbursement extends to a spouse or family member;
      2. The Associate is not presenting at the meeting or conference;
      3. The primary focus for the travel is social with minimal or no business activity (e.g., golf or other recreation); or
      4. The event location appears extravagant, including but not limited to being held outside of the United States; and
      5. Paying or receiving 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.
5. Reporting
   1. The Facility takes seriously issues regarding inappropriate relationships with business referral sources, and encourages all of its Associates to be aware of the laws, rules, and regulations regarding business courtesies and the Facility’s policies regarding the provision of gifts, entertainment, and business courtesies to business referral sources. The Facility requires its Associates to identify and report any issues immediately. Associates must report concerns to their immediate supervisor, the Compliance and Ethics Officer, or to report the concern through the confidential Compliance and Ethics Hotline.
6. The Facility shall provide all Associates access to this policy.
7. The Facility shall revise this policy as necessary to comply with changes in the law and shall document and implement any changes.
8. Associates should be aware of the Facility’s Code of Conduct, which also addresses the Facility’s policy for appropriately offering and receiving gifts, entertainment, and business courtesies.

A copy of the Code of Conduct is available from any supervisor as well as from the Compliance and Ethics Officer.

**{Facility}**

**Charitable Contributions Policy and Procedure**

**PURPOSE**

To enable {Facility} (the “Facility) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for {Facility} (“Associates”), to comply with applicable laws, rules, regulations and other directives of federal, state and local governments, departments and agencies governing charitable contributions, and to ensure that all Associates do not offer or give anything of value in exchange for referral of any item or service furnished under federal or state health care programs.

**POLICY**

The Facility requires that Associates be educated regarding the laws and regulations governing the support of charitable and cultural institutions that improve the quality of life in the community, and regarding their roles in ensuring that charitable contributions are appropriately extended to and received from charitable and cultural institutions.

**PROCEDURE**

1. The Facility shall implement the following processes and requirements:
   1. The Facility and all Associates shall comply with all laws, rules, and regulations regarding charitable contributions.
   2. The Facility and all Associates may at any time choose not to offer charitable contributions to charitable and cultural institutions that improve the quality of life in the community.
   3. Charitable contributions must generally be made to a public charity, recognized as tax exempt by the Internal Revenue Service (“IRS”) as an organization described in Internal Revenue Code (“IRC”) §501(c)(3). The Facility will not make charitable contributions to private foundations, or any other type of organization not described in IRC §501(c)(3), unless the contribution is reviewed by the Compliance and Ethics Officer in consultation with the Facility’s legal counsel.
   4. No contributions to the Facility customers or potential customers may be promised without the express consent of the Compliance and Ethics Officer.
   5. Contributions must be an unrestricted gift, or if restricted, the restriction may not be in any way tied to the provision of any services offered or provided by the Facility. Gifts may be for the general operation, administration, or capital needs of the charity.
   6. Requests for charitable gifts from health care organizations will be considered as part of the Facility’s overall pattern and plan of giving to community organizations.
   7. The size of the gift cannot be dependent upon the volume of business with or the number of referrals by the charity.
   8. 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 patient 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.
   9. The fundraising solicitation by the charity should be one that is being made broadly to the general public and not just to vendors and business associates.
   10. Any incidental benefits offered in exchange for the donation, such as attendance at a fundraising event, may be used by the Facility personnel. Such benefits may NOT be given away to others to generate business or referrals.
2. Reporting
   1. The Facility takes seriously issues regarding charitable contributions, and encourages all of its Associates to be aware of the laws, rules, and regulations regarding charitable contributions and the Facility’s policies regarding the charitable contributions. The Facility requires its Associates to identify and report any issues immediately. Associates must report concerns to their immediate supervisor, the Compliance and Ethics Officer, or to report the concern through the confidential Compliance and Ethics Hotline.
3. The Facility shall provide all Associates access to this policy.
4. The Facility shall revise this policy as necessary to comply with changes in the law and shall document and implement any changes.

Associates should be aware of the Facility’s Code of Conduct, the Facility’s Business Courtesies to Potential Referral Sources Policy and Procedure, and the Facility’s Prohibition on Self-Referrals, Kickbacks, and Inducements to Refer Policy and Procedure, which are related to the Facility’s policy for charitable contributions.

**{Facility}**

**Billing Policy and Procedure**

**PURPOSE**

To ensure the prompt, complete, and accurate billing of all services provided to residents for payment by residents, government agencies, or other third-party payors.

**POLICY**

{Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) are committed to prompt, complete, and accurate billing of all services provided to residents for payment by residents, government agencies, or other third-party payors. Billing shall be made only for services actually provided, directly or under contract, pursuant to all terms and conditions specified by the government or third-party payor and consistent with industry practice.

The Facility and any Associates shall not make or submit any false or misleading entries on any bills or claim forms, and no Associate shall engage in any arrangement, or participate in such an arrangement at the direction of another Associate (including any officer of the Facility or a supervisor), that results in such prohibited acts. Any false statement on any bill or claim form shall subject the Associate to disciplinary action by the Facility, including possible termination of employment.

**PROCEDURE**

1. The Facility and its Associates shall ensure the submission of accurate and properly documented claims on a timely basis.
   1. “Timely basis” means that all practitioners must provide proper and timely orders and documentation before billing is performed to ensure that only accurate and properly documented services are billed.
2. Prohibited Billing Practices
   1. 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.
   2. The Facility and Associates shall specifically refrain from engaging in the following billing practices:
      1. Making 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. There should be adequate information to indicate that supplies or services were provided before any claim for reimbursement is submitted. Documentation must be maintained and available for audit and review during the appropriate retention period. Information necessary for submitting such claims includes:
         1. the date and time the supply or service was provided,
         2. a description of the supply or service,
         3. the person for whom the supply or service was provided,
         4. the ordering practitioner’s information documentation must be legible Submitting 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. Submitting 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. Submitting 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. The Facility and its Associates shall take special care to ensure the use of correct and accurate billing codes.
   5. Submitting claims to any payor, including Medicare and Medicaid, for individual items or services when such items or services either are included in the Facility’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 billing (billing for the same time or service more than once);
   7. Unbundling;
   8. Upcoding;
   9. Improperly waiving copayments or deductibles;
   10. Not refunding credit balances in a timely and appropriate manner;
   11. Providing inaccurate or misleading information for use in determining the Resource Utilization Groups, version III (RUG);
       1. The Facility shall ensure that residents are classified into the correct resource utilization group and requires accurate and comprehensive reporting about a resident’s conditions and needs. Inaccurate reporting of data could result in the misrepresentation of the resident’s status, the submission of false claims and potential enforcement actions.
   12. Providing inaccurate or misleading information for use in determining the Resource Utilization Groups, version III 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);
   13. Paying or receiving 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) (See the Facility’s Prohibition on Self-Referrals, Kickbacks, and Inducements to Refer Policy and Procedure for further explanation); or
   14. Billing residents for services or supplies that are included in the per-diem payment from Medicare, Medicaid, a managed care plan, or other payor.
3. Reporting False Billing Practices
4. If an Associate has any reason to believe that anyone (including the Associate himself or herself) is engaging in false billing practices, that Associate shall immediately report the practice to his or her immediate supervisor, the Compliance and Ethics officer, or any of the officers designated to receive such report verbally or in writing.
5. Failure to act when an Associate has knowledge that someone is engaged in false billing practices shall be considered a breach of that Associate’s responsibilities and shall subject the Associate to disciplinary action by the Facility, including possible termination of employment.
6. Associates should refer to the Facility’s Code of Conduct for more information.
7. The Facility shall provide its Associates access to this policy.
8. The Facility shall revise this policy as necessary to comply with changes in the law and shall document and implement any changes.

**{Facility}**

**Overpayment Self-Disclosure Policy and Procedure**

**PURPOSE**

To provide {Facility} (the “Facility”) and any appropriate individuals with a consistent process for self-disclosure and repayment of Medicare and Medicaid overpayments within 60 days of identification as is mandatory for Medicare and Medicaid providers under section 6402(a) of the Patient Protection and Affordable Care Act (PPACA) of 2010.

**POLICY**

Following an investigation and confirmation that a Medicare or Medicaid overpayment was made, the Facility shall identify, self-disclose, explain, and repay overpayments within 60 calendar days of identification of the overpayment regardless of the financial threshold of participation in the government program.

An overpayment is defined as any funds that the Facility receives or retains under Medicare or Medicaid to which the Facility, after appropriate reconciliation is not entitled. Examples of Medicare overpayments include instances where a provider is: (1) Paid twice for the same service either by Medicare or by Medicare and another insurer or beneficiary; or (2) paid for services planned but not performed or for non-covered services.

Failure to timely report and return any Medicare and Medicaid overpayment can have severe consequences, including potential liability under the False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicare and Medicaid programs.

**PROCEDURE**

1. Process for Identifying Overpayment
   1. Routine Monitoring
      1. The Facility shall conduct routine monitoring to ensure detect any possible overpayments.
      2. Overpayments founds during routine monitoring shall be considered identified overpayments as of the date the overpayment was verified.
2. Internal Audits and Investigations
   1. The Facility shall conduct periodic internal audits and investigations to detect possible overpayments.
3. Overpayments founds during routine monitoring shall be considered identified overpayments as of the date that a final report is issued.
4. Mandatory Self-Disclosure
   1. Pursuant to 42 U.S.C. §1320a-7k(d)(1), if the Facility receives an overpayment it shall:
      1. report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
      2. notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.
   2. The Facility shall report an overpayment when the following conditions are met:
      1. Overpayment is NOT included in another separate review or an audit being conducted by vendors, or OIG.
      2. Overpayment is NOT related to a broader state-initiated rate adjustment, cost settlement, or other broader payment adjustment mechanisms. (These include retroactive rate adjustments, charity care, cost reporting, etc.).
5. Examples of issues appropriate for self-disclosure reporting include, but are not limited to:
   1. Routine errors
      1. Overpayments resulting from incorrect reporting of third-party payments,
      2. e.g., balance billing
      3. Medicare coinsurance reporting with no reported Medicare paid amount
      4. Multiple overpayments resulting from billing lab services provided during a patient’s stay
      5. Overpayments resulting from billing incorrect ICD-9 assignment
      6. Errors in case-mix classifications
   2. Systemic errors
      1. Inability to reprocess adjustment(s) through systems
6. Self-Disclosure Process
7. Prior to contacting the OIG, the Facility shall fully investigate and determine the issue and prepare the disclosure including all the required information and documentation. Once an inappropriate payment is discovered, the Facility will determine whether the repayment warrants a self-disclosure or whether it would be better handled through administrative billing processes. The repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims or sending the OIG a letter containing the pertinent data and a check. Each incident will be considered on an individual basis.
8. Factors to consider include:
   1. identification of the exact issue
   2. the amount involved
   3. any patterns or trends that the problem may demonstrate within the Facility’s billing system
   4. the extent of the period affected
   5. the circumstances that led to the overpayment, and
   6. whether or not the Facility has an corporate integrity agreement (CIA) which requires self-disclosure.
9. The Facility shall conduct an internal investigation and report its findings to the OIG in its submission. If the Facility is unable to complete its internal investigation before sending its submission, then the Facility must certify in its submission that it will complete the internal investigation within 90 days of the date of its initial submission.
10. Submission Content
    1. For all disclosures, the narrative submission must include:
       1. The name, address, type of health care provider, provider identification number(s), and tax identification number(s) of the disclosing party and the Government payors (including Medicare contractors) to which the Facility submits claims or a statement that the Facility does not submit claims.
       2. If the Facility is an entity that is owned or controlled by or is otherwise part of a system or network, an organizational chart, a description or diagram describing the pertinent relationships; the names and addresses of any related entities; and any affected corporate divisions, departments, or branches.
       3. The name, street address, phone number, and email address of the Facility’s designated representative for purposes of the voluntary disclosure.
       4. A concise statement of all details relevant to the conduct disclosed, including, at minimum, the types of claims, transactions, or other conduct giving rise to the matter; the period during which the conduct occurred; and the names of entities and individuals believed to be implicated, including an explanation of their roles in the matter.
       5. A statement of the Federal criminal, civil, or administrative laws that are potentially violated by the disclosed conduct.
       6. The Federal health care programs affected by the disclosed conduct.
       7. An estimate of the damages to each Federal health care program relevant to the disclosed conduct, or a certification that the estimate will be completed and submitted to OIG within 90 days of the date of submission. When the Facility can determine the amount of actual damages to Federal health care programs, the actual damages amount must be provided instead of an estimate.
       8. A description of the Facility’s corrective action upon discovery of the conduct.
       9. A statement of whether the Facility has knowledge that the matter is under current inquiry by a Government agency or contractor. If the Facility has knowledge of a pending inquiry, it must identify any involved Government entity and its individual representatives. the Facility must also disclose whether it is under investigation or other inquiry for any other matters relating to a Federal health care program and provide similar information relating to those other matters.
       10. The name of an individual authorized to enter into a settlement agreement on behalf of the Facility.
       11. A certification by the Facility or its authorized representative stating that to the best of the individual’s knowledge, the submission contains truthful information and is based on a good faith effort to bring the matter to the Government’s attention for the purpose of resolving potential liability to the Government and to assist OIG in its resolution of the disclosed matter.
    2. For conduct involving false billing, the disclosure submission must include:
       1. Review Objective: A statement clearly articulating the objective of the review.
       2. Population: A description of the group of claims about which information is needed, an explanation of the methodology used to develop the population, and the basis for this determination.
       3. Sources of Data: A full description of the source of the data reviewed and the information upon which the review was based, including the sources of payment data, and the documents that were relied upon.
       4. Personnel Qualifications: The names and titles of the individuals who conducted the review. The review should be conducted by qualified individuals, e.g., statisticians, accountants, auditors, consultants, and medical reviewers, and the review report should describe their qualifications.
       5. Characteristics Measured: The review report should identify the characteristics used for testing each item. For example, in a review designed to estimate the value of overpayments due to duplicate payments, the characteristics used are those that must exist for an item to be a duplicate. The amount of the duplicate payment is the measurement of the overpayment. The report must also explain the method for determining whether an item entirely or partially meets the criterion for having the characteristics measured.
    3. For overpayments related to billing for excluded persons, the disclosure submission must include:
       1. The identity of the excluded individual and any provider identification number.
       2. The job duties performed by that individual.
       3. The dates of the individual’s employment or contractual relationship.
       4. A description of any background checks that the disclosing party completed before and/or during the individual’s employment or contract.
       5. A description of the disclosing party’s screening process (including any policy or procedure that was in place) and any flaw or breakdown in that process that led to the hiring or contracting with the excluded individual.
       6. A description of how the conduct was discovered.
       7. A description of any corrective action (including a copy of any revised policy or procedure) implemented to prevent future hiring of excluded individuals.
       8. In addition, before disclosing the employment of an excluded individual, the Facility shall screen all current employees and contractors against the relevant federal and state exclusion lists and databases. Once this has been done, the Facility shall disclose all excluded persons in one submission.
11. The Facility may choose to self-disclose using one of following methods:
    * 1. Voluntarily disclose self-discovered potential fraud to the OIG under the Self-Disclosure Protocol (SDP) at https://forms.oig.hhs.gov/selfdisclosure/Self-Disc-Form-protocol.aspx?AspxAutoDetectCookieSupport=1.
      2. Disclosures may also be submitted by mail to the Chief of the Administrative and Civil Remedies Branch, Office of Counsel to the Inspector General, Office of Inspector General, Department of Health and Human Services, 330 Independence Avenue, SW, Cohen Building, Room 5527, Washington, DC 20201.
      3. The Facility shall use these protocols carefully, and with legal counsel’s input, to consider the advantages and disadvantages of self-disclosure, as there are specific risks and responsibilities.
      4. The Facility can fill out an OIG “Contractor Self-Disclosure Form” (See Attachment 3).
    1. In the event that the Facility is unable to determine if the self-disclosure issue resulted in non-Compliance overpayments or has difficulty identifying the overpayments, OIG staff can possibly assist in the disposition of the issue. The Facility, or its designated agent, may request data for the sole purpose of quantifying and validating a potential overpayment (see Attachment 4- Data Request from Providers).
12. Access to Information
    1. The Facility shall promptly comply with OIG requests to provide documents and information materially related to the disclosure and to speak with relevant individuals. Discussions with the Facility’s Compliance and Ethics Officer, counsel, or other staff may be necessary to obtain information and agreement to complete the disclosure in a timely manner.
13. Access to Data
    1. All documentation and data shall be protected for confidentiality under the Health Insurance Portability and Accountability Act (HIPAA) by the Facility and any of its representatives (e.g. staff, lawyer, or contractor). Pursuant to the US Department of Health and Human Services’ HIPAA guidance, the Facility shall obtain satisfactory assurances from its business associates that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of the Facility.

B. These satisfactory assurances must be submitted in writing to the OIG whether in the form of a contract or other agreement between the Facility and the business associate.

1. Restitution
   1. Once a repayment amount has been established, assuming full repayment has not previously been made, the Facility shall reimburse the state for the overpayment. Should the Facility be interested in extended repayment terms due to hardship, the Facility will be required to submit audited financial statements and/or other documentation to assist the OIG in making that determination. Once the repayment has been finalized, then the OIG will issue a letter indicating closure of the matter.
2. Prevention
3. Following the detection and self-disclosure of an overpayment, the Facility and the Compliance and Ethics Officer shall take steps to prevent future occurrences of overpayment. The Facility and the Compliance and Ethics Officer will investigate all relevant facts and circumstances surrounding the overpayment, including, but not limited to:
   1. The reason for the overpayment
   2. The extent and scope of the billing error
   3. Compliance with applicable federal and state laws and regulations
4. The Facility will take the following actions, if applicable, as necessary:
   * 1. Staff education
     2. Disciplinary action
     3. Other corrective actions
     4. Future monitoring processes to prevent recurrence of the overpayment

**Updated OIG’s Provider Self-Disclosure Protocol**

**SUMMARY:** This notice, issued on April 17, 2013, updates the Provider Self- Disclosure Protocol.

**FOR FURTHER INFORMATION CONTACT:** Patrice S. Drew, Department of Health and Human Services, Office of Inspector General, Congressional and Regulatory Affairs, at (202) 619-1368.

**I. Background**

In 1998, the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) published the Provider Self-Disclosure Protocol (the SDP) at 63 Fed Reg. 58399 (October 30, 1998) to establish a process for health care providers to voluntarily identify, disclose, and resolve instances of potential fraud involving the Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act), 42 U.S.C. 1320a–7b(f)). The SDP provides guidance on how to investigate this conduct, quantify damages, and report the conduct to OIG to resolve the provider’s liability under OIG’s civil monetary penalty (CMP) authorities. Over the past 15 years, we have resolved over 800 disclosures, resulting in recoveries of more than $280 million to the Federal health care programs.

Since the original publication, we identified areas where additional guidance would be beneficial to the health care community and would improve the efficient resolution of SDP matters. To that end, we issued three Open Letters to Health Care Providers in

2006, 2008, and 2009. Since the last Open Letter, we continued to evaluate our SDP process. We also solicited comments about the SDP on June 18, 2012, and we received numerous helpful comments from the public. On the basis of our experience and the comments we received, we have decided to revise the SDP in its entirety at this time. This revised SDP supersedes and replaces the 1998 *Federal Register* Notice and the Open Letters, as described below.

**A. Why Disclosure Is Important**

For many years, OIG has emphasized the importance of dealing with the Federal health care programs with integrity. All members of the health care industry have a legal and ethical duty to do so. This duty includes an obligation to take measures to detect and prevent fraudulent and abusive activities, including implementing specific procedures and mechanisms to investigate and resolve instances of potential fraud involving the Federal health care programs. Whether as a result of voluntary self-assessment or in response to external forces, participants in the health care industry must be prepared

to investigate such instances, assess the potential losses suffered by the Federal health care programs, and make full disclosure to the appropriate authorities.

**B. Benefits of Disclosure**

We recognize that whether to disclose potential fraud to OIG is a significant decision. However, there are significant benefits to disclosing potential fraud to OIG that should make that decision easier.

First, we believe that good faith disclosure of potential fraud and cooperation with OIG’s review and resolution process are typically indications of a robust and effective compliance program. As a result, we have instituted a presumption against requiring integrity agreement obligations in exchange for a release of OIG’s permissive exclusion authorities in resolving an SDP matter. Since 2008, we have resolved 235 SDP cases through settlements. In all but one of these cases, we have released the disclosing parties from permissive exclusion without requiring any integrity measures.

Second, we believe that individuals or entities that use the SDP and cooperate with OIG during the SDP process deserve to pay a lower multiplier on single damages than would normally be required in resolving a Government-initiated investigation. The specific multiplier that we accept may vary depending on the facts of each case. OIG’s general practice in CMP settlements of SDP matters is to require a minimum multiplier of 1.5 times the single damages, although we determine in each individual case whether a higher multiplier may be warranted.

Third, we believe that using the SDP may mitigate potential exposure under section

1128J(d) of the Act, 42 U.S.C. 1320a-7k(d). Section 1128J(d)(2) of the Act requires that a Medicare or Medicaid overpayment be reported and returned by the later of (1) the date that is 60 days after the date on which the overpayment was identified or (2) the date any corresponding cost report is due, if applicable. Any overpayment retained by a “person,” as defined in section 1128J(d)(4)(C) of the Act after this deadline may create liability under the Civil Monetary Penalties Law (CMPL), section 1128A of the Act, and the False Claims Act (FCA), 31 U.S.C. 3729. In its Notice of Proposed Rulemaking,

77 Fed. Reg. 9179-9187 (February 16, 2012), the Centers for Medicare & Medicaid

Services (CMS) proposes to suspend the obligation to report overpayments under section 1128J(d) of the Act when OIG acknowledges receipt of a submission to the SDP so long as the submission is timely made. CMS also proposes to suspend the obligation to return overpayments until a settlement agreement is entered into, or the provider or supplier withdraws or is removed from the SDP. As necessary, we will provide additional guidance on OIG’s web site concerning section 1128J of the Act and the SDP after CMS issues its final rule.

Finally, we commit to working with individuals and entities that use the SDP in good faith and cooperate with OIG’s review and resolution process. OIG created the SDP to provide a specific and detailed process that can be relied upon by all participants in the

health care industry as one that OIG will consistently follow. As part of this commitment, we streamlined our internal process to reduce the average time a case is pending with OIG to less than 12 months from acceptance into the SDP. To further facilitate timely resolutions of SDP matters, we are changing the timeframe to submit the findings of the completed internal investigation and damages calculation from 90 days from acceptance into the SDP to 90 days from the date of the initial submission.

**II. Eligibility Criteria and Guidance**

This section explains the eligibility criteria for the SDP, including who may use the SDP

and what conduct is and is not eligible for acceptance into the SDP.

**A. Who May Use the SDP**

All health care providers, suppliers, or other individuals or entities who are subject to OIG’s CMP authorities found at 42 C.F.R. Part 1003 are eligible to use the SDP. The SDP is not limited to any particular industry, medical specialty, or type of service. For

example, a pharmaceutical or medical device manufacturer may use the SDP to disclose

potential violations of the Federal anti-kickback statute (AKS), section 1128B(b) of the Act, because such violations trigger CMP liability under section 1128A(a)(7) of the Act, a provision of the CMPL. For purposes of the SDP, we refer to all individuals or entities that make a submission to the SDP as “disclosing parties.” The disclosing party should disclose conduct for which it may be liable, including potential successor liability based on its purchase of another entity. For example, a disclosing party could have liabilities as the result of a merger or an acquisition. However, disclosing parties should not use the SDP to disclose conduct of another, unrelated party. OIG’s hotline should be used to report potential misconduct of other parties (1-800-OIG-TIPS or <https://oig.hhs.gov/fraud/report-fraud/index.asp>).

Disclosing parties already subject to a Government inquiry (including investigations, audits, or other oversight activities) are not automatically precluded from using the

SDP. The disclosure, however, must be made in good faith and must not be an attempt to circumvent any ongoing inquiry. Disclosing parties under Corporate Integrity Agreements (CIA) with OIG may also use the SDP in addition to making any reports required in the CIA.

**B. Conduct Eligible for the SDP**

The SDP is available to facilitate the resolution of matters that, in the disclosing party’s reasonable assessment, potentially violate Federal criminal, civil, or administrative laws for which CMPs are authorized. In making a disclosure, a disclosing party must acknowledge that the conduct is a potential violation. Disclosing parties must explicitly identify the laws that were potentially violated and should not refer broadly to, for example, “Federal laws, rules, and regulations” or “the Social Security Act.” OIG has

found that disclosing parties who avoid acknowledging that there is a potential violation are more likely to have unclear or incomplete submissions or unrealistic expectations about resolutions, which result in a lengthier review and resolution process. In

addition, statements such as “the Government may think there is a violation, but we

disagree” raise questions about whether the matter is appropriate for the SDP. The resulting back-and-forth over these issues can create unnecessary delays in reaching a resolution and may result in the disclosing party’s removal from the SDP.

**C. Conduct Ineligible for the SDP**

First, the SDP is not available for a matter that does not involve potential violations of Federal criminal, civil, or administrative law for which CMPs are authorized, such as one exclusively involving overpayments or errors. In this situation, the matter should be disclosed directly to the appropriate CMS or other responsible contractor under the payor’s voluntary refund process.

Second, the SDP is not available to request an opinion from OIG regarding whether an actual or potential violation has occurred. For example, a disclosure that broadly describes a business arrangement and requests a determination from OIG regarding whether the arrangement violates the AKS is not appropriate for the SDP. The Advisory Opinion process is the only vehicle to obtain an OIG opinion, as described at

<https://oig.hhs.gov/compliance/advisory-opinions/index.asp>.

Third, the SDP is not available for disclosure of an arrangement that involves only liability under the physician self-referral law, section 1877 of the Act (the Stark Law), without accompanying potential liability under the AKS for the same arrangement. Disclosing parties must analyze each arrangement involving a physician to determine whether it raises potential liability under the AKS, the Stark Law, or both laws. Stark- only conduct should be disclosed to CMS through its Self-Referral Disclosure Protocol (SRDP), which can be found at: <http://www.cms.gov/PhysicianSelfReferral/>. OIG reserves the right to determine whether an arrangement is appropriate for resolution in the SDP.

**D. Tolling the Statute of Limitations**

As described above, one of the benefits of disclosure is that CMS has proposed that the time for repayment of an identified overpayment under section 1128J(d) of the Act will be tolled for the disclosing party. To preserve the rights of the parties while the matter is being resolved through the SDP, OIG expects disclosing parties to disclose with a good faith willingness to resolve all liability within the CMPL’s six year statute of limitations as described in section 1128A(c)(1) of the Act. Accordingly, the disclosing party agrees, as a condition precedent to the OIG’s acceptance into the SDP, to waive and not to plead statute of limitations, laches, or any similar defenses to any

administrative action filed by OIG relating to the disclosed conduct, except to the extent

that such defenses would have been available to the disclosing party had an administrative action been filed on the date of submission.

**E. Corrective Action**

Prior to disclosure, the disclosing party should ensure that the conduct has ended or, at least, in the case of an improper kickback arrangement, that corrective action will be taken and the improper arrangement will be terminated within 90 days of submission to the SDP. Additionally, all other necessary corrective action should be complete and effective at the time of disclosure.

**III. Submission Content**

To be considered for admission into the SDP, the disclosing party must include the following information in its submission:

A. **Requirements for All Disclosures**

The disclosing party is expected to conduct an internal investigation and report its findings to OIG in its submission. If the disclosing party is unable to complete its internal investigation before sending its submission, the disclosing party must certify in its submission that it will complete the internal investigation within 90 days of the date of its initial submission.

Disclosures may be submitted through OIG’s Web site at <https://oig.hhs.gov/compliance/self-disclosure-info/index.asp>. Disclosures may also be submitted by mail to the Chief of the Administrative and Civil Remedies Branch, Office of Counsel to the Inspector General, Office of Inspector General, Department of Health and Human Services, 330 Independence Avenue, SW, Cohen Building, Room

5527, Washington, DC 20201. Submissions by facsimile or other means will not be

accepted. The narrative submission must include:

1. The name, address, type of health care provider, provider identification number(s), and tax identification number(s) of the disclosing party and the Government payors (including Medicare contractors) to which the disclosing party submits claims or a statement that the disclosing party does not submit claims.

2. If the disclosing party is an entity that is owned or controlled by or is otherwise part of a system or network, an organizational chart, a description or diagram describing the pertinent relationships; the names and addresses of any related entities; and any affected corporate divisions, departments, or branches.

3. The name, street address, phone number, and email address of the disclosing party’s designated representative for purposes of the voluntary disclosure.

4. A concise statement of all details relevant to the conduct disclosed, including, at minimum, the types of claims, transactions, or other conduct giving rise to the matter; the period during which the conduct occurred; and the names of entities and individuals believed to be implicated, including an explanation of their roles in the matter.

5. A statement of the Federal criminal, civil, or administrative laws that are potentially violated by the disclosed conduct.

6. The Federal health care programs affected by the disclosed conduct.

7. An estimate of the damages, as described in the applicable section below, to each Federal health care program relevant to the disclosed conduct, or a certification that the estimate will be completed and submitted to OIG within 90 days of the date of submission. When a disclosing party can determine the amount of actual damages to Federal health care

programs, the actual damages amount must be provided instead of an

estimate.

8. A description of the disclosing party’s corrective action upon discovery of

the conduct.

9. A statement of whether the disclosing party has knowledge that the matter is under current inquiry by a Government agency or contractor. If the disclosing party has knowledge of a pending inquiry, it must identify any involved Government entity and its individual representatives. The disclosing party must also disclose whether it is under investigation or other inquiry for any other matters relating to a Federal health care program and provide similar information relating to those other matters.

10. The name of an individual authorized to enter into a settlement agreement on behalf of the disclosing party.

11. A certification by the disclosing party, or, in the case of an entity, an authorized representative on behalf of the disclosing party, stating that to the best of the individual’s knowledge, the submission contains truthful information and is based on a good faith effort to bring the matter to the Government’s attention for the purpose of resolving potential liability to

the Government and to assist OIG in its resolution of the disclosed matter.

**B. Requirements for Conduct Involving False Billing**

When a disclosure involves the submission of improper claims to Federal health care programs, the disclosing party must conduct a review to estimate the improper amount paid by the Federal health care programs (referred to as “damages”) and prepare a report of its findings that follows the requirements in this section. OIG will verify a disclosing party’s calculation of damages.

The disclosing party’s estimation of damages must consist of a review of either: (1) all the claims affected by the disclosed matter or (2) a statistically valid random sample of the claims that can be projected to the population of claims affected by the matter. A disclosing party may not extend the time to resubmit claims to Federal health care programs through the SDP; therefore, the damages estimation must not include a reduction, or “netting” for any underpayments discovered in the review.

When using a sample to estimate damages, the disclosing party must use a sample of at least 100 items and use the mean point estimate to calculate damages. If a probe sample was used, those claims may be included in the 100-item sample if statistically appropriate. To avoid unreasonably large sample sizes, the SDP does not require a minimum precision level for the review of claims. As a result, the disclosing party may select an appropriate sample size to estimate damages as long as the sample size is at least 100 items. As a general rule, smaller sample sizes (closer to 100) will suffice where the population has a high level of homogeneity, and larger sample sizes will be necessary where the population contains a more diverse mixture of claim types. The disclosing party should keep in mind that a careful and complete definition of the population will assist in making accurate findings.

The disclosing party’s report must include, at a minimum, the following information:

1. Review Objective: A statement clearly articulating the objective of the review.

2. Population: A description of the group of claims about which information is needed, an explanation of the methodology used to develop the population, and the basis for this determination.

3. Sources of Data: A full description of the source of the data reviewed and the information upon which the review was based, including the sources of payment data, and the documents that were relied upon.

4. Personnel Qualifications: The names and titles of the individuals who conducted the review. The review should be conducted by qualified individuals, e.g., statisticians, accountants, auditors,

consultants, and medical reviewers, and the review report should describe their qualifications.

5. Characteristics Measured: The review report should identify the characteristics used for testing each item. For example, in a review designed to estimate the value of overpayments due to duplicate payments, the characteristics used are those that must exist for an item to be a duplicate. The amount of the duplicate payment is the measurement of the overpayment. The report must also explain

the method for determining whether an item entirely or partially meets the criterion for having the characteristics measured.

If the financial review was based upon a sample, the review report must also include the Sampling Plan that was followed. At a minimum, this includes:

1. Sampling Unit: Any of the designated elements that constitute the population of interest.

2. Sampling Frame: The totality of the sampling units from which the sample was selected and the way in which the audit population differs from the sampling frame (and the effect this difference has on conclusions reached as a result of the audit).

3. Sample Size: The size of the sample reviewed to reach the estimate of the damages. The sample size must be at least 100 claims.

4. Source of Random Numbers: The sample must be selected through random numbers. The source of the random numbers used must be shown in the report. We strongly recommend the use of OIG’s Statistical Sampling Software, also known as ‘‘RAT-STATS,’’ which is currently available free of charge at [https://oig.hhs.gov/compliance/rat-](https://oig.hhs.gov/compliance/rat-stats/index.asp)

[stats/index.asp](https://oig.hhs.gov/compliance/rat-stats/index.asp).

5. Method of Selecting Sampling Units: The method for selecting the sample units.

6. Sample Design: Unless the disclosing party demonstrates the need to use a different sample design, the review should use simple random sampling. If necessary, the disclosing party may use stratified or multistage sampling. Details about the strata, stages, and clusters should be

included in the review report.

7. Missing Sample Items and Other Evidence: If the review was based on a sample, missing sample items should be treated as errors, pursuant to Federal health care program rules requiring the retention of supporting information for submitted claims. Missing sample items should be noted

in the report. The report must also describe any evidence, other than the sample results, that was considered in arriving at the review results.

8. Estimation Methodology: If the review was based on a sample, because the general purpose of the review is to estimate the monetary losses to the Federal health care programs, the methodology to be used must be variables sampling (treating each individual item in the population as a

sampling unit) using the difference estimator (estimates of the total errors

in the population are made from the sample differences by multiplying the average audited difference by the number of units in the population).

**C. Requirements for Conduct Involving Excluded Persons**

Many SDP submissions disclose the employment of, or contracting with, individuals who appear on OIG’s List of Excluded Individuals and Entities (LEIE) (available online at [https://exclusions.oig.hhs.gov](https://exclusions.oig.hhs.gov/) ). We are providing additional guidance here to help disclosing parties gather the necessary information for a complete disclosure.

Specific Information

In addition to providing the general information required by section III.A, the disclosure must provide the following information:

1. The identity of the excluded individual and any provider identification number.

2. The job duties performed by that individual.

3. The dates of the individual’s employment or contractual relationship.

4. A description of any background checks that the disclosing party completed before and/or during the individual’s employment or contract.

5. A description of the disclosing party’s screening process (including any policy or procedure that was in place) and any flaw or breakdown in that process that led to the hiring or contracting with the excluded individual.

6. A description of how the conduct was discovered.

7. A description of any corrective action (including a copy of any revised policy or procedure) implemented to prevent future hiring of excluded individuals.

In addition, before disclosing the employment of an excluded individual, a disclosing party must screen all current employees and contractors against the LEIE. Once this has been done, the disclosing party should disclose all excluded persons in one submission.

Calculating Damages

Federal health care programs may not pay, directly or indirectly, for items or services furnished, ordered, or prescribed by excluded individuals or entities. If a disclosing party employed or contracted with an excluded person who was a direct provider, such as a physician or a pharmacist, and the items or services furnished, ordered, or prescribed by that person were separately billed to Federal health care programs, the disclosure must include the total amounts claimed and paid by the Federal health care programs for those items or services.

We understand that when an excluded individual provided items or services that are not billed separately to Federal health care programs, such as many items or services furnished by nurses, respiratory therapists, and billing and other administrative personnel, the damages amounts can be difficult to quantify. For purposes of resolving SDP matters involving such non-separately-billable items or services, we use the disclosing party’s total costs of employment or contracting during the exclusion to estimate the value of the items and services provided by that excluded individual. The costs of employment or contracting include, but are not limited to, all salary and benefits and other money or items of value, health insurance, life insurance, disability insurance, and employer taxes paid related to employment of the individual (e.g., employer’s share of FICA and Medicare taxes). This total amount should be multiplied by the disclosing party’s revenue-based Federal health care program payor mix for the relevant time period. (If a disclosing party can measure the Federal payor mix for the department or unit in which the excluded person worked, it is appropriate to apply that payor mix. If the departmental payor mix cannot reasonably be measured, the disclosing party must apply the payor mix for the whole entity.) The resulting amount will be used, for purposes of compromising OIG’s CMP authorities in a settlement, as a proxy for the amount paid and the single damages to the Federal health care programs resulting from the employment of the excluded individual. When the disclosing party is using a Federal payor mix, the disclosure must include a separate calculation for each Federal health care program. For example, if the disclosing party’s Federal payor mix is

60 percent, the disclosure should break down how the Federal health care programs make up that 60 percent, such as 40 percent Medicare, 10 percent Medicaid State A, 5 percent Medicaid State B, and 5 percent TRICARE.

**D. Requirements for Conduct Involving the Anti-Kickback**

**Statute and Physician Self-Referral Law**

Another large category of SDP submissions relates to potential violations of the AKS (including conduct that violates both the AKS and the Stark Law). This section provides further guidance to help disclosing parties gather the necessary information for

complete disclosure.

Specific Information

In this section, we provide additional guidance on submitting the information described in section III.A. Any disclosure must clearly acknowledge that in the disclosing party’s reasonable assessment of the information available at the time of the disclosure, the subject arrangement(s) constitute potential violations of the AKS and, if applicable, the Stark Law. In the past, some disclosing parties have failed to include this acknowledgment in their submissions to the SDP while others have phrased their acknowledgments as suggestions that OIG could view the disclosed conduct as potential violations. OIG will not accept any disclosing party into the SDP that fails to acknowledge clearly that the disclosed arrangement constitutes a potential violation of the AKS and, if applicable, the Stark Law.

As with other self-disclosed conduct, OIG needs to understand the precise nature of the disclosed conduct that creates potential AKS liability or both AKS and Stark Law

liability. Therefore, the disclosing party must include in its narrative submission (not by

reference to attachments or other documents) a concise statement of all details directly relevant to the disclosed conduct and a specific analysis of why each disclosed arrangement potentially violates the AKS and Stark Laws. The description should include the participants’ identities, their relationship to one another to the extent that the relationship affects their potential liability (e.g., hospital-landlord, referring physician-tenant); the payment arrangements; and the dates during which each

suspect arrangement occurred. Further, the disclosure should explain the relevant

context and the features of the arrangement that raise potential AKS or both AKS and

Stark Law liability.

Below are several examples of the type of information OIG finds helpful in assessing and resolving disclosed conduct involving potential AKS and, if applicable, Stark Law violations. These illustrations are by no means comprehensive or exclusive; rather, they reflect some common issues that have arisen in SDP submissions. For example:

1. How fair market value was determined and why it is now in question.

2. Why required payments from referral sources, under leases or other contracts, were not timely made or collected or did not conform to the negotiated agreement and how long such lapses existed.

3. Why the arrangement was arguably not commercially reasonable (e.g., lacked a reasonable business purpose).

4. Whether payments were made for services not performed or documented and, if so, why.

5. Whether referring physicians received payments from Designated Health

Service entities that varied with, or took into account, the volume or value

of referrals without complying with a Stark Law exception. Finally, the submission must describe the corrective action taken to remedy the suspect arrangement(s), as well as any safeguards implemented by the disclosing party to prevent the conduct from reoccurring.

Calculating Damages

AKS compliance is a condition of payment of the Federal health care programs. Under section 1128B(g) of the Act, claims that include items or services resulting from an AKS violation constitute false or fraudulent claims for purposes of the FCA. Stark Law compliance is also a condition of payment under section 1877 of the Act. Thus, a disclosing party must submit an estimate of the amount paid by Federal health care programs for the items or services associated with potential violations of the AKS and,

if applicable, the Stark Law. A disclosing party may use the methodology in section

III.B to calculate the estimate. Alternatively, a disclosing party may identify another reliable methodology to calculate this claims-based estimate and explain that methodology in its submission.

Consistent with OIG’s CMPL authorities, a disclosing party must include the total amount of remuneration involved in each arrangement without regard to whether the disclosing party believes a portion of the total remuneration was offered, paid, solicited, or received for a lawful purpose. A disclosing party may also explain what it believes is the value of the financial benefit conferred under the arrangement and whether it believes any portion of the total remuneration should not be considered by OIG in determining an appropriate settlement of OIG’s CMP authorities. Given the various legal authorities at issue, OIG has broad discretion in determining an appropriate resolution in these cases. For purposes of resolving SDP matters, we generally exercise this discretion by compromising our CMP authorities for an amount based upon a multiplier of the remuneration conferred by the referral recipient to the individual or entity making the referral. While this is our general approach, OIG’s determination of the appropriate settlement amount depends on the facts and circumstances of each matter. We generally use this remuneration-based methodology in the SDP as an incentive to encourage disclosure of potential AKS violations. OIG’s use of a remuneration-based methodology in the SDP settlement context does not govern OIG’s position in other situations, such as Government-initiated investigations, in which the Government may use any legally supportable measure of damages, multipliers, and penalties.

**IV. Resolution**

Resolution of a matter in the SDP depends on cooperation, realistic expectations, and clear communication between OIG and the disclosing party. This section provides some basic information about successful resolution of SDP matters.

**A. Cooperation Is Essential**

The benefits of self-disclosure, such as a speedy resolution, lower multiplier, and an exclusion release without integrity agreement obligations, depend on the disclosing party’s willingness to work cooperatively with OIG throughout the process.

Cooperation includes, for example, conducting a thorough investigation, submitting all

necessary information, communicating through a consistent point of contact, being responsive to OIG requests for additional information, and being willing to pay a penalty or multiplier of damages for self-disclosed conduct. Disclosing parties who fail to cooperate with OIG in good faith will be removed from the SDP.

**B. OIG Coordination With DOJ on Civil Matters**

OIG will coordinate with the Department of Justice (DOJ) on in resolving SDP matters. If OIG is the sole agency representing the Federal Government, the matter will be settled under OIG’s applicable CMP authorities. In some cases, disclosing parties may request release under the FCA, and in other cases, DOJ may choose to participate in the settlement of the matters. If DOJ participates in the settlement, the matter will be resolved as DOJ determines is appropriate consistent with its resolution of FCA cases,

which could include a calculation of damages resulting from violations of the AKS based

on paid claims. OIG will advocate that the disclosing party receive a benefit from disclosure under the SDP and the matter be resolved consistent with OIG’s approach in similar cases. However, DOJ determines the approach in cases in which it is involved.

**C. OIG Coordination With DOJ on Criminal Matters**

OIG encourages disclosing parties to disclose potential criminal conduct though the SDP

process. OIG’s Office of Investigations investigates criminal matters, and any disclosure of criminal conduct through the SDP will be referred to DOJ for resolution.

As in civil cases referred to DOJ, OIG will advocate that the disclosing parties receive a benefit from disclosure under the SDP.

**D. OIG Coordination With the SRDP**

Disclosing parties need to decide whether OIG’s SDP or CMS’s SRDP is the appropriate protocol to disclose potential Stark Law violations. Both protocols should not be used for the same arrangement. As stated above, disclosing parties must analyze each arrangement to determine whether the arrangement raises potential violations of the AKS, the Stark Law, or both. If the arrangement raises a potential violation of only the AKS or of both the AKS and the Stark Law, the arrangement should be disclosed to OIG under the SDP. If the arrangement raises a potential violation of only the Stark Law, the arrangement should be disclosed to CMS under the SRDP. OIG coordinates with

CMS on the review and resolution of matters disclosed to either agency as appropriate. However, OIG does not participate in SRDP settlements.

**E. Minimum Settlement Amounts**

While OIG does not demand an admission of liability in settlement agreements, disclosing parties should expect to pay above single damages for disclosed conduct that potentially violates Federal law. OIG’s general practice is to require a minimum multiplier of 1.5 times the single damages, although in each case, we determine whether a higher multiplier is appropriate. As a general practice, for purposes of settlement in the SDP, OIG applies this multiplier to the amount paid by Federal health care programs, not the amount claimed.

To better allocate disclosing party and OIG resources in resolving matters through the SDP and to promote transparency and realistic expectations in the SDP process, we require minimum settlement amounts for self-disclosed matters. For kickback-related submissions accepted into the SDP, OIG will require a minimum $50,000 settlement amount to resolve the matter. This minimum amount is consistent with OIG’s statutory authority to impose a penalty of up to $50,000 for each such transaction and an assessment of up to three times the total remuneration. See section 1128A(a)(7) of

the Act. For all other matters accepted into the SDP, OIG will require a minimum

$10,000 settlement amount to resolve the matter. This minimum amount is consistent with OIG’s statutory authority to impose a penalty of at least up to $10,000 for each improper claim submitted as described in the CMPL, section 1128A(a) of the Act. These minimum amounts account for Federal health care program damages and any relevant multiplier.

In the unusual instance when OIG determines that no potential fraud liability exists for conduct disclosed under the SDP, OIG will refer the matter to the appropriate payor for acceptance of the overpayment and no CMP release will be provided.

**F. Financial Inability To Pay**

In some situations, disclosing parties may be unable to pay otherwise appropriate settlement amounts. In preparing the disclosure, disclosing parties should determine whether an inability to pay may be an issue. If a disclosing party asserts that it cannot pay a proposed settlement amount (i.e., damages plus a multiplier or penalty amount), OIG will require extensive financial information, including audited financial statements, tax returns, and asset records. Disclosing parties must certify to the truthfulness and completeness of the financial disclosure. In addition to submitting the financial forms, disclosing parties should include an assessment of how much they believe they can afford to pay.

Disclosing parties should raise potential inability-to-pay issues at the earliest possible time, preferably in the SDP submission. Doing so enables OIG to promptly send the disclosing party the financial disclosure forms and consider that information in determining an appropriate resolution.

**G. Overpayment Reconciliation**

If, prior to resolving an SDP matter, a disclosing party refunds an overpayment related to the same conduct disclosed under the SDP, OIG will credit the amount paid toward the ultimate settlement amount. However, OIG is not bound by any amount that is repaid outside the SDP process. OIG may question the methodology of the overpayment calculation, particularly if the disclosing party estimated the overpayment amount by some method other than as described in the SDP. If OIG disputes the methodology used to calculate the overpayment, OIG may require the disclosing party to redo the review or conduct an independent damages review, which may result in a damages or overpayment amount that is higher than the disclosing party’s estimate. Moreover, even if OIG agrees with the methodology used to calculate the overpayment, the disclosing party should expect to pay a multiplier on the damages under the SDP.

**H. FOIA Implications of Disclosure**

Disclosing parties should clearly identify any portion of their submissions that they believe are trade secrets or are commercial, financial, privileged, or confidential and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. Information identified as exempt must meet the criteria for exemption from disclosure under FOIA as determined by an OIG FOIA officer. Consistent with the Department of Health and Human Services’ FOIA procedures, set forth in 45 C.F.R. Part 5, OIG will make a reasonable effort to notify a disclosing party

prior to any release by OIG of information submitted by a disclosing party and identified

upon submission by a disclosing party as trade secrets or as commercial, financial, privileged, or confidential under the FOIA rules. With respect to such releases, a disclosing party will have the rights set forth at 45 C.F.R. § 5.65(d).

**ACKNOWLEDGEMENT OF Receipt Of AND training in Overpayment Self-Disclosure Policy and Procedure**

I hereby acknowledge that I have received a copy of the facility’s Overpayment Self-Disclosure Policy and Procedure, and that I must report any Compliance and Ethics concerns to either my manager, the Administrator, the Compliance and Ethics Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or as a last resort by calling our Compliance and Ethics Hotline at (800) 610-2544. I hereby agree to abide by the requirements of this Overpayment Self-Disclosure Policy and Procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**{Facility}**

**New and Current Employee, Contractors, Vendors, Physicians, and Other Healthcare Practitioners Exclusions Screening Policy and Procedure**

**PURPOSE**

Federal law prohibits entities that participate in federal health care programs (including Medicare, Medicaid, and other governmental programs), such as {Facility} (the “Facility”), from entering into or maintaining certain relationships with individuals or entities that have been excluded from participation in federal health care programs. The Medicare statute also excludes from coverage any item or service that has been ordered, supervised, or furnished by an individual or entity during time when the individual or entity has been excluded from the federal program.

The Facility is committed to maintaining high quality care and service as well as integrity in its financial and business operations. The purpose of this policy is to set forth the procedures the Facility follows in determining whether any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) are excluded from participation in such federal programs.

**POLICY**

1. The Facility will perform initial, annual, and/or ongoing exclusion reviews to ensure that Associates have not been sanctioned or excluded from participating in any federal health care program as prohibited by federal law.
2. For purposes of this policy, an “ineligible individual/entity” is anyone who:
   1. Is currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs or in federal procurement or non-federal procurement programs; or
   2. Has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible.
3. If the Facility identifies an ineligible individual/entity in the exclusions verification process, the Facility will contact its compliance and ethics legal counsel will for advice and direction on proceeding with an appropriate course of action.

**PROCEDURE**

The following screening procedures will be conducted by the Facility.

1. Employee Screening Prior to Hire
   1. Prior to the hiring of any the Facility employee, the Human Resources Department will screen all potential employees by:
      1. Requiring applicants to disclose whether they are ineligible; and
      2. Reviewing the United States General Services Administration Excluded Parties List System ("EPLS") (“GSA Exclusion List”), available at <https://www.sam.gov/SAM/>
      3. Reviewing the United States Department of Health and Human Services, Office of Inspector General List of Excluded Individuals/Entities (“LEIE”) available at <http://exclusions.oig.hhs.gov>
2. Reviewing the State of Georgia Medicaid Exclusions List available at <https://dch.georgia.gov/georgia-oig-exclusions-list>
3. The Human Resources Department shall notify the Compliance and Ethics Officer and the Facility’s legal counsel of any matches found during any of the above screening processes. If a potential employee is determined to be an excluded individual, the individual will no longer be eligible for hire.
4. For GA only. Prior to hiring an employment applicant, the Facility shall request a criminal record check from GCIC to determine whether the applicant has a criminal record.
   * + 1. The Facility shall make a written determination for each applicant for whom a criminal record check is performed.
       2. The Facility shall not employ a person with an unsatisfactory determination.
       3. Requests for criminal record checks may be submitted to any county sheriff or municipal law enforcement agency having access to GCIC information.
       4. All applications provided by the Facility shall conspicuously state the following: “FOR THIS TYPE OF EMPLOYMENT, STATE LAW REQUIRES A CRIMINAL RECORD CHECK AS A CONDITION OF EMPLOYMENT”.
   1. At hire
      1. After hire, all employees shall be required to complete the Code of Conduct training and sign the accompanying acknowledgement form to certify that the employee has not been excluded, has no knowledge of an impending exclusion, and agrees to notify the Compliance and Ethics Officer if they should become aware of their potential exclusion.
   2. Existing Employees
      1. The Facility shall conduct periodic exclusion checks pursuant to the policies stated below.
5. Contractors/Vendors
   1. The Facility shall conduct exclusion checks prior to entering an agreement with a contractor. If the exclusion check indicates that a bidder or contractor has been excluded from federal or state healthcare programs, the bid will not be accepted, or the contract will not be executed. The Facility will screen all potential contractors/vendors by:
      1. Requiring applicants to disclose whether they are ineligible; and
      2. Reviewing the United States General Services Administration Excluded Parties List System ("EPLS") (“GSA Exclusion List”), available at <http://sam.gov/>
      3. Reviewing the United States Department of Health and Human Services, Office of Inspector General List of Excluded Individuals/Entities (“LEIE”) available at <http://exclusions.oig.hhs.gov>
      4. Reviewing the State of Georgia Medicaid Exclusions List available at <https://dch.georgia.gov/georgia-oig-exclusions-list>
      5. The Compliance and Ethics Officer and the Facility’s legal counsel shall be notified of any matches found during any of the above screening processes. If a potential contractor/vendor is determined to be an excluded individual, the individual will no longer be eligible for hire.
   2. All contracts entered into or bids accepted by the Facility will contain a certification that the contractor/bidder and its employees and subcontractors are not excluded by the federal or state government.
   3. The Compliance and Ethics Officer shall assure that an exclusion check of the contractor is conducted prior to entering a business contract with the contractor/vendor and thereafter pursuant to this policy and procedure.
   4. If the exclusion check indicates that a contractor has been excluded from federal or state healthcare programs, the contract will be terminated.
   5. If the exclusion check indicates that the bidder has been excluded from federal or state healthcare programs, the bid will not be accepted.
   6. The Compliance and Ethics Officer shall maintain the results of all exclusion checks for one year.
6. Physicians and Other Healthcare Practitioners
   1. The Facility will verify that all instances in which physicians and healthcare practitioners order or prescribe Medicaid or Medicare funded goods or services have not been excluded from participation in a federal or state healthcare program.
   2. The Compliance and Ethics Officer shall assure that an initial exclusion check is conducted on each practitioner who prescribes or orders Medicaid or Medicare funded goods or services. The Facility will screen all potential physicians and healthcare practitioners by:
      1. Requiring applicants to disclose whether they are ineligible; and
      2. Reviewing the United States General Services Administration Excluded Parties List System ("EPLS") (“GSA Exclusion List”), available at <http://sam.gov/>
      3. Reviewing the United States Department of Health and Human Services, Office of Inspector General List of Excluded Individuals/Entities (“LEIE”) available at <http://exclusions.oig.hhs.gov>
      4. Reviewing the State of Georgia Medicaid Exclusions List available at <https://dch.georgia.gov/georgia-oig-exclusions-list>
      5. The Compliance and Ethics Officer and the Facility’s legal counsel shall be notified of any matches found during any of the above screening processes. If a potential physician or healthcare practitioner is determined to be an excluded individual, the individual will no longer be eligible for hire.
7. The Compliance and Ethics Officer shall assure that exclusion screening is conducted prior to entering a business relationship with the physician or healthcare practitioner and thereafter pursuant to this policy and procedure.
8. If the exclusion check indicates that a practitioner has been excluded from federal or state healthcare programs, the services or goods will not be billed to Medicaid or Medicare.
9. The Compliance and Ethics Officer shall maintain the results of all exclusion checks.
10. Monthly Screening for Existing Associates.
    1. The Facility will screen all applicable Associates on a monthly basis to verify that they have not been excluded from federal or state programs since the last review.
    2. If the Facility identifies that a current Associate is an ineligible individual/entity in the exclusions verification process, the Facility will immediately report the finding to the Department of Community Health, Provider Enrollment Section and the Facility’s legal counsel will be contacted for advice and direction on proceeding with an appropriate course of action.
    3. The Compliance and Ethics Officer shall be responsible to ensure that exclusion screenings are conducted on all Associates and shall maintain the results of all exclusion checks for a period of one year.
11. Credentials Verification
    1. In addition to exclusion screening, the credentials of medical/healthcare and other professionals employed by the Facility will be verified with appropriate licensing and disciplining authorities, including any adverse actions taken against the individuals that might impair his or her performance of duties, or fiduciary responsibilities on behalf of the Facility. The process is applicable to all Associates for which the license/certification is required for the performance of their duties. The screening and verification will be conducted as part of the hiring process and at least annually, on their hire date, thereafter.
12. If any Associate is charged with a criminal offense related to healthcare, or is proposed or found to be subject to exclusion from federal healthcare programs, the Associate shall be removed from direct responsibility or involvement in any federally funded healthcare program while the matter is pending.
13. All Associates have an obligation to notify their immediate supervisor or the Compliance and Ethics Officer immediately upon receipt of any information indicating that any Associate has been charged with a crime related to health care or is facing a proposed debarment, exclusion, or other ineligibility for participation in any federal health care program. Failure to make such notification to the Compliance and Ethics Officer shall result in disciplinary action, including possible termination.

**{Facility}**

**Conflict of Interest Policy and Procedure**

**PURPOSE**

{Facility} (the “Facility”) expects any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) to conduct their business according to the highest ethical standards of conduct and to comply with all applicable laws and to avoid any potential conflict of interest.

**POLICY**

To increase awareness of potential conflicts of interest and establish a procedure for reporting them.

**PROCEDURE**

1. Conflict of Interest
   1. Associates should always act in the best interest of the Facility and not use the Facility’s relationship with its residents, vendors, suppliers, and contractors for private gain or to obtain benefits for themselves or members of their family. An Associate found to violate this policy may be removed from his/her position with the Facility.
      1. For purposes of this policy, a potential conflict of interest occurs when an Associate’s outside interests interfere with the Facility’s interests or the Associate’s work-related duties.
      2. An interest of a member of the immediate family will be considered to be the same as the interest of the Associate involved.
2. Any Associate who performs work or renders services for any competitor of the Facility or for any organization with which the Facility does business or which seeks to do business with the Facility outside of the normal course of his/her employment with the Facility must notify and seek the approval of either the Compliance and Ethics Officer or legal counsel.
3. No Associate shall be a director, officer, or consultant for any organization with which the Facility does business or which seeks to do business with the Facility outside of the normal course of his/her employment with the Facility, nor permit his/her name to be used in any fashion that would tend to indicate a business connection with such organization without the prior approval of either the Compliance and Ethics Officer or legal counsel.
4. Disclosure and Approval
   1. Associates are required to disclose, and to obtain approval for, any interest or situation, which may produce a conflict of interest. Conflicts of interest include, but are not limited to:
      1. Any outside financial or commercial interest that does or may conflict with, or give the impression of conflicting with, their decisions or actions for the Facility. This includes any financial interest of an Associate or an immediate family member in any outside enterprise or transaction, which does business with or competes against the Facility unless such business is insubstantial in relation to the total business of the outside enterprise.
      2. Ownership in or employment by any outside entity which does business with the Facility unless the situation was disclosed to and approved by the Compliance and Ethics Officer or legal counsel.
      3. Conducting any business not on behalf of the Facility, with any vendor, supplier, contractor, or agency, or any of their officers or employees, unless previously authorized by the Compliance and Ethics Officer or legal counsel.
      4. Disclosure or use of confidential, special, or inside information of or about the Facility, either for financial gain or for some other advantage to the Associate or member of his or her household.
         1. All executive employees and contractors in a position to influence the Facility’s decision making regarding contracts shall be required to disclose annually his or her affiliations and to execute an acknowledgement form confirming that he or she has complied with the Facility’s Code of Conduct
5. (See the Facility’s Annual Compliance and Ethics and Conflicts of Interest Disclosure Statement).
6. Reporting Procedure
   1. Associates that become aware of any potential conflict of interest or ethical concern regarding their own employment or that of another employee must promptly speak to or otherwise contact their supervisor or the Compliance and Ethics Officer as soon as possible. The Facility will thoroughly investigate all concerns regarding conflicts of interest. The Facility will determine whether a conflict of interest exists and what action should be taken. Associates who act in a supervisory, managerial, or other administrative role have an additional obligation to promptly report any potential violation reported to them by subordinates.
7. No Retaliation: No one will be subject to, and the Facility prohibits, any form of discipline, reprisal, intimidation, or retaliation for good faith reporting of incidents of harassment of any kind, pursuing any harassment claim or cooperating in related investigations.
8. Violations of this Policy: Any Associate, regardless of position or title, who is determined to have subjected an individual to harassment or retaliation in violation of this policy, will be subject to discipline, up to and including immediate termination of employment.
9. Administration of this Policy: The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.
10. Employees Covered under a Collective Bargaining Agreement: The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

**Annual Compliance and Ethics and Conflicts of Interest**

**Disclosure Statement**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Conflict of Interest Policy**

{Facility}’s (the “Facility”) Conflict of Interest Policy requires each executive employee and contractor in a position to influence the Facility’s decision making regarding contracts to disclose annually his or her affiliations and to execute an acknowledgement confirming that he or she has complied with the Facility’s Code of Conduct.

Disclosure of an executive employee and contractor’s affiliations is intended to assist the Facility 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 executive employee or contractor.

**Instructions**

Please answer all of the questions in Section 3 to the best of your knowledge. If you answer “yes” to any question on this form, please respond fully to the information requested or identify whether the position or relationship is compensated, involves equity (i.e. stock, or other beneficial ownership interest), or involves another financial interest. Use additional sheets if necessary to fully answer any question.

**DISCLOSURE STATEMENT**

1. Do you or, to your knowledge, any member of your family have any interest in any entity which conducts business with the Facility?

\_\_\_\_No \_\_\_\_\_Yes If yes, please explain

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1. Do you or, to your knowledge, any member of your family hold any position as a director, officer, partner, trustee, employee, agent or consultant of any entity which conducts business with the Facility?

\_\_\_\_No \_\_\_\_\_Yes If yes, please explain

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1. Have you or, to your knowledge, any member of your family given, directly or indirectly, any gift, entertainment, compensation, reward, or other benefit during the past twelve (12) months to any entity which conducts business with the Facility?

\_\_\_\_No \_\_\_\_\_Yes If yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you or, to your knowledge, any member of your family received, directly or indirectly, any gift, entertainment, compensation, reward, or other benefit of more than nominal value during the past twelve (12) months from any entity which conducts business with the Facility?

\_\_\_\_No \_\_\_\_\_Yes If yes, please explain

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1. Are you a member of the governing body or an officer, trustee, employee, agent, or consultant of, any other healthcare provider or supplier other than the Facility?

\_\_\_\_No \_\_\_\_\_Yes If yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate whether you are currently debarred, suspended, excluded, or otherwise ineligible to participate in any federal program.

\_\_\_\_\_\_\_No, I am NOT currently debarred, suspended, excluded, or otherwise ineligible to participate in any federal program

\_\_\_\_\_\_\_Yes, I am currently debarred, suspended, excluded, or otherwise ineligible to participate in any federal program. Please provide details of debarment, suspension, or exclusion.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate whether you have ever been convicted of a criminal offense related to the provision of health care items or services.

\_\_\_\_\_\_\_No, I have never been convicted of a criminal offense related to the provision of health care items or services.

\_\_\_\_\_\_\_Yes, I have been convicted of the following criminal offense related to the provision of health care items or services. Please explain and include the offense, date of conviction, and state where offense occurred.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate whether you have entered into or been a party to any agreement or settlement with any governmental body or agency relating to an allegation of non-Compliance with, or violation of, any healthcare laws.

\_\_\_\_No \_\_\_\_\_Yes If yes, please explain the nature of the settlement and include the violation, date of settlement, and state where the violation occurred

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Please indicate your knowledge of whether or not the Facility is currently noncompliant with any applicable healthcare laws or regulations or under investigation, audit, or review for any alleged non-compliance with healthcare laws.

\_\_\_\_\_\_\_No, I have NO knowledge of any non-Compliance with applicable healthcare laws by the Facility, or knowledge of any investigation, audit, or review of alleged non-compliance with healthcare laws by the Facility.

\_\_\_\_\_\_\_Yes, I am aware of and have knowledge of non-compliance with healthcare laws by the Facility, or I have knowledge of an investigation, audit, or review of alleged non-compliance with healthcare laws. Please explain, in detail, what you have knowledge of by providing a complete explanation and all relevant facts and circumstances.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement**

I hereby certify that I have carefully read and understand all of instructions, questions and disclosures in this Annual Disclosure Statement. I agree to immediately update the information provided in this Annual Disclosure Statement in writing to the Facility Compliance and Ethics Officer in the event of any changes.

I further certify that the information contained on this form is true and correct to the best of my knowledge and I have made reasonable efforts to assure that accurate and complete information has been provided.

Additionally, I certify that it is my responsibility to read, understand and abide by the Facility Code of Conduct and agree to comply with my obligations under the Code of Conduct.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_

**{Facility}**

**Relationships with Government Employees**

**Policy and Procedure**

**PURPOSE**

To assist {Facility} (the “Facility”) in establishing parameters for appropriate relationships with government employees.

**POLICY**

The Facility requires that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) be aware of their roles in ensuring that the Facility engages in appropriate relationships with government employees, including federal, state, and local public officials.

**PROCEDURE**

1. The Facility shall provide its Associates access to this policy.
2. The Facility shall revise this policy as necessary to comply with changes in the law and shall document and implement any changes.
3. The Facility shall implement the following processes and requirements:
   1. The Facility and its Associates shall not provide gifts or other remuneration to government employees under any circumstances. This includes without limitation gifts of meals, entertainment, and monetary donations. This excludes appropriate political contributions made in Compliance with the Facility’s policies and applicable law.
   2. The Facility shall not accept gifts from government employees.
   3. The provisions allowing for extending and receiving gifts, business courtesies, and entertainment in the Facility’s Business Courtesies to Potential Referral Sources Policy and Procedure, do not apply to government employees.
   4. Reporting Procedure: Associates that become aware of any potential violation of this policy must promptly speak to or otherwise contact their supervisor or the Compliance and Ethics Officer as soon as possible.
   5. The Facility will thoroughly investigate all concerns regarding violations of this policy, and determine what course of action should be taken. Associates who act in a supervisory, managerial, or other administrative role have an additional obligation to promptly report any potential violation reported to them by subordinates.
   6. No Retaliation: No one will be subject to, and the Facility prohibits, any form of discipline, reprisal, intimidation, or retaliation for good faith reporting of incidents of violations of this policy.
   7. Violations of this Policy: Any Associate, regardless of position or title, who is determined to have violated this policy, will be subject to discipline, up to and including immediate termination of employment.
   8. Administration of this Policy: The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.

**{Facility}**

**Contract Review and Approval Policy and Procedure**

**PURPOSE**

To ensure that all contractual agreements on behalf of {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) are undertaken and performed in accordance with applicable legal and regulatory requirements and to ensure that all business arrangements meet or exceed the Facility’s business, ethical, and Compliance and Ethics related expectations.

**POLICY**

It is the policy of the Facility to comply with all state and federal laws. The Facility is subject to numerous federal and state laws and regulations, which include, by way of example, the federal Stark Law and Anti-Kickback Statute, and applicable state laws and regulations. Violations of these laws and regulations can result in severe civil and/or criminal penalties for the Facility.

The Facility shall review every contract it enters into to ensure that it is in material Compliance with applicable legal and regulatory requirements. All business arrangements that involve written contractual agreements that meet certain specific criteria must be reviewed and approved by the Chief Financial Officer (“CFO”). To the extent that a contractual arrangement raises a Compliance and Ethics issue or concern either at the outset of the contracting process or after partial or complete performance of the agreement, the Compliance and Ethics issue or concern must be reported to the Compliance and Ethics Officer and/or through the appropriate Compliance and Ethics Program requirements.

**PROCEDURE**

1. New Contracts and Amendments to Existing Contracts
   1. All business arrangements that involve written contractual agreements that meet certain specific criteria must be reviewed and approved by the CFO in accordance with this policy.
   2. Where applicable, the Facility’s legal counsel shall review the business arrangement for Compliance or other legal issues.
2. Compliance and Ethics Issues or Concerns
   1. Whether raised during contract negotiations or after partial or complete performance of an agreement, whenever an Associate has a Compliance and Ethics related issue or concern regarding a contractual agreement, the issue or concern should be reported through the appropriate Compliance and Ethics related reporting mechanism in accordance with the Individual Reporting of Compliance and Ethics Concerns Policy and Procedure.

**{Facility}**

**Records Management Policy and Procedure**

**PURPOSE**

To set forth the internal control mechanisms by which {Facility} (the “Facility”) seeks to comply with applicable laws, rules, regulations, and industry guidelines pertaining to the retention and destruction of information and records.

**POLICY**

It is the policy of the Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) to maintain and preserve all information and records, (defined below) including compliance and ethics, business, and medical records, and to secure them against loss, destruction, unauthorized access, unauthorized reproduction, corruption, or damage. The Facility and all Associates will maintain documentation consistent with all federal and state government laws, rules, and regulations concerning document retention periods. The Facility shall implement reasonable physical, technical, and procedural safeguards to: (i) attempt to identify and prevent the unauthorized or unlawful processing or transmittal of information and records by the Facility; and (ii) attempt to prevent the accidental or intentional loss or destruction of, or damage to, information and records.

For the purposes of this policy, “records” means all stored information (even if deemed unimportant by an Associate) whether in electronic or non-electronic form such as paper, e-mail, instant messaging transcripts and other electronic records stored on computer servers, CDs, hard disks, floppy disks, or other electronic data processing storage media.

**PROCEDURE**

1. Records Retention
   1. All records shall be retained according to the Record Retention Schedule attached hereto as Attachment A.
   2. Records may be retained for longer periods upon the decision of the Compliance and Ethics Officer or legal counsel. In such an event, the Compliance and Ethics Officer shall adopt a schedule setting forth the type of record and length of retention.
2. Compliance and Ethics Officer
   1. The Compliance and Ethics Officer shall be responsible for implementing, in cooperation with the Facility’s IT department as necessary, and overseeing the Facility’s compliance with this policy in all relevant the Facility departments.
   2. The Compliance and Ethics Officer shall collaborate with the Facility’s legal counsel to periodically review this policy, and to provide ongoing guidance, support, and feedback regarding the compliance with this policy.
3. Record Retention Process
   1. The Compliance and Ethics Officer shall:
      1. Implement the Facility-wide classification process for information and records
      2. Oversee the retention, storage, and transfer of information and records, and the destruction of the same where permitted under applicable law.
      3. Coordinate the Facility-wide information and data retention processes, including active filing systems, inactive information and record transfer and storage, historical preservation, server backup, etc.
      4. Ensure that the Facility’s program of compliance with this Policy is kept current under applicable law and implementing periodic internal audits.
      5. Ensure that exceptions to this policy have received appropriate legal, financial, and management review.
      6. Apprise Associates of changes to this policy and issues that may arise in terms of compliance with this policy.
4. Types of Records
   * 1. Temporary Records: These are information and records that have short-term value to the Associates who created them but do not have long-term value to the Facility for any legal or business reason, such as:
        1. drafts of documents, dictation to be typed in the future, reminders, to-do lists, notes, copies of Final Records, and similar documents, intra-company memoranda, and general e-mail correspondence.
     2. Final Records: These include all information and records listed on the Record Retention Schedule attached as Attachment A to this Policy. Information or records that pertain to, modify, describe, or are otherwise related to the information and records listed on the Record Retention Schedule may also constitute Final Records. Correspondence (including e-mail) may also fall into this category depending on the nature of the content.
        1. Questions regarding whether information and records is a Transitory Record should be referred to the Compliance and Ethics Officer.
     3. Tangible Records: These include information and records which must be physically stored, such as paper records (including printed versions of electronically saved documents), photographs, video and audio tapes, advertisements, and promotional items.
     4. Electronic Records: These include all electronically stored information, such as e-mails, spreadsheets, word processing documents, voicemail messages, electronic calendars and diaries, instant messages, computer and network activity logs, backup data, image files, web pages, databases, software, and other items which have not yet been reduced to Tangible Records.
5. Storage and Destruction
   1. Tangible Transitory Records
      1. These may be stored in individual work areas until they are no longer needed. Once no longer needed, they are to be destroyed by shredding or by some other means that will render them unreadable.
         1. The Facility may utilize the services of a third party for purposes of collecting and destroying records.
   2. Electronic Transitory Records
      1. These shall be stored only on the Facility’s media or devices, not on individual Associate’s personal hard drive, laptop, flash drive, CD, or other media or device.
      2. Once such records are no longer needed, Associates shall delete these records by moving them to a “recycle bin” located on the Facility’s servers.
      3. Associate hard drives will be purged periodically of such records.
      4. The Facility shall periodically purge and permanently delete the records stored in the “recycle bin,” as permitted under applicable law.
   3. Final Records
      1. Tangible Final Records
         1. These shall be stored as set forth in the Record Retention Schedule attached as Attachment A.
         2. Tangible Final Records are not to be removed from storage, taken home, or retained personally by any Associate with the purpose of keeping them permanently or for extended periods of time beyond their specified retention period.
         3. At the end of the retention periods set forth in the Record Retention Schedule, the Facility shall dispose of them as permitted under applicable law.
      2. Electronic Final Records
         1. These shall be stored on the Facility’s servers as set forth in the Record Retention Schedule attached as Attachment A.
         2. At the end of the retention periods, the Facility shall delete the information and records as permitted under applicable law.
6. Encryption of Electronic Records.
   1. The Facility shall comply with applicable federal, state, local, and foreign laws, rules, and regulations in connection with the storage and transmission of Electronic Records, including, without limitation, the implementation of data encryption technologies as required under applicable law.
7. Cessation of Record Destruction upon Hold Notice.
   1. Notwithstanding anything contained in this policy to the contrary, if a lawsuit or investigation is pending, threatened or is imminent, or an investigation or request for information has been initiated or delivered to the Facility by a regulatory or governmental agency, all destruction or permanent deletion of information and records that has been requested in connection with the litigation, investigation, or request for information, or that may be relevant to the litigation, investigation, or request for information, must cease immediately.
   2. In such cases, the Facility will issue a Record Destruction Hold Notice under and governed by the Record Destruction Hold Policy attached as Attachment B.
   3. Compliance with the Record Destruction Hold Notice and Record Destruction Hold Policy is mandatory. If any Associate of the Facility fails to comply with a Record Destruction Hold Notice and/or the Record Destruction Hold Policy, such Associate may be, in the discretion of the Facility, subject to termination by the Facility.

**ATTACHMENT A**

**RECORD RETENTION SCHEDULE**

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **ACCOUNTING RECORDS** |  |
| Accounts Payable Record (Vendor Invoices and Check Requests) and Accounts Receivable Records (Deposits, Batch Edit Reports) | Retain 7 years UNLESS business need is reassessed and found to be fulfilled solely through retention for 4 years. |
| Vendor Listing | Retain most current version of record. |
| Monthly Financial Statements, Trial Balances, and General Ledger Summaries | Retain 1 year after relevant fiscal year ends. |
| Journal Entries and Reconciliation Records (Bank Statements and Cancelled Checks | Retain 5 years after the end of the fiscal year detailed in the record. |
| Year-End Audit Records | Retain 7 years. |
| Tax Records (Federal and States Tax Returns and Supporting Records, Records Supporting State and Local Taxes (Franchise Taxes, Property Taxes), 1099 Filings, W-9 Certifications | Retain permanently UNLESS business need is reassessed and found to be fulfilled through retention for 7 years. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **ADMINISTRATIVE RECORDS** |  |
| Departmental Budgets and Reconciliations | Retain 2 years. |
| Employee and Policy Manuals | Retain 2 years. |
| Organizational Charts | Retain 5 years. |
| Records Management Policies and Supporting Materials | Retain most current version of record. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **BUSINESS DEVELOPMENT RECORDS** |  |
| **MARKETING RECORDS** |  |
| Convention Program Guides and Convention “Who’s Who” Directories | Retain 5 years after relevant event. |
| Collateral Materials for Conferences, Meetings, and Congressional Briefings (Postcards, Mailings, Brochures, Advertising, Web Site Content) | Retain 3 years after relevant event. |
| Convention Budgets | Retain 3 years after relevant event. |
| Magnet Mail Newsletters | Retain 2 years. |
| Weekly Marketing Staff Meeting Notes | Retain 2 years. |
| Yearly Marketing Schedule (Newsletter Schedule, Advertising Purchase Schedules, Publication Schedules) | Retain 3 years. |
| Images and Photographs Used in Marketing Materials | Retain permanently UNLESS business need is reassessed and found to be fulfilled solely through retention for a shorter period of time. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **BUSINESS DEVELOPMENT RECORDS (Continued)** |  |
| **PUBLICATION PRODUCTION AND MARKETING RECORDS** |  |
| Financial Reports and Production Budgets (Monthly State Revenue Sharing Reports) | Retain 3 years. |
| Weekly Reports from Publication Order Fulfillment Center | Retain 3 years. |
| Annual Publications Catalog | Retain 1 year. |
| Publication Product Specific Marketing Materials (Postcards, Mailings, Advertisements) | Retain 2 years. |
| Copies of Publication Products | Retain 5 years. |
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| **AFFINITY PROGRAM RECORDS** |  |
| Contracts and Vendor Documentations | Retain 2 years after termination of contract. CONSIDER whether additional retention of affinity program contracts is required in light of considerations relevant to the retention of contracts (see LEGAL RECORDS: Records Related to Contracts). |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **CONGRESSIONAL AFFAIRS RECORDS** |  |
| **POLITICAL ACTION COMMITTEE RECORDS** |  |
| Communications and Records Regarding Decisions to Support Congressional Candidates | Retain until decision is made. |
| CEO Approval of Congressional Candidate Support | Retain permanently. |
| Invitation from Congressional Campaigns for Support (NOT APPROVED) | Retain 1 year. |
| Candidate Support Files (Approved Invitations from Congressional Campaigns for Support, Copy of Support Check) | Retain 10 years after file no longer active. |
| Federal Election Commission Filings | Retain 1 year. |
| Committee Newsletters | Retain 1 year. |
| Committee Bylaws | Retain 2 years after superseded. |
| Committee Budget and Budget-to-Actual Comparisons | Retain 5 years. |
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| **MEDICARE, MEDICAID, AND REGULATORY LOBBYING RECORDS** |  |
| Research Records | Retain permanently UNLESS business need is reassessed and found to be fulfilled solely through retention for a shorter period of time. |
| Hearing Testimony and Lobbying Materials | Retain 5 years after relevant program reauthorization. |
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| **GRASSROOTS INITIATIVE RECORDS** |  |
| Yearly Plan of Grassroots activities and Information and Materials Related to Grassroots Programs | Retain 2 years. |
| Database of All Congressional Member Contact Information | Retain most recent version of record. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **HUMAN RESOURCES** |  |
| **BENEFIT RECORDS** |  |
| Employee Benefit Records (Included Cafeteria Plan Administration Records, COBRA Insurance Administration Records, Flexible Benefits Records, Insurance Contracts, Plans and Booklets, Insurance Administration Records, Pension Plan Records, Profit Sharing Plan (401k) and Savings Plan Records, Records Relating to the Health Insurance Portability and Accountability Act (HIPAA), Retirement Records) | Retain permanently UNLESS business need is reassessed and found to be fulfilled through retention for the longer of 6 years after the filing of the plan OR 1 year after the termination of the plan. |
| Benefit Claim Records | Retain as part of employee personnel files. CONSIDER retaining employee personnel filed for a shorter period of time. |
| Requests for leave under the Family and Medical Leave Act (FMLA) and Related Records | Retain 7 years UNLESS business need is reassessed and found to be fulfilled through retention for 3 years. |
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| **EDUCATION AND TRAINING** |  |
| Educational Reimbursement and Assistance Records | Retain as part of employee personnel files.  CONSIDER retaining employee personnel files for a shorter period of time. |
| External and Internal Education Attendance Records (Seminar Participation Records, Internal Training Attendance Records) | Retain as part of employee personnel files. CONSIDER retaining employee personnel files for a shorter period of time. |
| Internal Education and Training Materials | Retain 15 years UNLESS business need is reassessed and found to be fulfilled through a shorter period of retention. |
| Training Calendars | Retain 1 year. |
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| **HUMAN RESOURCES ADMINISTRATION** |  |
| Records Relating to Applicants Not Hired (Job Applications, Resumes and References, Background Checks, Job Descriptions, Tests and Test Results, Results of Physical Examinations and Other Medical Records, Requests for Reasonable Accommodation, Other Records Related to Hiring Decision) | Retain for the longer of 1 year from the date of personnel action involved OR 1 year from the date the record is made. |
| Recruitment Records (Advertisements, Notices to Employees and Public Notices About Job Openings, Promotions, Training Programs, or Overtime Opportunities, Job Requisitions and Job Orders to Employment Agencies or Labor Organizations for Recruitment of Personnel) | Retain all recruitment records 5 years UNLESS business need is reassessed and found to be fulfilled solely through retention for 2 years. |
| Employee Confidentiality Agreements and Conflict of Interest Letters | Retain as part of employee personnel files. CONSIDER retaining employee personnel files for a shorter period of time. CONSIDER whether  additional retention of employee confidentiality agreements is required in light of considerations relevant to the retention of contracts (See LEGAL RECORDS: Records Related to Contracts). |
| INS Employment Eligibility (1-9) Forms | Retain permanently UNLESS business need is reassessed and found to be fulfilled solely through retention for longer of either employment + 1 year OR 3 years after hire. |
| New Hire, Transfer, Promotion, and Termination Logs | Retain most current version of record. |
| Wage Administration Records (Spreadsheet of Yearly Salaries) and Payroll Records (Bonus Records, Deduction Records (Pension Deductions, Nontaxable Payroll Deductions), Garnishment Accounting Records and Garnishment Orders, Holiday Pay Estimations, Payroll Registers (Hourly, Semi-Monthly), Attendance Records, Weekly and Monthly Headcounts by Employee, Monthly listings of Vacation and Personal Days, Over and Under Reports (Monthly, Quarterly), NACH Direct Deposit Transactions, Payroll Bank Records (Bank Statements, Check Register, Cancelled Checks), Payroll General Ledger Interface Records, Payroll Histories, Payroll State Tax Information, Payroll Tax Records for Unemployment Tax Purposes, Profit Plan Employee Lists, Salaried Payroll Records (Information, Register), Personal Time, Sick Leave, and Vacation Time, Safes Commissions, Tax Forms (W-2, W-4), Time Cards | Retain 8 years. |
| Personnel Files, Performance Appraisals, and Merit Reviews (Job Applications, Resumes and References, Background Checks, Job Descriptions, Tests and Test Results (including Medical Tests), Records Regarding Selection for Training and Other Training Documentation, Employee Evaluations, Requests for Reasonable Accommodation, Other Records Related to Hiring, Firing, Transfer, Demotion, Promotion, or Layoff Decisions | Retain permanently UNLESS business need is reassessed and found to be fulfilled solely through retention for a shorter period of time, such as 4 years. Remove disciplinary reports, letters of reprimand, or other records of disciplinary action after 4 years when these records are to be released to a third party, except when the release is ordered to a party in a legal action or arbitration. |
| Employment Contracts | CONSIDER retaining all contracts and related  records for 3 years after termination of the  contract. |
| Records of Employee Evaluation Standards and Overview of Employee Evaluation Findings | Retain 5 years UNLESS business need is reassessed and found to be fulfilled through retention for 4 years. Remove disciplinary reports, letters of reprimand, or other records of disciplinary action after 4 years when these records are to be released to a third party, except when the release is ordered to a party in a legal action or arbitration. |
| Employee Self-Evaluations | Retain 1 year. |
| Service Awards | Retain as part of employee personnel files.  CONSIDER retaining employee personnel files for a shorter period of time. |
| Table Tracking Attendance Awards | Retain 5 years. |
| Employee Outing and Party Records (Vendor Contracts, Agenda lists, Seminar Information) | Retain 1 year. CONSIDER whether additional  retention of vendor contracts is required in light  of considerations relevant to the retention of  contracts (See LEGAL RECORDS: Records Related to Contracts). |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **INFORMATION TECHNOLOGY RECORDS** |  |
| Reports on Membership Database (Weekly Reports, Reports in Response to Specific Requests) | Retain 6 months. |
| Membership Contact Information | Retain most current version of record. |
| Records Related to Help Desk Requests and Responses | Retain 1 year. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **LEGAL RECORDS** |  |
| Monthly Invoices from Outside Counsel | Retain 4 years. |
| Records Related to Contracts (Contracts and Supporting Records, Contract Administration Records, Records of Contract Changes, Contract Compliance and Ethics, or Contract-Related Correspondence) | CONSIDER retaining all contracts and related records for 3 years after termination of the contract. |
| Litigation and Dispute Records in Which the Facility IS A PARTY (Case Files (Pleadings, Discovery and Correspondence), Claim Letters and Responses, Judgments and Settlement Agreements) | Retain until resolution of dispute. |
| Litigation and Dispute Records in which the Facility IS NOT A PARTY (Amicus Briefs, Other Litigation Records Related to Providing Member Services) | Retain 5 years UNLESS business need is reassessed and found to be fulfilled through retention for a shorter period of time. |
| Legal Committee Records (Agendas, Minutes, Materials) | Retain 2 year. |
| Ethics Committee Records (the Facility Officer Candidate Records) | Retain until relevant election is finished. |
| The Facility Officer Conflict of Interest Statements | Retain 1 year. |
| Not-for-Profit Committee Records (Agendas, Minutes, Materials) | Retain 2 years. |
| All Trade Marks and Service Marks and materials related to their development | Retain permanently. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **THE FACILITY ORGANIZATIONAL RECORDS** |  |
| The Facility Organizational Records and all amendments currently in effect, Constitution and Corporate Bylaws (Original or Restate) and all amendments currently in effect). | Retain permanently. |
| The Facility Organizational Records (Meeting Minutes and Materials), Meeting and Organizational Budgets | Retain 2 years. |
| The Facility Governing Body: meeting agendas, packets and meeting materials, minutes | Retain 5 years. |
| The Facility Annual Reports | Retain permanently. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **PUBLIC AFFAIRS RECORDS** |  |
| Press Releases | Retain 5 years. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **QUALITY AND PROFESSIONAL DEVELOPMENT RECORDS** |  |
| Budgeting Records | Retain 5 years after close of event. |
| Vendor Contracts | Retain 6 years after close of event UNLESS business need is reassessed and found to be fulfilled solely through retention for a shorter period of time. CONSIDER whether a shorter period of retention for these vendor contracts would be prudent in light of considerations relevant to the retention of contracts (see LEGAL RECORDS: records related to contracts). |
| Evaluation Records for Presenters and Speakers | Retain 2 years after close of event. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **REIMBURSEMENT ISSUES AND RESEARCH RECORDS** |  |
| Reports Address specific reimbursement issues generated from Research Data | Retain Permanently UNLESS business need is reassessed and found to be fulfilled through a shorter period of retention. |
| Reports Addressing REIMBURSEMENT ISSUES COMMON FROM YEAR TO YEAR Generated from Research Data | Retain 15 years UNLESS business need is reassessed and found to be fulfilled through a  shorter period of retention. |
| Public Data and Reports Retrieved from CMS | Retain until relevant project is complete OR until  termination of license with CMS. |
| Public Data and Reports Retrieved from Outside Sources Other than CMS | Retain 30 years UNLESS business need is reassessed and found to be fulfilled through a  Shorter period of retention. |

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| ***RECORD CATEGORIES*** | ***RECOMMENDED RETENTION PERIOD*** |
| **PROVIDER MAGAZINE ADVERTISING RECORDS** |  |
| Contracts with Advertisers | Retain 1 year after termination of contract. CONSIDER whether additional retention of acquisition contracts is required in light of considerations relevant to the retention of contracts (See LEGAL RECORDS: Records Related to Contracts). |
| Artwork and Correspondence Regarding Advertising Copy | Retain 1 year after end of advertisement run. |
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| **SPONSORSHIP RECORDS** |  |
| Contracts with Sponsors and Related Correspondence | Retain 1 year after termination of contract. CONSIDER whether additional retention of acquisition contracts is required in light of considerations relevant to the retention of contracts (See LEGAL RECORDS: Records Related to Contracts). |
| Logos | Retain most current version of record. |

**Attachment B  
RECORD DESTRUCTION HOLD POLICY**

**PURPOSE**

This policy governs the retention of information and records related to, relevant to, or requested in connection with any threatened, anticipated, or imminent investigation or litigation involving the Facility. It is implemented through the issuance of a Record Destruction Hold Notice (sample attached). Information and/or records identified in a Record Destruction Hold Notice are to be retained until the Compliance and Ethics Officer issues notice that they may be handled in accordance with the Record Retention Policy.

**POLICY**

This policy applies to all information and records, whether or not they are maintained in accordance with the Record Retention Policy. This includes, without limitation, originals and copies of the following: memos, correspondence, e-mail messages, spreadsheets, voicemail messages, files, handwritten notes, worksheets, calendars and diaries, minutes, instant messages, ledgers, orders, invoices and bills, checks, and video, audio or digital recordings and transcripts of them. It also includes computer and network activity logs, hard drives, backup data, removable storage media such as tapes, disks, and cards, printouts, image files, web pages, databases, software, books, telephone message logs, and photographs. Information that serves to identify, locate, or link such material, such as file inventories, file folders, indices, and metadata in electronic documents is also included in this definition. Drafts and non-identical copies are considered separate items of information and records. Items maintained on personal hard drives, fragments of incompletely deleted files, informally maintained “desk files,” and other documents that arise as a result of activities that may not be consistent with the Record Retention Policy fall within the scope of this Record Destruction Hold Policy. All of the foregoing information and records, and all other information that is relevant to any pending, threatened, anticipated or imminent litigation, investigation or request for documents or information must be preserved when a Record Destruction Hold Notice is issued. In the event that there is any question as to whether any item of information or any record should be destroyed in accordance with the Facility’s Record Retention Policy, or should be retained under this Record Destruction Hold Policy, a conservative approach should be taken which militates toward retention of the applicable information or record unless and until a determination is made by the Facility that the item of information or record is not covered by this Record Destruction Hold Policy.

**PROCEDURE**

1. Because of the broad definition of “record” set forth in this policy, it is not sufficient to simply print out and retain hard copies of electronic records. Instead, the Facility must retain and preserve electronic files, including fragments of files that are identified in a Record Destruction Hold Notice or are relevant to any information or record identified in a Record Destruction Hold Notice, including, without limitation, the following:
   1. All email and information about email sent or received by anyone relating to the topics listed in the attached Record Destruction Hold Notice;
   2. All databases containing any reference to and/or information about those topics;
   3. All logs of activity on any computer system that may have been used to process or store electronic documents and data containing information about those topics;
   4. All word processing files containing information about those topics;
   5. All files containing information from application programs that process financial, accounting, and billing data, and containing information from electronic calendars and scheduling programs regarding those topics; and
   6. All electronic documents and data files created or used by electronic spreadsheet programs where such data files contain information about the topics listed in the attached message.
2. The following sources of electronic documents and data must be included in document retention and preservation efforts:
   1. Records stored on {Facility}’s servers, computers, and other devices supplied by the Facility for use in connection with the Facility’s business (including, without limitation, cellular telephones, PDAs, laptop computers, and the like), or connected to, or which can be used to access, the Facility’s network.
   2. Records stored on individual hard drives, laptops, backups, archives, floppy disks, zip drives, tapes, CDs, hand-held devices, disconnected hard drives, and other electronic media
      1. Associates must not modify or delete any electronic documents or data files relating to the topics listed in a Record Destruction Hold Notice until a true and correct electronic copy has been made and steps have been taken to assure that such a copy will be preserved and accessible. The Compliance and Ethics Officer will work with the Facility’s legal counsel to ensure that appropriate steps are taken to preserve information and records in compliance with applicable law.
3. Replacement of data storage devices
   1. Associates must not dispose of any data storage devices or media that may be replaced due to failure or other reasons, if they may contain electronic information or records covered by a Record Destruction Hold Notice.
4. Programs and Utilities
   1. Associates must preserve all software applications and utilities that may be used to process electronic information and records covered by this Policy. This must be done even if the programs become obsolete or if the hardware utilized is taken out of productive use.
5. Documents created after receipt of a record destruction hold notice
   1. With regard to electronic information and records created after the beginning of a lawsuit or investigation, or after the initiation of a request for information or records, and relevant thereto, such information and records must not be destroyed and the Facility must take whatever steps are necessary and appropriate to avoid destruction of the same.
6. Notice of pending investigation or litigation
   1. In the event that the Facility is notified that an investigation or litigation is anticipated or has commenced, the Compliance and Ethics Officer will take the following steps to implement this Record Destruction Hold Policy:
      1. Distribution of Record Destruction Hold Notice
         1. The Compliance and Ethics Officer shall identify all persons likely to possess or have access to relevant records, and shall prepare and send a Record Destruction Hold Notice to each such person.
      2. The Compliance and Ethics Officer shall identify all individuals with direct day-to-day responsibility for relevant records, including individuals with knowledge about specific records what records are stored, where they are stored, how they are stored, who may have access to them, and how they may be retrieved.

**Attachment C  
  
SAMPLE RECORD DESTRUCTION HOLD NOTICE**

A RECORD DESTRUCTION HOLD NOTICE IN THE FOLLOWING FORM IS TO BE SENT BY THE COMPLIANCE AND ETHICS OFFICER, IN CONSULTATION WITH THE FACILITY’S LEGAL COUNSEL, TO ALL PERSONS WHO MAY POSSESS OR HAVE ACCESS TO INFORMATION OR RECORDS RELEVANT TO ANY PENDING, ANTICIPATED, OR IMMINENT LITIGATION OR INVESTIGATION BY A GOVERNMENTAL OR REGULATORY INQUIRY, OR REQUEST FOR INFORMATION.

**RECORD DESTRUCTION HOLD NOTICE**

Case or Matter Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As you may be aware, [\_\_\_\_\_\_\_\_\_\_ has sued the Facility regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “Litigation”] OR [\_\_\_\_\_\_\_\_\_\_\_\_ has initiated an investigation of the Facility (the “Investigation”)] OR [\_\_\_\_\_\_\_\_\_\_\_\_ has requested information from the Facility regarding \_\_\_\_\_\_\_\_\_ (the “Request”)].

The purpose of this Record Destruction Hold Notice is to instruct you to preserve all information and Records related to [the Litigation] OR [the Investigation] OR [the Request], regardless of form. For the purposes of this notice, the term “records” means all stored information whether in electronic or non-electronic form. Records can be in many forms and on a wide variety of media, including but not limited to those printed on paper, e-mail (including messages created and retrieved on wireless devices) and other electronic records stored on computer servers, microfiche, magnetic tape, CDs, hard disks, floppy disks, or other electronic data processing storage media.

The Facility has a duty to preserve information and records that may be relevant to [the Litigation] OR [the Investigation] OR [the Request], regardless of the form in which the information is stored or available. This scope is very broad, and includes, for example, e-mail messages, stored voice mail messages, other digital or electronic documents and spreadsheets, paper documents, correspondence, contracts, notes, calendars, disks and diskettes, backup tapes and drives, and other forms of data, among other things. To fulfill this duty, we must ensure that relevant information and records are retained and not destroyed, and we must discontinue information and record destruction and backup tape recycling policies that could result in the destruction of relevant information and records. This includes your personal practices of deleting old e-mails, including any automated practices that you may have enabled. **All information and records relevant to this matter must be retained.** If you are unsure as to whether any item of information or any record must be preserved, you must make inquiry of the Facility’s Compliance and Ethics Officer - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. [He/she] can be reached at (\_\_\_) \_\_\_-\_\_\_\_, or by email at \_\_\_\_\_\_\_\_\_\_. Therefore, please be certain to retain, and not to alter, destroy or delete, any information or records, including e-mails, within your possession or under your control regarding the following topics:

[Insert relevant topics.]

A failure to preserve relevant information and records can lead to adverse consequences, including fines, penalties, and other sanctions. Additionally, failure to preserve relevant information and records can subject the person or persons who have failed to comply with this Record Destruction Hold Notice to civil and criminal penalties under applicable law. If you have any question about whether particular information or records may be relevant, err on the side of caution and preserve the information or records in question. Also, please retain any information or record that you think might be relevant even if it does not seem to you to fall within any category on the list above.

If you are aware of any other personnel who should receive this notice, either because they had any involvement with respect to the [matters at issue in the Litigation] OR [the subject matter of the Investigation] OR [the subject matter of the Request], or are otherwise connected to the subjects above, please advise the Facility’s Compliance and Ethics Officer. Any Associate who becomes aware of anyone who leaves the Facility while this Record Destruction Hold Notice is in effect, must advise the Facility’s Compliance and Ethics Officer so that appropriate steps can be taken to preserve information and records of the Facility.

**Any Associate who has questions or comments about the substantive matters in the [Lawsuit] OR [Investigation] OR [Request], should NOT reply to this e-mail with such questions. Instead, Associates with such questions should inform the Facility’s Compliance and Ethics Officer, \_\_\_\_\_\_\_\_\_\_, of such questions. [\_\_\_\_\_\_\_\_\_\_\_\_\_\_] can be reached at (\_\_\_) \_\_\_-\_\_\_\_, or by e-mail at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Any replies to this e-mail should be limited strictly to information or record retention issues.**

Thank you very much for your assistance in this important matter.

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**{Facility}**

**Medical Necessity and Quality of Care Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) provide all residents with the best possible quality of care that is deemed to be medically necessary for the care of the resident, in Compliance with applicable federal and state laws and regulations.

**POLICY**

The Facility is committed to the provision of quality care to each of its residents and to ensuring that the services for which the Facility bills any payor source meet applicable standards of medical necessity.  
 **PROCEDURE**

1. The Facility shall ensure that its provision of care to residents shall be based on medical necessity. The Facility shall require, among other things, that:
   1. The treatment, service, procedure, or supply (“treatment”) provided to the resident is necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms and based on medical need.
   2. The treatment is order by a qualified medical professional.
   3. The treatment is rendered with appropriate frequency.
   4. The types of treatments are delineated clearly.
   5. The treatments are discontinued at the appropriate times.
   6. That the medical records clearly document the resident’s progress.
   7. The appropriate treatment shall be within generally accepted standards of medical care in the community.
   8. The appropriate treatment must not be solely for the convenience of the resident, the resident’s family or the Facility.
2. The Facility’s provision of medically necessary quality of care has many components. The Facility will make every effort to, among other things,
   1. Staff in such a way that individual nursing care assignments are based upon resident needs, skill levels, and individual personnel abilities;
   2. Communicate in such a way that nursing personnel are able to adequately inform physicians to facilitate the interpretation and processing of diagnostic and therapeutic orders given for resident care and to provide for their implementation and coordination;
   3. Ensure that residents receive appropriate restorative and personal care services to allow residents to attain and maintain their highest practicable level of functioning;
   4. Provide resident care in such a way that nursing personnel administer appropriate medications, provide all treatments and, in general, facilitate the best possible resident outcomes;
   5. Maintain all information received from or about a resident in a confidential manner so that the information is only shared with appropriate facility personnel or other authorized individuals for the benefit of the individual involved;
   6. Conduct care and discharge plans in such a way that each resident is evaluated on an ongoing basis to determine care needs and discharge status, receives the necessary care and is encouraged and assisted to return home if at all possible;
   7. Provide resident education in such a way that nursing personnel instruct residents and/or families as necessary concerning treatments, conditions and medications in keeping with professional and legal guidelines;
   8. Maintain all nursing facility records, care plans and reports in accordance with the Facility’s policies and procedures;
   9. Address safety in such a way that all employees are able to recognize possible safety hazards and demonstrate proper protocol to follow in the event of such hazards; and
   10. Orient all employees completely to the facility and appropriate policies and procedures.
3. The Facility will review and analyze the results of any government surveys of the facility, to ensure that all quality of care deficiencies or concerns cited in the surveys have been addressed fully and effectively, and where appropriate, will train or retrain employees to ensure that patient care standards are met or exceeded.

**Business Associate Agreement**

**This Business Associate Agreement** (“Agreement”) is entered into by and between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereafter referred to as the Covered Entity (“CE”) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereafter referred to as the Business Associate (“Associate”), and is effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (the “Agreement Effective Date”).

**RECITALS**

**WHEREAS,** Business Associate and CE have entered into an Agreement under which Business Associate performs or assists CE with functions or activities involving the use or disclosure of Individually Identifiable Protected Health Information (PHI) or electronic PHI;

**WHEREAS,** CE and Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), which privacy regulations are codified at 45 C.F.R. parts 160 and 164 and which security regulations are codified at 45 C.F.R. part 160, [162](http://prod.resource.cch.com/resource/scion/citation/pit/45CFR162/HCOMP-ALL?cfu=Legal&cpid=WKUS-Legal-IC&uAppCtx=RWI) and 164, as such regulations may be amended from time to time, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the “HITECH Act”), and the Omnibus Rule enacted in 2013. (collectively referred to herein as the “HIPAA Standards”);

**WHEREAS,** CE and Business Associate acknowledge and agree that capitalized terms used, but not otherwise defined, herein are as defined in the HIPAA Standards;

**WHEREAS,** the HIPAA Standards require that CE obtain satisfactory assurances that Business Associate will appropriately safeguard the PHI used or disclosed by Business Associate in the course of performing services pursuant to the Agreement.

**DEFINITIONS**

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

1. Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 CFR 160.103.
2. Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103.
3. HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

**OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE**

1. Compliance with Applicable Laws and Regulations. Business Associate shall, in the performance of its duties under this Business Associate Agreement, comply with all applicable state and federal laws, regulations, and rules including, without limitation, HIPAA’s Security Rule and the HITECH Act’s Privacy Provisions. Pursuant to this obligation, Business Associate must, at a minimum, perform a risk analysis, periodically reassess and update security protections and implement reasonable and appropriate security policies and procedures. Additionally, when carrying out a HIPAA obligation of CE, Business Associate must comply with the HIPAA Privacy Rule to the same extent as CE would be required to.
2. Nondisclosure. Business Associate shall not use or disclose PHI other than as permitted or required by the Agreement or as required by law. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by CE. Additionally, to the extent Business Associate is to carry out one or more of CE’s obligation(s) under Subpart E of 45 CFR Part 164, Business Associate must comply with the requirements of Subpart E that apply to CE in the performance of such obligation(s), except for the specific uses and disclosures set forth in this Agreement.
3. Safeguards. Business Associate shall use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement.

Business Associate shall implement and maintain safeguards as necessary to ensure that all PHI, including without limitation any electronic protected health information, is used or disclosed only as authorized under the HIPAA Standards and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to PHI in its possession and develop, implement, and maintain the administrative, physical, and technical safeguards required by the HIPAA Standards that protect the confidentiality, availability, and integrity of the PHI that Business Associate creates, receives, maintains, or transmits on behalf of CE. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Standards. Business Associate also agrees to implement policies and procedures that address Business Associate’s compliance with applicable HIPAA Standards and its efforts to detect, prevent, and mitigate the risks of identity theft resulting from the improper use and/or disclosure of an Individual's information.

1. Notification of Breach. Business Associate shall report to CE any use or disclosure of PHI not provided for by this Agreement of which it becomes aware, including suspected breaches of unsecured PHI as required at 45 CFR 164.410, or an Individual’s information not provided for by this Business Associate Agreement, including without limitation, any breach of PHI, unsecured PHI, or an Individual’s information, and any Security Incident involving the PHI or an Individual’s information of which Business Associate becomes aware, within twenty-four (24) hours of discovery of the suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. A breach shall be considered “discovered” as of the first day on which the breach is known, or reasonably should have been known, to Business Associate or any employee, officer, or agent of Business Associate, other than the individual committing the breach. Such notice shall identify the nature of the breach, including (i) a description of what happened; (ii) the date of the breach and (iii) specific elements of PHI that were subject to the breach.

Business Associate shall take any action necessary or requested by CE to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a security incident or use or disclosure of PHI, unsecured PHI, or an Individual’s information by Business Associate in violation of the requirements of this Business Associate Agreement. In the event of a breach of PHI or unsecured PHI, Business Associate’s notice to CE of such breach shall include, to the extent possible, the identification of each individual whose PHI has been, or is reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed during such breach. Business Associate shall also provide CE any other available information that CE is required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any action necessary as requested by CE to assist CE in complying with any applicable breach notification requirements.

Business Associate shall further take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations. Business Associate shall also report a pattern of material breach of PHI by a subcontractor, pursuant to 45 CFR 164.504 (e)(1)(ii).

Business Associate agrees to reasonably cooperate and coordinate with CE in the investigation of any violation of the requirements of this Agreement and/or any security incident or breach. Business Associate shall also reasonably cooperate and coordinate with CE in the preparation of any reports or notices to the individual, a regulatory body, or any third party required under HIPAA, the HITECH Act, or any other Federal or State laws, rules or regulations, provided that any such reports or notices shall be subject to the prior written approval of CE. Notwithstanding anything in this section to the contrary, Business Associate may delay notification of a breach of a Unsecured PHI to CE in the event Business Associate is instructed to do so by a law enforcement official.

1. Subcontractors. Business Associate shall,in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information. Business Associate acknowledges that if it or any of its subcontractors, regardless of any business associate agreement between Business Associate and such subcontractor, violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.
2. Availability of Information to the Department of Health and Human Services (HHS). Business Associate shall make available to HHS its internal practices, books, and records relating to the use and disclosure of PHI received from, or created, or received by Business Associate on behalf of, CE for purposes of HHS determining CE’s compliance a with the HIPAA Privacy Rule.
3. Availability of Information to Individuals and CE. Business Associate shall make available PHI in a designated record set to CE or to an individual designated by CE as necessary to satisfy CE’s obligations under 45 CFR 164.524. Business Associate shall also make available to CE such information as CE may require to fulfill CE’s obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to the HIPAA Laws as necessary to satisfy CE’s obligations under 45 CFR 164.524 and 45 CFR 164.528.
4. Amendment to PHI. Business Associate shall make any amendment(s) to PHI in a designated record set as directed or agreed to by CE pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy CE’s obligations under 45 CFR 164.526. Business Associate shall incorporate any amendments to the information in the designated record set within three (3) business days. Where CE receives a request for inspection and/or copying of PHI, which is created and maintained by Business Associate, CE’s Privacy Officer will pass along the request to Business Associate, and Business Associate shall be responsible for fulfilling the request as appropriate.
5. Accounting of Disclosures. Business Associate shall maintain and make available such disclosures of PHI and information related to such disclosures as would be required for CE or Business Associate to respond to a request by an Individual for an accounting of disclosures of PHI to satisfy CE’s obligations under 45 CFR 164.528. Business Associate shall provide the accounting of disclosures within five (5) business days.
6. Responding to an Individual’s Request for Accounting of Disclosures. Business Associate shall provide to CE, in a time and manner designated by CE, information pertaining to disclosures of PHI by Business Associate to permit CE to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of disclosures of PHI made by Business Associate during the six (6) years prior to the date of such request, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. §164.528.
7. Restrictions on Certain Disclosures of PHI. If an Individual requests that Business Associate restrict the disclosure of the Individual’s PHI to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the individual or by someone on his or her behalf (other than the health plan) for said item or service.
8. To the extent Business Associate is to carry out one or more of CE’s obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to CE in the performance of such obligation(s).
9. Internal Practices. Business Associate shall make its internal practices, books, records, and compliance and ethics reports relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, CE available to CE or the Secretary, in a time and manner designated by CE or the Secretary, for purposes of the Secretary determining CE’s or Business Associate’s compliance with the HIPAA Standards.

**PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE**

1. Business associate may only use or disclose PHI in only accordance with the specifications set forth in this Agreement and in accordance with 45 CFR 164.502 (e) (1) (iii) and 45 CFR 164.38 (b) (2), which can be modified at any time if agreed upon by both parties.
2. Business Associate is expressly prohibited from de-identifying PHI as defined in 45 CFR 164.514.
3. Business Associate may use or disclose PHI as required by law.
4. Except as otherwise permitted by the HIPAA Standards, when using or disclosing PHI or responding to a request for PHI, Business Associate must limit such PHI, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request consistent with CE’s minimum necessary policies and procedures.
5. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by CE, except for the specific uses and disclosures set forth below.
6. Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.
7. Business Associate may disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
8. Except as otherwise permitted by the HIPAA Standards, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any PHI unless CE has obtained from an Individual a valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the Individual’s PHI.
9. Except as otherwise permitted by the HIPAA Standards, Business Associate agrees that it will not use or disclose PHI in connection with any fundraising and/or marketing communication for or on behalf of CE unless CE has obtained a valid authorization from each Individual who will be a recipient of any such communication.
10. Business Associate shall develop and implement a system of sanctions for any employee, subcontractor or agent who violates this Agreement, the HITECH Act or HIPAA.
11. Business Associate may provide “data aggregation” services relating to the health care operations of CE. For purposes of this Section, “date aggregation” means, with respect to CE’s PHI, the combining of such PHI by Business Associate with the PHI received by Business Associate in its capacity as a Business Associate of another CE to permit data analyses that relate to the health care operations of the respective Covered Entities.

**OBLIGATIONS OF COVERED ENTITY**

1. CE shall provide Business Associate with the Notice of Privacy Practices that CE produces in accordance with 45 C.F.R. §164.520, as well as any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.
2. CE shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.
3. CE shall notify Business Associate of any restriction to the use or disclosure of PHI that CE has agreed to in accordance with 45 C.F.R. §164.522.
4. CE shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Standards if done by CE.
5. CE shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy, and security of PHI transmitted to Business Associate pursuant to this Agreement, in accordance with the standards and requirements of the HIPAA Laws, until such PHI is received by Business Associate.

**TERM AND TERMINATION**

1. Term. The Term of this Agreement shall be effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and shall terminate (1) when all of the PHI provided by CE to Business Associate, or created or received by Business Associate on behalf of CE, is destroyed or returned to CE, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with the termination provisions in this Section, or (2) on the date CE terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.
2. Termination for Cause. Business Associate authorizes termination of this Agreement by CE if CE determines Business Associate has violated a material term of the Agreement. CE may, at its discretion, allow Business Associate to cure a violation or breach of the contract before termination for cause within a timeframe specified by CE. If Business Associate does not cure the breach or end the violation within the timeframe specified by CE, or if cure is not possible, then CE shall terminate this Agreement forthwith. If termination of this Agreement is not feasible, CE shall report Business Associate’s breach or violation to the Secretary of the Department of Health and Human Services.

Material Breach shall include Business Associate’s improper use or disclosure of PHI and any changes or any diminution of Business Associate’s reported security procedures or safeguards that render any or all of Business Associate’s safeguards unsatisfactory to CE, in CE’s sole discretion.

Judicial or Administrative Proceedings – Either party may terminate this Agreement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of the HIPAA Laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of the HIPAA Laws or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

1. Obligations of Business Associate Upon Termination. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from CE, or created, maintained, or received by Business Associate on behalf of CE, shall:
2. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
3. Return to CE or, if agreed to by CE, destroy, the remaining PHI that Business Associate still maintains in any form;

In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to CE notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

1. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
2. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out above under “Permitted Uses and Disclosures By Business Associate” which applied prior to termination;
3. Return to CE or, if agreed to by CE, destroy, the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities;
4. Ensure the destruction of PHI created, received, or maintained by Business Associate’s subcontractors.

The parties hereto understand and agree that the terms of this Agreement are reasonable and necessary to protect the interests of CE and the Business Associate. The parties further agree that CE would suffer irreparable harm if the Business Associate breached this Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, CE shall be entitled to obtain injunctive relief to enforce the terms of this Agreement.

**MISCELLANEOUS**

1. Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.
2. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.
3. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.
4. Interpretation. This Agreement shall be interpreted as broadly as necessary to implement and comply with the Privacy and Security laws, rules and regulations as well as applicable state laws. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the parties to comply with the HIPAA Standards.
5. No Private Cause of Action. This Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Agreement, as a result of any claim arising out of the breach of this Agreement, the HIPAA Standards, or other state or federal law or regulation relating to privacy or confidentiality.
6. Application of State Law. Where any applicable provision of state law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Standards, the parties shall comply with the applicable provisions of state law.
7. Severability. If any provision of this Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable, or illegal provision shall be valid, enforceable, and legal to the maximum extent permitted by law.
8. Governing Law. This Agreement shall be interpreted, construed and governed according to the laws of the state in which CE maintains its principal place of business. The parties agree that venue shall lie in federal and state courts in the state in which CE maintains its principal place of business, without regard to its conflicts of law principles, regarding any and all disputes arising from this Agreement.
9. Notices. Any notice or other communication given pursuant to this Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the address set forth above and shall be considered given upon delivery.
10. Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement, Business Associate shall indemnify, hold harmless and defend CE (including CE’s Board of Directors, individually and collectively, and its officers, owners, members, employees, agents, and other representatives, individually and collectively) from and against any and all claims, losses, liabilities, costs, and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and/or subcontractors, in connection with any use or disclosure of PHI, Unsecured PHI or an Individual’s information not provided for by this Agreement, including without limitation any Breach of PHI, Unsecured PHI, or an Individual’s information, or any expenses incurred by CE in providing required breach notifications.
11. Disclaimer. CE makes no warranty or representation that compliance by Business Associate with this Agreement, the HIPAA Laws will be adequate or satisfactory for Business Associate’s own purposes or that any information in Business Associate’s possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
12. Certification. To the extent that CE determines that such examination is necessary to comply with CE’s legal obligations pursuant to the HIPAA Laws relating to certification of its security practices, CE or its authorized agents or contractors, may, at CE’s expense, examine Business Associate’s facilities systems, procedures, and records as may be necessary for such agents or contractors to certify to CE the extent to which Business Associate’s security safeguards comply with the HIPAA Laws or this Agreement. Business Associate may elect to retain an independent third-party to conduct a privacy audit in lieu of inspection by CE or its authorized agents or contractors. Business Associate’s selection of an independent third-party is subject to CE’s approval. CE and Business Associate agree to equally share the expense incurred in hiring such independent third-party.
13. Agreement. CE and Business Associate agree that both CE and Business Associate are required to comply as “covered entities” under the HIPAA Laws and the obligations of this Agreement are intended to apply mutually to both CE and Business Associate.
14. Agreement to Comply with Law. The parties acknowledge that applicable state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of the HIPAA Laws and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all PHI that it receives or creates pursuant to this Agreement. Upon CE’s request, Business Associate agrees to promptly to enter into negotiations with CE concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of the HIPAA Laws or other applicable laws. CE may terminate this Agreement upon thirty (30) days written notice in the event that (1) Business Associate does not promptly enter into negotiations to amend this Agreement when requested by CE pursuant to this Section; or (2) Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of the HIPAA Laws.
15. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself, and any subcontractors, employees, or agents assisting Business Associate in the performance of its obligations under this Agreement, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers, or employees based upon claimed violation of the HIPAA Laws or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee, or agent is a named adverse party.
16. No Third-Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
17. Effect on Agreement. Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the Agreement shall remain in force and effect.
18. Integration and Interpretation. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter.

IN WITNESS WHEREOF, the parties hereto have executed this Business Associate Agreement as of the Effective Date.

BUSINESS ASSOCIATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Title

COVERED ENTITY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Title

*Date*

*Name of vendor representative*

*Vendor/Health Care Provider Name*

*Address*

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a part of {Facility}’s Compliance and Ethics program to meet and exceed all regulatory requirements, we are contacting our business associates regarding recent changes to HIPAA and HITECH regulations. In particular, new regulations require additional efforts on the part of business associates in protecting health care information. This includes the preparation, distribution, and signing of new business associate agreements laying out these new government efforts. Please read, sign, and return the enclosed agreements. You can always contact us with any questions that you may have.

Under these new regulations, business associates are expected to institute and maintain HIPAA Compliance and Ethics programs. Among the new requirements are standards for utilizing electronic records. Specific safety programs must be in place to prevent unintended or unauthorized breaches of protected health information. Additionally, business associates must take a proactive approach in supervising the HIPAA Compliance of any subcontractors. All business associates and subcontractors can be investigated by the U.S. Department of Health and Human Services, even if their services are not health related. Criminal charges are a possibility for severe situations.

We appreciate your attention to this matter and look forward to continuing our business relationship.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Administrator

Decision Tree: When is a Business Associate Agreement Required?

Covered Entities (CE) under HIPAA, are required to sign Business Associate Agreements (BAAs) with certain organizations and individuals to whom they share Protected Health Information (PHI). Business Associates are outside organizations or individuals who perform some function or service for the CE that requires them to have access to residents’ PHI.

Point 1:

* “Is Protected Health Information (PHI) being disclosed to an outside entity?”
* You must understand what constitutes PHI to make this determination. PHI can be broadly defined as meaning:
  + Any oral or recorded information relating to past, present, or future physical or mental health of an individual, the provision of health care to the individual, or the payment for health care which also contains information which makes it possible to identify the individual.

If you decide that PHI is actually being disclosed from your site, then move on to Point 2.

**Point 2:**

* Is PHI being disclosed to another healthcare provider for treatment purposes only?
* Frequent disclosures made to outside entities are for services or products used solely to treat a resident or group of residents. When the disclosure of PHI is to outside entities for treatment only purposes, then a BAA is not required.
* *The following are common examples of disclosures of PHI that do not require BAAs due to the “treatment only” provision:*
  + *Providers of direct health care services for residents such as: attending physicians, dentists, podiatrists, psychologists, hospitals, clinics, dialysis facilities, laboratories, radiology providers, pharmacy distributors, and optometrists.*
  + *Providers of medical or care related supplies including such as pumps and other durable medical equipment.*
  + *Ambulance and other medical transportation systems that request residents billing information in order to transport.*
  + *SPECIAL NOTE: There are instances where health care professionals provide treatment directly to the resident on their behalf, yet also perform other services on the facility’s behalf and would be considered a Business Associate. For example, a pharmacy may not only distribute medications but may also provide pharmacy consultant services. Likewise, a medical supply company may not only supply the wound care product but may also provide wound therapy consultation.*

These situations highlight the importance of examining all dimensions and functions of the relationship between the outside entity and the facility before making a quick decision. You cannot assume exemption simply based on job title or function.

**Point 3:**

* Is PHI being disclosed to an insurance plan for Payment Purposes?
* A facility may disclose PHI to an insurance plan, including private insurance, Medicaid and Medicare, for residents, in order to assure payment for those services. Neither the health plan nor the facility is considered business associates of each other since both are considered to act individually on behalf of the resident.
* *The following examples illustrate payment for services that do not require a BAA:*
  + *Resident information sent to CMS for categorization and payment.*
  + *Rehabilitation progress notes sent to a managed care company to verify treatment sessions.*
  + *Benefit and eligibility verification on the part of the facility.*
  + *SPECIAL NOTE: If documents containing PHI, such as a remittance advice or Explanation of Benefits (EOB), are given to a bank in order to consolidate payments to the facility, then a BAA would be required. In this situation, they are performing a function on behalf of the facility and not for the individual resident.*
  + *Psychotherapy notes are an exception that cannot be released for payment without patient authorization.*

**Point 4:**

* Is PHI being disclosed for official investigation or proceeding?
* There are a number of exemptions to the BAA requirement if the PHI that is disclosed is required for:
  + Activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections and licensure; disciplinary actions; civil, administrative, or criminal proceedings or actions.
  + Appropriate governmental oversight of health care systems, government benefit programs, or government regulatory programs
* *The following examples illustrate disclosure of PHI to oversight, regulatory and legal agencies that do not require a BAA.*
  + *Reporting of state-required reportable diseases to the Department of Public Health. Some examples of diseases that may require notification are:*
    - *AIDS, Malaria*
    - *Anthrax, Plague*
    - *Botulism, Rubella*
    - *Diphtheria, Streptococcal disease, invasive, group A*
    - *Legionellosis, Syphilis*
    - *Malaria, Tuberculosis*
  + *A CMS survey (e.g. the facility’s annual health department survey) where PHI is reviewed by a surveyor*
  + *A Department of Health/DHHS/State agency visit which was prompted due to staff/visitor/patient complaint*
  + *Death reporting to the state*
  + *Law enforcement officials investigating abuse of a patient*
  + *OSHA reporting*
  + *To a social services or protective agency authorized to receive reports of abuse, neglect, or domestic violence (except child abuse)*
  + *For judicial or administrative proceedings where required by order of a court or in response to a subpoena or discovery request.*

Decide first if the oversight agency has legal authority to receive the PHI. If so, then a BAA is not required.

**Point 5:**

* Is PHI being disclosed or accessed on behalf of the facility?
* The term “on behalf of the facility” means a function or service that is necessary for a facility, but the organization chooses to outsource to another entity. These situations will require a BAA when the exchange of PHI is necessary for the function or service to be performed.
* The function or service is provided for the direct benefit of the facility and typically involves activities that support, and/or enhance the facility’s ability to provide direct care to residents.
* Specific examples include:
  + Accounting
  + Collections
  + Claims processing or administration
  + Data analysis, processing or administration
  + Billing
  + Benefit management
  + Practice management
  + Medical director (administrative role)
  + Legal services
  + Actuarial services
  + Consulting on operational or business functions including audit and health information technology
  + Data aggregation as defined by HIPAA
  + Software hosting
  + Management of data or clinical services
  + Utilization review
  + Resident safety organizations
  + Accreditation bodies
  + HealthInfoNet or other regional IT exchange
  + E-prescribing gateways
  + Other entity that provides data transmission services requiring routine access to PHI
  + Personal health record service provider
  + Financial services
  + Transcription services
  + Medicaid transportation broker
  + Private vendors that provide eligibility or pre-authorization services
  + Quality assurance
  + Administrative services
  + Those who store or otherwise maintain PHI[[4]](#footnote-5)
  + Health Information Organizations (HIOs), e-prescribing gateways and others who provide data transmission services to a covered entity and require routine access to PHI
  + Subcontractors[[5]](#footnote-6) of business associates, if the business associate delegates to the subcontractor a function, activity or service that the business associate has agreed to perform for the CE, or for another business associate and any of the delegated functions, activities or services involve the creation, receipt, maintenance, or transmission of PHI. Essentially, all downstream entities with access to PHI are now covered.
  + Anyone who offers a personal health record to individuals on behalf of a CE.
* *The following are examples of services provided on the CE’s behalf that would require a BAA.*
  + *Agencies providing accreditation services*
  + *Medical Directors acting in their administrative role on behalf of a facility*
  + *Software vendors having access to PHI during the course of business*
  + *Computer hardware service companies having access to PHI in electronic form*
  + *Companies providing billing services that have access to PHI in the course of receiving electronic transactions to submit to payers for reimbursement*
  + *Non-Facility Consultants such as: HIM/Medical Record, Dietary, Infection Control*
  + *Payers performing functions that are in addition to, and not directly related to the provision of insurance*
  + *Attorneys who are representing the facility in a legal dispute*
  + *Shredding services that have direct access to PHI in order to do their job.*

*SPECIAL NOTE: In the vast majority of cases where PHI is exchanged with an outside entity on the facility’s behalf, the facility is responsible to pay the entity for the service or product the outside entity provides. This is in contrast to the “treatment only” situation where the patient themselves or their insurer are typically financially responsible.*

**Point 6:**

* Is the entity that is receiving the PHI considered part of your workforce?
* Workforce is defined as employees, volunteers, students, trainees, and other persons whose conduct, in the performance of work, is under the direct control of the covered entity, whether or not they are paid by the covered entity.
* *The following examples are typical instances of people who are not employed by us but are defined by HIPAA as “workforce”, and would not need a BAA.*
  + *A volunteer working in HIM/Medical records filing loose reports of discharged patients – The volunteer’s conduct is under the control of the facility.*
  + *A student performing a clinical internship at the facility - Although their internship defines the scope of their activities, while they are in the facility, the performance of these activities is supervised/overseen by a member of the CE’s workforce.*

**Point 7:**

* Is PHI being disclosed preparatory to research purposes?
* The Privacy Rule permits CEs to use and disclose PHI for research purposes with individual resident authorization and without authorization under limited circumstances, although research protocols will require Institutional Review Board (IRB) approval.
* During the preparatory to research process, a researcher who is an employee or member of the CE’s workforce can use PHI to contact prospective research subjects. The preparatory research provision would allow such a researcher to identify prospective research participants for purposes of seeking their authorization to use or disclose PHI for a research study.
* A CE could also contract a Business Associate, who may assist in contacting individuals on behalf of the entity to obtain their authorization. In this situation, a BAA is required.

**{Facility}**

**Identity Theft Prevention And Detection/Red Flags Rule Policy And Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with all federal and state statutes and regulations with regard to identifying, detecting, and responding to potential cases (“Red Flags”) of the theft of a resident’s identity.

**POLICY**

It is the policy of the Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the facility (“Associates”), to follow all federal and state statutes and regulations regarding identity theft. Specifically, this policy outlines how the Facility will identify, detect, and respond to Red Flags. A Red Flag includes a pattern, practice, or specific account or record activity that indicates possible identity theft.

The Compliance and Ethics Officer/Security Officer shall be responsible for implementing and maintaining the Red Flags Rule requirements, and will be provided sufficient resources and authority to fulfill these responsibilities. Additionally, pursuant to the Facility’s HIPAA Privacy and Data Security policies and procedures, the Facility shall ensure that appropriate physical, administrative, and technical safeguards will be in place to reasonably safeguard protected health information (PHI) and sensitive information related to resident identity from any intentional or unintentional use or disclosure.

**PROCEDURE**

1. Identify Red Flags
   1. In the course of caring for residents, the Facility may encounter inconsistent or suspicious documents, information, or activity that may signal identity theft, such as:
      1. A complaint or question from a resident based on the resident’s receipt of:
         1. A bill for another individual;
         2. A bill for a product or service that the resident denies receiving;
         3. A bill from a health care provider that the resident never patronized; or
         4. A notice of insurance benefits (or explanation of benefits) for health care services never received.
      2. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the resident.
      3. A complaint or question from a resident about the receipt of a collection notice from a bill collector.
      4. A resident or health insurer report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.
      5. A complaint or question from a resident about information added to a credit report by a health care provider or health insurer.
      6. A dispute of a bill by a resident who claims to be the victim of any type of identity theft.
      7. A resident who has an insurance number but never produces an insurance card or other physical documentation of insurance.
      8. A notice or inquiry from an insurance fraud investigator for a private health insurer or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.
2. Detecting Red Flags
   1. The Facility’s Associates will be alert for discrepancies in documents and resident information that suggest risk of identity theft or fraud. The Facility will verify resident identity, address, and insurance coverage at the time of resident registration/check-in.
      1. Upon admission, the resident or the person admitting the resident, be asked to provide the following:
         1. Driver's license or other photo ID;
         2. Current health insurance card; and
         3. Utility bills or other correspondence showing current residence if the photo ID does not show the resident’s current address.
   2. Associates should be alert for the possibility of identity theft in the following situations:
      1. The photograph on a driver’s license or other photo ID submitted by the resident does not resemble the resident.
      2. The resident submits a driver’s license, insurance card, or other identifying information that appears to be altered or forged.
      3. Information on one form of identification the resident submitted is inconsistent with information on another form of identification or with information already in the Facility’s records.
      4. An address or telephone number is discovered to be incorrect, non-existent or fictitious.
      5. The resident fails to provide identifying information or documents
      6. The resident’s signature does not match a signature in the Facility’s records.
      7. The Social Security number or other identifying information the resident provided is the same as identifying information in the Facility’s records provided by another individual, or the Social Security number is invalid.
3. Response to a Red Flag
   1. If a Red Flag is detected by an Associate, the Facility shall:
      1. The Associate shall gather all documentation and report the incident to his or her immediate supervisor or the Facility’s Compliance and Ethics Officer,
      2. The Compliance and Ethics Officer shall conduct an investigation in order to determine whether the Red Flag activity is fraudulent or authentic.
      3. If the Compliance and Ethics Officer determines that the Red Flag activity is indeed fraudulent activity, then the Facility shall take immediate action, including but not limited to:
         1. Canceling the transaction in question;
         2. Notifying appropriate law enforcement;
         3. Notifying the affected resident, or the resident’s family;
         4. Notifying the resident’s insurance company;
         5. Changing any passwords, security codes, or other security devices that permit access to an account;
         6. Notifying affected healthcare providers;
         7. Adjusting charges to the covered account that were fraudulently incurred; and
         8. Promptly considering what further remedial act/notifications may be needed under the circumstances.
      4. The Compliance and Ethics Officer and the Medical Records Director will review the affected resident’s medical record to confirm whether documentation was made in the resident’s medical record that resulted in inaccurate information in the record. If such inaccuracies due to identity theft exist, a notation should be made in the record to indicate identity theft.
      5. The Compliance and Ethics Officer and Medical Records Director will determine whether any other records and/or ancillary service providers are linked to inaccurate information. Any additional files containing information relevant to identity theft will be removed and appropriate action taken.
   2. If following investigation, it does not appear that the resident was a victim of identity theft; the Facility will take whatever action it deems appropriate.
4. If a resident claims to be a victim of identity theft – even if the Facility has not been able to substantiate the claim:
   1. The resident should be encouraged to file a police report for identity theft if he/she has not done so already.
   2. The resident should be encouraged to complete the ID Theft Affidavit developed by the Federal Trade Commission, along with supporting documentation. (See a copy of this Affidavit attached to this policy.)
   3. The Facility will compare the resident’s documentation with personal information in the Facility’s records.

{Facility}

Anti-Harassment Policy and Procedure

PURPOSE

To ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for {Facility} (the “Facility” or “Associates”) are not subject to harassment in the workplace.

POLICY

The Facility strictly prohibits and has zero tolerance for any unlawful harassment against any Associates because of race, religion, creed, national origin, ancestry, sex (including pregnancy), gender (including gender nonconformity and status as a transgender or transsexual individual), age (40 and over), physical or mental disability, reprisal, parental status, marital status, political affiliation, citizenship, genetic information, past, current or prospective service in the uniformed services, or any other characteristic protected under applicable federal, state, or local law.

PROCEDURE

1. Definition of Harassing Conduct

For the purposes of this policy, harassing conduct is defined as any unwelcome verbal or physical conduct based on any characteristic protected by law when:

* 1. The behavior can reasonably be considered to adversely affect the work environment; or
  2. An employment decision affecting the employee is based upon the employee's acceptance or rejection of such conduct.

1. Sexual Harassment

All the Facility Associates are prohibited from harassing Associates based on that individual’s sex or gender (including pregnancy and status as a transgender or transsexual individual) and regardless of the harasser’s sex or gender.

Sexual harassment means any harassment based on someone’s sex or gender. It includes harassment that is not sexual in nature (for example, offensive remarks about an individual’s sex or gender), as well as any unwelcome sexual advances or requests for sexual favors or any other conduct of a sexual nature, when any of the following is true:

* 1. Submission to the advance, request, or conduct is made either explicitly or implicitly a term or condition of employment.
  2. Submission to or rejection of the advance, request or conduct is used as a basis for employment decisions.
  3. Such advances, requests or conduct have the purpose or effect of substantially or unreasonably interfering with an Associate’s work performance by creating an intimidating, hostile or offensive work environment.

1. Sexual harassment may be verbal or physical, exhibited by a man to a woman, by a woman to a man, or within the same gender. The Facility will not tolerate any form of sexual harassment, regardless of whether it is:
   1. Verbal (for example, epithets, derogatory statements, slurs, sexually-related comments or jokes, unwelcome sexual advances or requests for sexual favors).
   2. Physical (for example, assault or inappropriate physical contact).
   3. Visual (for example, displaying sexually suggestive posters cartoons, or drawings, sending inappropriate adult-themed gifts, leering or making sexual gestures).

This list is illustrative only, and not exhaustive. No form of sexual harassment will be tolerated.

Harassment is prohibited both at the workplace and at the Facility-sponsored events.

1. Other Types of Harassment

The Facility’s anti-harassment policy applies equally to harassment based on an Associate’s race, religion, creed, national origin, ancestry, sex (including pregnancy), gender (including gender nonconformity and status as a transgender or transsexual individual), age (40 and over), physical or mental disability, reprisal, parental status, marital status, political affiliation, citizenship, genetic information, past, current or prospective service in the uniformed services, or any other characteristic protected under applicable federal, state or local law.

1. Such harassment often takes a similar form to sexual harassment and includes harassment that is:
   1. Verbal (for example, epithets, derogatory statements, slurs, derogatory comments or jokes).
   2. Physical (for example, assault or inappropriate physical contact).
   3. Visual (for example, displaying derogatory posters, cartoons, drawings or making derogatory gestures).

This list is illustrative only, and not exhaustive. No form of harassment will be tolerated.

Harassment is prohibited both at the workplace and at the Facility-sponsored events.

1. Reporting
   1. Associates that witness or are subjected to any conduct that violates this policy, must report such conduct to their department head or any other department head as soon as possible. Associates may also directly report such conduct to the Compliance and Ethics Officer.
   2. The Facility will directly and thoroughly investigate all complaints of workplace violence and will take prompt corrective action, including discipline, if appropriate. The Facility reserves the right to contact law enforcement, if appropriate.
2. No Retaliation

No one will be subject to, and the Facility prohibits, any form of discipline, reprisal, intimidation, or retaliation for good faith reporting of incidents of harassment of any kind, pursuing any harassment claim or cooperating in related investigations.

1. Violations of this Policy

Any Associate, regardless of position or title, who is determined to have subjected an individual to harassment or retaliation in violation of this policy, will be subject to discipline, up to and including immediate termination of employment.

1. Administration of this Policy

The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.

1. Employees Covered under a Collective Bargaining Agreement

The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

**{Facility}**

**Anti-Intimidation and Anti-Retaliation Policy and Procedure**

PURPOSE

To ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for {Facility} (the “Facility” or “Associates”) are not subject to intimidation and/or retaliation for participating in any activity protected by law.

POLICY

The Facility has a zero-tolerance policy for intimidation, retaliation, or retribution against any Associate who, in good faith, reports suspected misconduct or fraud, waste, and abuse, by any Associate. All forms of unlawful retaliation are prohibited, including any form of discipline, reprisal, intimidation, or other form of retaliation taken against an Associate for participation in any activity protected by law.

**PROCEDURE**

1. Examples of protected activities include:
   1. Lodging a good faith complaint (even an informal compliant) with the Compliance and Ethics Officer or any department head alleging a violation of any federal or state law.
   2. Lodging a good faith internal complaint (written or oral) with human resources or management specifically opposing unlawful discrimination or harassment or complaining about violations of wage and hour law.
   3. Lodging a good faith complaint alleging a violation of any federal or state fraud, waste, and abuse law.
   4. Filing a good faith complaint of unlawful discrimination or harassment with the US Equal Employment Opportunity Commission (EEOC) or in court.
   5. Participating in the Facility's internal investigation into allegations of sexual harassment.
   6. Supporting another Associate’s internal or administrative complaint of unlawful discrimination.
   7. Requesting an accommodation under the Americans with Disabilities Act or any state anti-discrimination statutes.
   8. Requesting or taking leave under the Family and Medical Leave Act or any state leave statutes.
   9. Filing a worker’s compensation claim.
   10. Filing a complaint with a federal or state enforcement or administrative agency.
   11. Participating in or cooperating with a federal or state enforcement agency that is conducting an investigation of the Facility regarding alleged unlawful activity.
   12. Testifying as a party, witness, or accused regarding alleged unlawful activity.
   13. Associating with another Associate who is engaged in any of these activities.
       1. The examples above are illustrative only, and not exhaustive. No form of retaliation for any protected activity will be tolerated.
2. Reporting
   1. Associates that witness or are subjected to any conduct that violates this policy, must report such conduct to their department head or any other department head as soon as possible. Associates may also directly report such conduct to the Compliance and Ethics Officer.
   2. The Facility will directly and thoroughly investigate all complaints of intimidation and retaliation and will take prompt corrective action, including discipline, if appropriate. The Facility reserves the right to contact law enforcement, if appropriate.
3. No Intimidation and Retaliation
   1. No one will be subject to, and the Facility prohibits, any form of discipline, reprisal, intimidation, or retaliation for all good faith participation in the Compliance and Ethics program, reporting of Compliance and Ethics issues, and for cooperating in related investigations. This includes, but is not limited to, reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials.
   2. The Facility strictly prohibits intimidation, retaliation, discrimination, harassment, or any other adverse action by management or any other person or group, either directly or indirectly, against any individual or group for good-faith participation in the Facility’s 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; for reporting a potential violation of the Compliance and Ethics Program; or for other misconduct in good faith. No individual may intimidate or threaten to retaliate against another individual for filing such a report or for participating in good faith in an investigation of any Compliance and Ethics matter, including matters related to resident safety and treatment or resident confidentiality.
   3. Prohibited retaliation includes, but is not limited to,
      1. Termination
      2. Suspension
      3. Demotion
      4. Failure to consider for promotion
      5. Harassment
      6. Reduction in compensation
      7. Adverse change in working conditions.
   4. Retaliation is prohibited even if it is determined that the allegedly improper conduct covered by a report was proper or did not occur, provided that the report was made in good faith. The Facility reserves the right to take disciplinary action against any employee who maliciously or intentionally files a report he or she knows to be untrue.
4. Violations of this Policy

Any Associate, regardless of position or title, who is determined to have subjected an individual to harassment or retaliation in violation of this policy, will be subject to discipline, up to and including immediate termination of employment.

1. Administration of this Policy

The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.

1. Employees Covered under a Collective Bargaining Agreement

The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

**{Facility}**

**Discipline Policy and Procedure**

**PURPOSE**

To ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for {Facility} (the “Facility” or “Associates”) are aware of corrective/disciplinary measures to be taken upon noncompliance with the Facility’s Compliance and Ethics Program or improper/illegal activities related to the Compliance and Ethics Program as a means of facilitating the overall goals of the Compliance and Ethics Program. The Facility has well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the Compliance and Ethics Program by all Associates.

**POLICY**

It is the policy of the Facility to take appropriate disciplinary action against Associates that violate the letter or spirit of the Compliance and Ethics Program when conducting their daily business affairs. All Associates are expected to comply with governing laws and regulations, as well as provisions of the Facility’s Compliance and Ethics Program, Code of Conduct, and any other applicable policies. All Associates are required to participate in required Compliance and Ethics trainings and in-services that educate Associates as to Compliance and Ethics in general and with regard to specific Compliance and Ethics expectations and issues. Failure to do so may result in the use of disciplinary action to correct such situations and, as appropriate, motivate Associates to participate directly in the resolution of the matter.

Disciplinary action shall be administered on a fair and equitable basis, appropriate to the seriousness of the violation and consistent with the Facility’s personnel policies and procedures. Enforcement of disciplinary action will be consistent across all levels and rankings within the company. Depending on the severity of the violation, progressive steps in the disciplinary action process may be omitted if appropriate in order that immediate corrective measures, including termination, can be taken.

The actions listed below are guidelines only. Nothing in this Policy or any other Compliance and Ethics Policies and Procedures should be construed as preventing, limiting, or delaying the Facility from taking other appropriate disciplinary action, including immediate termination, in any circumstances where the Facility, in its sole discretion, deems such action appropriate.

Nothing in this policy or any other Compliance and Ethics Policies and Procedures is intended to alter the “at-will” nature of the employment relationship between the Facility and its employees as set forth in the Facility’s employment policies.

**PROCEDURE**

1. Violations Subject to Disciplinary Actions
   1. The following are examples of violations that will subject an Associate to discipline ranging from an oral reprimand to termination:
      1. Violation of federal or state law related to health care
      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
      5. Negligently providing false or misleading information to the organization, including but not limited to a government agency, customer, insurer, or the like
      6. Negligent violation of any federal, state, or local law, rule or regulation
      7. Failure to report another Associate’s conduct which violates any law, rule, or regulation
      8. Failure or refusal to cooperate with the Facility in any Compliance and Ethics investigation
      9. Failure or refusal to assist in the resolution of Compliance and Ethics issues
      10. Supervisors failing to exercise adequate supervision of subordinate personnel where such failure leads, directly or indirectly, to a Compliance and Ethics incident
      11. Encouraging, directing, facilitating, or permitting non-compliant behavior
      12. Engaging in any other conduct which fails to comply with the duties and prohibitions, express or implied, set forth in the Code of Conduct.
   2. The following are examples of violations that will subject an Associate to immediate termination:
      1. Intentional violation of any federal, state, or local law, rule or regulation
      2. Intentionally providing false or misleading information to the organization, including but not limited to a government agency, customer, insurer, or the like
      3. Direct retaliation against any Associate who in good faith reports a Compliance and Ethics incident
      4. Indirect retaliation or attempting to directly or indirectly retaliate against an Associate who in good faith reports a Compliance and Ethics incident
      5. Sexual harassment or prohibited harassment or discrimination against another Associate.
2. Disciplinary Measures
   1. Associates will be subject to various forms of disciplinary measures or sanctions, depending on the offence committed, including:
      1. Oral or written warnings
      2. Suspension from employment or service
      3. Privilege revocation
      4. Termination
      5. Financial penalties
   2. The Compliance and Ethics Officer shall determine the form of discipline to be imposed based on the individual circumstances of the violation. The disciplinary measures will be consistently applied and enforced for all Associates that commit similar offences under similar circumstances.
   3. Associates that commit violations which are negligent or reckless in nature shall be subject to more severe disciplinary actions.
   4. Discipline will be enforced by the Compliance and Ethics Officer, department supervisors, or other members of administration as appropriate.
3. Investigation
   1. A thorough investigation shall be conducted before disciplinary action is administered. Depending on the situation, the investigation may be conducted by a supervisor, manager, Compliance and Ethics Officer, or outside entity. All Associates are required to assist in the resolution of the investigation in the appropriate manner. Associates who willfully hinder the investigation will themselves be subject to disciplinary action.
   2. If the Facility determines after a thorough investigation that action beyond counseling is warranted, it is the duty of the Compliance and Ethics Officer to initiate disciplinary action. Depending on the situation, the Compliance and Ethics Officer may need to discuss the action with outside legal counsel to ensure appropriate applicability, documentation, and procedure.
4. Suspension Pending Investigation
   1. During investigations of any Associate 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.
5. Evaluation of Relevant Circumstances
   1. The Facility shall consider the nature and seriousness of the infraction, all relevant facts and information, and any mitigating or aggravating circumstances when formulating disciplinary action. An Associate who has committed a violation of the Compliance and Ethics Program **may** be subject to a lesser or greater level of disciplinary action – at the sole discretion of the Facility – than that called for under the disciplinary guidelines.
   2. All guidelines shall be applied consistently and in a non-discriminatory manner, and thorough documentation is essential. Senior management, the Compliance and Ethics Officer, Human Resources, or legal counsel should be consulted as appropriate when evaluating the circumstances affecting disciplinary action.
   3. As a general rule, disciplinary action shall be more severe for conduct that is a knowing, intentional, willful, or reckless violation of the law or of the Facility’s standards or policies. Intentional or reckless noncompliance is to be punishable with “significant sanctions,” which can range from oral warnings to suspension or termination as appropriate. Where the guidelines below recommend termination, a lesser disciplinary action may be imposed, at the Facility’s sole discretion, after consideration of all relevant facts, including, without limitation, mitigating and aggravating circumstances.
   4. Mitigating Circumstances – Circumstances that shall be considered to be mitigating can include:
      1. The Associate promptly reported his or her own violation,
      2. The report constitutes the Facility’s first awareness of the violation and the Associate’s involvement, and
      3. The Associate cooperates fully in investigating and/or correcting the violation.
      4. Admission of wrongdoing does not guarantee protection from disciplinary or corrective action. The weight to be given to the admission shall depend on all the facts known to the Facility at the time the decision concerning disciplinary or corrective action is made. Such facts include whether the Associate’s conduct was known or its discovery was imminent prior to the admission, and whether the admission was complete and truthful.
   5. Aggravating Circumstances – Circumstances that shall be considered to be aggravating include, but are not limited to:
      1. The existence of a prior record of discipline and the nature and extent of that record
      2. The current misconduct found or acknowledged by the Associate evidences multiple acts of wrongdoing or demonstrates a pattern of misconduct
      3. The Associate’s misconduct was surrounded by or followed by bad faith, dishonesty, concealment, overreaching or other violations of the Facility’s policies and procedures
      4. The Associate’s misconduct significantly harmed the Facility
      5. The Associate demonstrated indifference toward rectification of or atonement for the consequences of his or her misconduct;
      6. The Associate displayed a lack of candor or cooperation with the Facility during the investigation or disciplinary process.
6. Compliance and Ethics Report
7. The Compliance and Ethics Officer will complete a Compliance and Ethics Program report and keep the report as part of the Compliance and Ethics Program. In addition to disciplinary actions, the Compliance and Ethics Officer, Department Supervisors, and members of Administration may utilize corrective action plans to address specific instances of non-Compliance.

**{Facility}**

**The Elder Justice Act and Reporting Suspected Crimes Against Residents Policy and Procedure**

**PURPOSE**

To facilitate efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation and to protect elders with diminished capacity while maximizing their autonomy and their right to be free of abuse, neglect, and exploitation.

**POLICY**

It is {Facility}’s (the “Facility”) policy to empower and enable any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others (“Associates”) working for the Facility to make reports to the relevant authorities pursuant to the provision of the Elder Justice Act (“EJA”) and CMS regulations. The Facility will not retaliate against any Associate in response to lawful acts done by the Associate pursuant to the EJA.

**PROCEDURE**

1. Duty to Report
   1. All Associates have a duty to report any “reasonable suspicion” of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the Facility pursuant to Section 1150B of the Social Security Act (the “Elder Justice Act”).
   2. The Facility has a duty to report all “alleged violations” of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, as well as the results of all investigations of alleged violations pursuant to 42 CFR 483.12(c).
      1. An injury shall be classified as an “injury of unknown source” when both of the following criteria are met:

* The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
* 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.

1. Failure to Report – Penalties
   1. Any Associate that fails to make the report required under Section I.A. above, shall be subject to a civil money penalty of up to $200,000; and the Secretary may make a determination to exclude the Associate from participation in any federal health care program.
   2. Increased harm
      1. If an Associate fails to make the reports required under I.A. above and thus the harm to the resident or another individual is exacerbated, the Associate individual shall be subject to a civil money penalty of up to $300,000; and the Secretary may make a determination to exclude the Associate from participation in any federal health care program.
2. What must be reported?

Crimes must be reported. Crimes include, but are not limited to,

* 1. Abuse. This includes:
     1. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
     2. 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.
     3. Instances of abuse of all residents, irrespective of any mental or physical condition, that cause physical harm, pain or mental anguish. This includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.
        1. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
        2. Sexual abuse is non-consensual sexual contact of any type with a resident.
  2. Exploitation

Defined as:

* + - 1. taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion, or
      2. the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.
  1. Neglect
     1. Neglect is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to maintain the health or safety of a resident and to avoid physical harm, pain, mental anguish, or emotional distress; or
     2. Self-neglect.
        1. Defined as an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including
           1. obtaining essential food, clothing, shelter, and medical care;
           2. obtaining goods and services necessary to maintain physical health, mental health, or general safety; or
           3. managing one's own financial affairs.
  2. Serious Bodily Injury
     1. Such as injuries:
        1. involving extreme physical pain;
        2. involving substantial risk of death;
        3. involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty;
        4. requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or
        5. criminal sexual abuse
           1. non-consensual sexual contact of any type with a resident, e.g. sexual abuse, aggravated sexual abuse, or any similar offense under state law.
  3. Mistreatment.
     1. Defined asinappropriate treatment or exploitation of a resident.
  4. Exploitation
     1. Defined as taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.
  5. Misappropriation of Resident Property
     1. 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.

1. Where to report?
   1. “Reasonable Suspicion” of a Crime
      1. Pursuant to the EJA, Associates must report reasonable suspicions of a crime to the State Survey Agency and at least one local law enforcement entity.
   2. “Alleged Violations” of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, as well as the results of all investigations of alleged violations –
      1. Pursuant to 42 CFR 483.12(c), Associates must report to the Administrator or other designated Facility representative (the “Facility”) and the Facility must report the alleged violations to (1) the State Survey Agency, (2) at least one local law enforcement entity (see below Section IV.C), and (3) the adult protective services if applicable state law provides for jurisdiction in long-term care facilities.
   3. Law Enforcement. Includes the full range of potential responders to elder abuse, neglect, and exploitation including:
      1. police, sheriffs, detectives, public safety officers, and corrections personnel;
      2. prosecutors;
      3. medical examiners;
      4. investigators; and
      5. coroners.
2. When to Report?
   1. Reasonable Suspicion under the EJA
      1. If there are events that cause suspicion that the resident may suffer, or has suffered from, a serious bodily injury, then the Associate must **report the suspicion immediately, but not later than 2 hours after forming the suspicion.**
      2. If the events that cause the suspicion do not result in serious bodily injury, the Associate must report the suspicion **not later than 24 hours after forming the suspicion**.
   2. Alleged Violations under 42 CFR 483.12(c)
      1. **Immediately** (for alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) but not later than:
         1. **2 hours-if the alleged violation involves abuse or results in serious bodily injury**
         2. **24 hours-if the alleged violation does not involve abuse and does not result in serious bodily injury.**
         3. **Results of all investigations of alleged violations-within 5 working days of the incident**

* An “Alleged violation” is defined as a situation or occurrence that is observed or reported by staff, resident, relative, visitor 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.

1. Non-Retaliation
   1. The Facility will not:
      1. Discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee pursuant to the EJA; or
      2. File a complaint or a report against a nurse or other employee with the appropriate state professional disciplinary agency because of lawful acts done by the nurse or employee, for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to the EJA.
   2. Penalties for Retaliation
      1. Violation of the non-retaliation policy can subject the Facility to a civil money penalty of up to $200,000 or the Secretary may classify the Facility as an excluded entity for a period of two years, or both.
2. Administrative
   1. Notice

The Facility shall post conspicuously in an appropriate location a sign specifying the rights of employees under the EJA. The sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of the EJA and information with respect to the manner of filing such a complaint.

* 1. Response

In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility shall:

* + 1. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to this policy.
    2. Have evidence that all alleged violations are thoroughly investigated.
    3. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
    4. 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.
  1. Notification

The Facility will annually notify each Associate of their duties under the Elder Justice Act and this Policy and Procedure.

* 1. Responsibility

The Compliance and Ethics Officer is responsible for enforcing this policy.

**NOTICE**

**Reporting Reasonable Suspicion of a Crime**

**All employees of {Facility}(the “Facility”) have the following responsibilities and rights under Federal law:**

If you reasonably suspect that a crime has occurred against a resident or person receiving care in the Facility, you **must** report that suspicion to the police, State Survey Agency (e.g. DOH) **and** Adult Protective Services:

**POLICE State DOH**

**Local Police Dept. Nursing Home Complaints**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Adult Protective Services**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

You must make the report within **two (2) hours** after you first reasonably suspect that a crime has occurred if the suspected crime involves **serious bodily injury** to the individual, [or an allegation of resident abuse or serious bodily injury was made,] or within **24 hours** if there is **no serious bodily injury** [or allegations of abuse] involved.

**WARNING**

**If you fail to report your reasonable suspicion of a crime, you may be subject to a civil monetary penalty of up to $300,000 and/or you may be excluded from participation in any Federal health care program.**

**No Retaliation**

The Facility cannot punish you or otherwise retaliate against you for reporting your reasonable suspicion of a crime against a resident or person receiving care from this facility.

**Right to Make a Complaint**

You have the right to make a complaint to the State Survey Agency if the Facility punishes you or otherwise retaliates against you for reporting your reasonable suspicion of a crime against a resident or person receiving care from this facility.

**Please see the Facility’s policies and procedures manual for additional details regarding your responsibilities and rights under the federal law.**

**{Facility}**

**ACKNOWLEDGEMENT OF RECEIPT OF POLICY AND PROCEDURE REGARDING RESIDENT FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION AND THE ELDER JUSTICE ACT**

I hereby acknowledge by my signature that I have received a copy of the above-referenced {Facility} policies and procedures. I hereby agree to abide by the requirements of these policies as well the Compliance and Ethics program in general. I further understand that adherence to these policies is a condition of employment or continued business dealings with {Facility}, and that I have a duty to report any Compliance and Ethics concerns to either my manager, the Administrator, the Compliance and Ethics Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or as a last resort by openly or anonymously calling our Compliance and Ethics Hotline at (800) 610-2544.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name (If Contractor) Date

**{Facility}**

Family and Medical Leave Policy and Procedure

PURPOSE

To ensure that {Facility} (the “Facility”) complies with applicable laws with regard to the Family and Medical Leave Act of 1993 (“FMLA”).

POLICY

It is the Facility’s policy to provide leave according to the FMLA requirements, which provide for unpaid, job-protected leave to certain employees in certain circumstances.

PROCEDURE

1. Eligibility   
   To qualify for FMLA leave, employees must: (1) have worked for the Facility for at least 12 months within the past seven years; (2) worked at least 1,250 hours within those 12 months; and (3) be employed at the Facility work site that has 50 or more employees within 75 miles.
2. Leave Policy

If eligible, employees may take up to 12 or 26 weeks of family or medical leave, whichever is applicable (as explained below), within the relevant 12-month period defined below. While employees are on FMLA leave, the Facility will maintain their group health insurance coverage at the same level and under the same circumstances as when they were actively working, as explained more fully below. Upon returning from approved FMLA leave, employees have the right to be restored to the same job or an equivalent position, subject to the terms, limitations, and exceptions provided by law.

1. Leave Entitlement

Eligible employees may take up to 12 weeks of unpaid FMLA leave in a 12-month period, which is measured forward from the date an employee’s first FMLA leave begins for any of the following reasons:

* 1. the birth of a son or daughter and in order to care for such son or daughter
     1. leave must be completed within one year of the child’s birth
  2. the placement of a son or daughter with the employee for adoption or foster care and in order to care for the newly placed son or daughter
     1. leave must be completed within one year of the child’s placement
  3. to care for a spouse, son, daughter, or parent with a serious health condition;
  4. to care for the employee’s own serious health condition, which renders the employee unable to perform any of the essential functions of his/her position; or,
  5. a qualifying exigency of a spouse, son, daughter, or parent who is a military member on covered active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty).
     1. Such employees may take up to 26 weeks of unpaid FMLA leave in a single 12-month period, beginning on the first day that they take FMLA leave to care for a spouse, son, daughter, or next of kin who is a covered service member and who has a serious injury or illness related to active duty service, as defined by the FMLA’s regulations (known as military caregiver leave).
  6. Serious health condition is defined as an illness, injury, impairment, or physical or mental condition that involves:
     1. any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility; or
     2. a period of incapacity requiring absence of more than three calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider; or
     3. any period of incapacity due to pregnancy, or for prenatal care; or
     4. any period of incapacity (or treatment therefore) due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc.); or
     5. a period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's, stroke, terminal diseases, etc.); or,
     6. any absences to receive multiple treatments (including any period of recovery therefrom) by, or on referral by, a health care provider for a condition that likely would result in incapacity of more than three consecutive days if left untreated (e.g., chemotherapy, physical therapy, dialysis, etc.).

1. Both Spouses Employed by the Facility

Spouses who are both employed by the Facility and eligible for FMLA leave may be limited to a:

* 1. Combined total of 12 weeks of leave during the 12-month period if leave is requested:
     1. for the birth of a son or daughter and in order to care for such son or daughter;
     2. for the placement of a son or daughter with the employee for adoption or foster care and in order to care for the newly placed son or daughter; or
     3. to care for an employee's parent with a serious health condition.
  2. Combined total of 26 weeks in a single 12-month period if the leave is either for:
     1. military caregiver leave; or
     2. a combination of military caregiver leave and leave for other FMLA-qualifying reasons.

1. Notice of Leave

If an employee’s need for FMLA leave is foreseeable, the employee must provide the Facility with at least 30 days’ prior written notice. Where the need for leave is not foreseeable, employees are expected to notify the Facility within one to two business days of learning of the need for leave, except in extraordinary circumstances. Failure to provide such notice may be grounds for delaying FMLA-protected leave, depending on the particular facts and circumstances. The Facility has FMLA request forms available from the Human Resources Department.

* 1. Additionally, employees that are planning a medical treatment or a series of treatments or are taking military caregiver leave, must consult with the Facility first regarding the dates of such treatment to work out a schedule that best suits the needs of both the employee or the military member, if applicable, and the Facility.

1. Medical Certification of Need for Leave

Employees requesting leave must provide the Facility with appropriate medical certification within 15 calendar days after the request for leave. Failure to provide requested medical certification in a timely manner may result in denial of FMLA-covered leave until it is provided. The Facility may also, at its own expense, require an employee to obtain a second medical certification from a health care provider.

1. The Facility also reserves the right to require certification from a military member’s health care provider if you are requesting military caregiver leave and certification in connection with military exigency leave.
2. Medical and Other Benefits

During approved FMLA leave, the Facility will maintain an employee’s health benefits as if they continued to be actively employed. Employees, however, must pay the Facility the health insurance premiums.

1. Exemption for Key Employees

Key employees, defined as salaried and FMLA-eligible employees who are among the highest paid 10% of all employees at a worksite or within 75 miles of that worksite, may not be returned to their former or an equivalent position following FMLA leave if restoration of employment will cause substantial and serious economic injury to the operations of the Facility. This fact-specific determination will be made by the Facility on a case-by-case basis. The Facility will notify employees if they qualify as a key employee, if the Facility intends to deny reinstatement and of their position in such instances.

1. Intermittent and Reduced Schedule Leave

If medically necessary, FMLA leave occasioned by a serious health condition may be taken intermittently (in separate blocks of time due to a serious health condition) or on a reduced leave schedule (reducing the usual number of hours worked per workweek or workday). FMLA leave may also be taken intermittently or on a reduced leave schedule for a qualifying exigency relating to covered military service.

1. If leave is unpaid, the Facility will reduce the employee’s salary based on the amount of time actually worked. In addition, while are on intermittent or reduced schedule leave, the Facility may temporarily transfer the employee to an available alternative position that better accommodates the leave schedule and has equivalent pay and benefits.
2. Upon an employee taking FMLA leave, the Facility may require the employee to use accrued paid leave or other benefits (including workers compensation benefits), concurrently with some or all of the FMLA leave. In addition, while out on FMLA leave an employee will not be eligible to accrue seniority or benefits, including vacation and holidays.
3. Returning from Leave

If taking leave because of their own serious health condition, employees will be required to provide medical certification that they are fit to resume work. Absent such certification, employees will not be permitted to resume work until it is provided.

# Job Restoration

# Upon return from FMLA leave, the employee shall be restored to his or her original job, or to an “equivalent: job, which means virtually identical to the original job in terms of pay, benefits, and other employment terms and conditions.

# In addition, an employee’s use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using (but not necessarily during) FMLA leave.

1. State or Local Family and Medical Leave Laws

Where state or local family and medical leave laws offer more protections or benefits to employees, the protections or benefits that are more favorable to the employee, as provided by such laws, will apply.

1. Employees Covered under a Collective Bargaining Agreement

The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

**{Facility}**

Family and Medical Leave Act Request Form

The federal Family and Medical Leave Act (FMLA) entitles eligible employees of {Facility} (the “Facility”) to take unpaid, job-protected leave for up to 12 or 26 weeks, depending on the reason for the leave. Please refer to the Facility’s Family and Medical Leave Policy for detailed information about eligibility and notice requirements, maintenance of health benefits, job reinstatement rights, and other important information regarding FMLA leave.

The Facility requires all FMLA leave requests to be made using this form. Once complete, it should be submitted to the Human Resources Department, who will review and process your request within five business days.

Employee Information

|  |  |
| --- | --- |
| Employee Name: | Date Request is Submitted: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Hire: | Date Leave is Requested to Start: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Position/Department: | Anticipated Duration of Leave: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Reason for Leave of Absence:

|  |  |  |
| --- | --- | --- |
| \_\_\_\_ To care for employee's own serious health condition (not work-related). | | |
| \_\_\_\_ To care for employee's child, spouse, or parent with a serious health condition. | | |
| \_\_\_\_ Birth of a child and care for the new-born child within one year of birth. | | |
|  | (Date of child's birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |
| \_\_\_\_ Placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement. | | |
|  | (Date of child's placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| \_\_\_\_ Qualifying exigency due to the employee's spouse, son, daughter, or parent being a covered military member on covered active duty. | | | |
|  | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| \_\_\_\_ To care for employee's spouse, child, parent, or next of kin who is a covered military member with a serious injury or illness. | | | |
|  | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

If the leave requested is intermittent (taken in separate blocks of time due to a serious health condition) or on a reduced hours basis, employee agrees to consult with his or her supervisor to make reasonable efforts to minimize disruptions to the department’s operations. \_\_\_\_\_\_\_\_ Employee initials

Prior Leave Taken

Within the 12 months immediately before the start date indicated above, have you taken any family or medical leave? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

|  |  |  |
| --- | --- | --- |
| If yes, please provide the period or periods of leave taken: | Reason for leave: |  |
| \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  to \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  to \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  to \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Pay During Leave

FMLA leave is unpaid. Eligible employees may choose to use any accrued and unused paid leave (for example, sick or vacation leave) while on unpaid FMLA leave. Please indicate your preference below:

|  |  |
| --- | --- |
| \_\_\_\_ Request to use accrued and unused paid leave while on unpaid FMLA leave (choose one or more): | |
|  | \_\_\_\_ Sick leave |
|  | \_\_\_\_ Vacation time |
|  | \_\_\_\_ Paid time off (PTO) |
|  | \_\_\_\_ Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| \_\_\_\_ Request unpaid FMLA leave. | |

I acknowledge that I have read this request form and accurately completed it:

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employee Signature | Date |

**{Facility}**

Social Media Policy and Procedure

PURPOSE

{Facility} (the “Facility”) recognizes that the internet provides unique opportunities to participate in interactive discussions and share information on particular topics using a wide variety of social media, such as Facebook, Twitter, blogs, and wikis. However, Associates’ (as defined below) use of social media can pose risks to the Facility’s confidential and proprietary information, reputation, and brands, can expose the Facility to discrimination and harassment claims, can jeopardize the Facility’s Compliance with rules and laws, and can violate residents’ privacy.

**POLICY**

To minimize these business and legal risks, to avoid loss of productivity and distraction from Associates’ job performance and to ensure that the Facility’s IT resources and communications systems are used appropriately as explained below, the Facility expects any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) to comply with and to adhere to the following guidelines and rules regarding use of social media.

# PROCEDURE

1. Compliance with Related Policies and Agreements
   1. All of the Facility’s other policies that might apply to use of social media remain in full force and effect. Associates should always adhere to them when using social media. Social media should never be used in a way that violates any other the Facility policy or any Associate obligations. For example, Associates are prohibited from using social media to:
      1. Violate the Facility's IT resources and communications systems policies.
      2. Violate the Facility's confidentiality and proprietary rights policies.
      3. Circumvent the Facility's ethics and standards of conduct policies.
      4. Engage in unlawful harassment.
      5. Circumvent policies prohibiting unlawful discrimination against current employees or applicants for employment.
      6. Violate the Facility's privacy policies.
      7. Violate the privacy of any resident.
      8. Violate any other laws or ethical standards.
   2. Employees who violate the Facility policies may be subject to discipline, up to and including termination of employment.
2. Personal Use of Social Media

Personal use of social media is never permitted on working time by means of the Facility's computers, networks, and other IT resources and communications systems.

1. No Expectation of Privacy

All contents of the Facility's IT resources and communications systems are the property of the Facility. Therefore, Associates should have no expectation of privacy whatsoever in any message, files, data, document, facsimile, telephone conversation, social media post, conversation, or message, or any other kind of information or communications transmitted to, received or printed from, or stored or recorded on the Facility’s electronic information and communications systems.  
Additionally, in order to prevent misuse, the Facility reserves the right to monitor, intercept, and review, without further notice, every Associate’s activities using the Facility’s IT resources and communications systems, including but not limited to social media postings and activities. This might include, without limitation, the monitoring, interception, accessing, recording, disclosing, inspecting, reviewing, retrieving and printing of transactions, messages, communications, postings, log-ins, recordings, and other uses of the systems as well as keystroke capturing and other network monitoring technologies.

The Facility also may store copies of such data or communications for a period of time after they are created, and may delete such copies from time to time without notice.

1. Business Use of Social Media

Associates that are required to use social media as part of their job duties for the Facility’s marketing, public relations, recruitment, corporate communications, or other business purposes should note that the Facility owns all social media accounts used on behalf of the Facility or otherwise for business purposes, including any and all log-in information, passwords, and content associated with each account, such as followers and contacts. The Facility owns all such information and content regardless of the Associate that opens the account or uses it, and will retain all such information and content regardless of separation of any Associate from employment with the Facility. If Associates’ job duties require them to speak on behalf of the Facility in a social media environment, they must still seek approval for such communication from their supervisor, who may require them to receive training and impose certain requirements and restrictions with regard to their activities. Likewise, if Associates are contacted for comment about the Facility for publication, including in any social media outlet, the Associate must direct the inquiry to their supervisor and not respond without the Facility’s written approval.

1. Guidelines for Associates’ Responsible Use of Social Media with Regard to the Facility

The above material covers specific rules, policies, and contractual obligations that Associates must follow in using social media, whether for personal or business purposes, in consideration of their employment and subject to discipline for violations. The following sections provide Associates with common-sense guidelines and recommendations for using social media responsibly and safely, in the best interests of the Facility. These guidelines reflect the “duty of loyalty” every Associate owes its employer, and are intended to add to, not contradict, limit, or replace, applicable mandatory rules, policies, legal requirements, legal prohibitions, and contractual obligations.

* 1. Protect the Facility’s Goodwill, Brands, and Business Reputation. Associates are personally responsible for information that they communicate in their personal social media that relates to the Facility.
  2. Respect Intellectual Property and Confidential Information. The Facility's Code of Conduct restricts Associates’ use and disclosure of the Facility’s confidential information and intellectual property. Thus, Associates must ensure that the Facility’s confidential information and intellectual property are not jeopardized through the Associate’s use of social media. Associates should also avoid misappropriating or infringing the intellectual property of other companies and individuals, which can create liability for the Associate and for the Facility.
  3. Respect and Comply with Terms of Use of All Sites Visited Associates shall take care not expose themselves or the Facility to legal risk by using a social media site in violation of its terms of use. Associates that use social media as part of their job duties should pay particular attention to terms relating to:
     1. Prohibitions or restrictions on the use of the social media site, including prohibitions or restrictions on use for advertising, marketing, and promotions or other commercial purposes.
     2. Ownership of intellectual property used on, or information collected or generated through use of, the site.
     3. Requirements for licenses or other permissions allowing use by the site owner and other third parties of the company’s trademarks or other intellectual property.
     4. Privacy rights and responsibilities of the site owner and users.
  4. Respect Others. Associates should not post anything that the Facility’s customers, clients, business partners, suppliers, or vendors would find offensive, including ethnic slurs, sexist comments, discriminatory comments, insults, or obscenity.
  5. Under no circumstances may Associates post fake blogs, create false positive or fake negative reviews of the Facility, its affiliates, policies, services and physicians or its competitors; nor may Associates impersonate someone associated with or speaking about the Facility.
  6. Associates may not use the Facility network logos, trademarks, or proprietary graphics that would create the appearance they are speaking on behalf of the Facility without prior authorization from appropriate the Facility management.

1. Guidelines for Associates’ Responsible Use of Social Media with Regard to Residents
   1. Associates may not use or disclose any patient identifiable information of any kind, including resident images, on any social media platform or smartphone application without the express written authorization of the resident. Even if a resident is not identified by name within the information at issue, if there is a reasonable basis to believe that the resident could still be identified from that information, then its use or disclosure could constitute a violation of the Health Insurance Portability and Accountability Act (HIPAA), state law, and/or the Facility policies. Additionally, online activities regarding residents that may compromise a resident’s personal dignity or otherwise make them question the confidentiality of the services provided by the Facility are prohibited.
   2. Associates are prohibited from transmitting any information that may be reasonably anticipated to violate a resident’s right to confidentiality and privacy, or otherwise degrade or embarrass a resident.
   3. Associates are prohibited from referring to residents in a disparaging manner in any forum or on any Social Media site, even if the resident in unidentified.
   4. For more information, please see the following policies: CCG 00446 Photographing, Video Audio Recording Policy and Procedure and CCG 00447 Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio Video Recordings by Staff Policy and Procedure.
2. Reporting
   1. Associates that witness or are subjected to any conduct that violates this policy, must report such conduct to their department head or any other department head as soon as possible. Associates may also directly report such conduct to the Compliance and Ethics Officer.
   2. The Facility will directly and thoroughly investigate all reported violations of this policy and will take prompt corrective action if appropriate. The Facility reserves the right to contact law enforcement, if appropriate.
3. No Retaliation

The Facility prohibits any form of discipline, reprisal, intimidation, or retaliation for reporting incidents of non-Compliance with this policy or cooperating in related investigations.

1. Administration of this Policy

The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.

1. Associates Covered under a Collective Bargaining Agreement  
   The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

**{Facility}**

Substance Abuse in the Workplace Policy and Procedure

PURPOSE

To ensure that {Facility} (the “Facility”) provides a safe, healthy, and productive work environment for all Associates (defined herein).

POLICY

The Facility is committed to providing a safe, healthy, and productive work environment. Consistent with this commitment, this policy establishes the Facility’s intent to maintain a drug and alcohol-free workplace. Because being under the influence of alcohol or illegal drugs (as classified under federal, state or local laws) while on the job poses serious health and safety risks to Associates, residents, members of the public, and others, any substance abuse by any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) is not tolerated.

PROCEDURE

1. Prohibited Conduct
   1. The Facility expressly prohibits the following activities at any time that Associates are either (1) on duty or conducting the Facility business (either on or away from the Facility's premises), or (2) on the Facility's premises (whether or not the employee is working):
      1. The use, abuse, or being under the influence of alcohol, illegal drugs, or other impairing substances.
      2. The possession, sale, purchase, transfer, or transit of any illegal or unauthorized drug, including prescription medication that is not prescribed to the employee or drug-related paraphernalia.
      3. The illegal use or abuse of prescription drugs.
   2. Nothing in this policy is meant to prohibit the appropriate use of over-the-counter medication or other medication that can legally be prescribed under both federal and state law, to the extent that it does not impair an Associate’s job performance or safety or the safety of others. Associates who take over-the-counter medication or other medication that can legally be prescribed under both federal and state law to treat a disability should inform their supervisors, the Administrator, or the Compliance and Ethics Officer if they believe the medication will impair their job performance, safety, or the safety of others or if they believe they need a reasonable accommodation before reporting to work while under the influence of that medication.
2. A violation of any of the above is subject to disciplinary action, up to and including immediate termination of employment.
3. Workplace Searches and Inspections

In order to achieve the goals of this policy and maintain a safe, healthy, and productive work environment, the Facility reserves the right at all times to inspect Associates, as well as their surroundings and possessions, for substances or materials in violation of this policy. This right extends to the search or inspection of clothing, desks, lockers, bags, briefcases, containers, packages, boxes, tools and tool boxes, lunch boxes, and the Facility-owned or leased vehicles and any vehicles on the Facility property where prohibited items may be concealed. Associates should have no expectation of privacy while on the Facility premises. For further detail, see the Facility’s Workplace Searches Policy and Procedure.

1. Administration of this Policy

The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.

1. Employees covered under a Collective Bargaining Agreement  
   The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

Acknowledgment of Receipt and Review

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that on \_\_\_\_\_\_\_\_\_\_\_\_, I received a copy of the Facility’s Substance Abuse in the Workplace Policy and Procedure and that I read it, understood it and agree to comply with it. I understand that the Facility has the maximum discretion permitted by law to interpret, administer, change, modify or delete this policy at any time, with or without notice. No statement or representation by a supervisor or manager or any other Associate, whether oral or written, can supplement or modify this policy. Changes can only be made if approved in writing by the Compliance and Ethics Officer. I also understand that any delay or failure by the Facility to enforce this policy will not constitute a waiver of the Facility’s right to do so in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

**{Facility}**

Workplace Searches Policy and Procedure

**PURPOSE**

# To enable {Facility} (the “Facility”) to maintain a safe, healthy, and productive work environment that ensures the safety of residents, staff, and visitors.

**POLICY**

In order to maintain a safe, healthy, and productive work environment, the Facility reserves the right at all times to search or inspect any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”)surroundings and possessions.

**PROCEDURE**

The Facility’s right to search extends to the search or inspection of clothing, offices, files, desks, credenzas, lockers, bags, briefcases, containers, packages, parcels, boxes, tools and tool boxes, lunch boxes, any the Facility-owned or leased vehicles and any vehicles parked on the Facility property. Associates should have no expectation of privacy while on the Facility premises, except in locations with a reasonable expectation of privacy. Refusal to allow search or inspection may result in discipline.

1. Violations of this Policy: Any Associate, regardless of position or title, who violations this policy, will be subject to discipline, up to and including termination of employment.
2. Administration of this Policy: The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.
3. Employees Covered under a Collective Bargaining Agreement: The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

Acknowledgment of Receipt and Review

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I received a copy of the Facility’s Workplace Searches Policy and Procedure and that I read it, understood it and agree to comply with it. I understand that the Facility has the maximum discretion permitted by law to interpret, administer, change, modify, or delete this policy at any time. No statement or representation by a supervisor or manager or any other Associate, whether oral or written, can supplement or modify this policy. Changes can only be made if approved in writing by the Compliance and Ethics Officer. I also understand that any delay or failure by the Facility to enforce any work policy or rule will not constitute a waiver of the Facility’s right to do so in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

**{Facility}**

Workplace Violence Policy and Procedure

PURPOSE

To ensure that {Facility}’s (the “Facility”) workplace remains safe for all employees and Associates (defined herein).

POLICY

The Facility prohibits and will not tolerate any form of workplace violence by any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) and visitors.

# PROCEDURE

1. Prohibited Conduct
   1. For purposes of this policy, workplace violence includes, but is not limited to,
      1. Making threatening remarks (written or verbal).
      2. Aggressive or hostile acts such as shouting, using profanity, throwing objects at another person, fighting or intentionally damaging an Associate’s property.
      3. Bullying, intimidating or harassing another person (for example, making obscene phone calls or using threatening body language or gestures such as standing close to someone or shaking your fist at them).
      4. Behavior that causes another person emotional distress or creates a reasonable fear of injury, such as stalking.
      5. Assault.
2. Weapons
   1. The Facility prohibits all Associates from possessing any weapons of any kind at the workplace. For purposes of this policy, the workplace is defined to include the Facility’s building(s), outdoor areas, and parking lots.
   2. Weapons include, but is not limited to,
      1. Guns
      2. Knives
      3. Mace
      4. Explosives
      5. Any item with the potential to inflict harm that has no common purpose
3. No Retaliation
   1. No one will be subject to, and the Facility prohibits, any form of discipline, reprisal, intimidation, or retaliation for good faith reporting of incidents of workplace violence of any kind, pursuing any workplace violence claim or cooperating in related investigations.
4. Violations of this Policy
   1. Any Associate, regardless of position or title, who is determined to have subjected an individual to harassment or retaliation in violation of this policy, will be subject to discipline, up to and including immediate termination of employment.
5. Administration of this Policy
   1. The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.
6. Employees Covered under a Collective Bargaining Agreement
   1. The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

**{Facility}**

**Employee and Independent Contractor Credentialing**

**Policy and Procedure**

**PURPOSE**

To ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for or with {Facility} (the “Facility” or “Associates”) provide appropriate proof to the Facility upon their initial hire that they are properly licensed and/or certified, maintain their current licensure and/or certification, and meet the Facility’s employment standards as identified in their job description.

**POLICY**

All the Facility Associates are responsible for maintaining their current licensure and/or certification and for providing appropriate proof to the Facility upon their initial hiring. Associates who become aware of potential licensing and/or certification violations will be instructed to immediately report those violations to their supervisor, Administrator, or the Compliance and Ethics Officer.

**PROCEDURE**

To ensure that the Facility Associates are properly licensed and/or certified to properly care for the residents the Facility shall require the following:

1. Proof of Licensure/Certification:
   1. The hiring supervisor is responsible to verify that each newly hired Associate possesses a valid license in good standing applicable to his or her position;
   2. The hiring supervisor is responsible to check with the State Board Licensing database to review the potential Associate’s licensing status;
   3. The Human Resource Department is responsible for verifying that each newly hired Associates has not been suspended or excluded by any government agency or court from participating in the Medicare, Medicaid, or any Federal or State health care program; and
   4. The Human Resource Department shall conduct a periodic review of the applicable government databases pursuant to the Facility’s New and Current Employee, Contractors, Vendors, Physicians, and Other Healthcare Practitioners Exclusions Screening Policy and Procedure.
2. Expired Credentials:
   1. Associates who do not provide proof of renewal by the expiration date of their credentials may be subject to immediate job reclassification, and their pay may be adjusted; and
   2. Associates who fail to provide proof of renewed credentials within 10 days of expiration may be terminated.
3. Loss of Licensure:
   1. Associates must inform their supervisors immediately if they lose their licensure or are placed on probation for any reason; and
   2. Associates who lose their license may be subject to immediate job reclassification, with appropriate pay change or termination.
4. Failed Licensure Exam:
   1. Associates must notify their supervisor immediately of licensure test results;
   2. Associates who do not pass their licensure exams may be subject to immediate job reclassification, with appropriate pay change or termination; and
   3. Associates who fail either a National and or State credentialing examination two consecutive times (regardless of whether both failures occur under employ) may be terminated.

**RE: Medical Staff Appointment**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

You have indicated your interest in becoming a member of the medical staff of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “Facility”). We have evaluated the credentials you submitted in response to the medical staff policies of our facility and have found them to be facially satisfactory. By virtue of your signature below, you acknowledge that we may rely on the veracity of your submission and that you are obligated to inform us should any of the information provided change in any way.

By your signature on the enclosed Physician Responsibility Agreement, you acknowledge receipt of the performance requirements expected of all physicians of the Facility and you agree to abide by the terms and conditions of this appointment.

We welcome you as a practitioner and we look forward to working with you.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator Medical Director

**Attachment A**

**Physician Responsibility Agreement**

Dear Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

We would like to take this opportunity to welcome you to the staff of \_\_\_\_\_\_\_\_\_(“Facility”). On behalf of myself and our Medical Director, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.D., we look forward to working with you to care for our residents.

There are comprehensive state and federal regulatory and licensure requirements that the Facility must carefully adhere to when providing medical services to our residents which are reflected in our policies and procedures. By signing this Agreement, you agree to adhere to all of the policies and procedures of the Facility and all applicable federal and state laws, including those applicable to Medicare and Medicaid benefits. In addition, we emphasize certain key policies and procedures as required by the Department of Health regulations and, by virtue of your signature below, you agree to strictly comply with these requirements as follows.

1. Within 48 hours of each admission and readmission, you agree to:
   1. Complete a History and Physical Examination
   2. Complete the Physician Plan of Care
   3. Write a Progress Note.
2. On a monthly basis for each resident, you agree to:
   1. Visit the Resident
   2. Write a Progress Note
   3. Timely acknowledge by “signoff” of all physician telephone orders.
3. On a yearly basis, you agree to complete a Physician Plan of Care for each resident.
4. You acknowledge that the Facility may indicate documents needing your signature by red "flag" but may not flag each document in all instances. Accordingly, you agree to check the following:
   1. All Physician Order Sheets
   2. All Certification/Re-certification for signature and date
   3. Pharmacy Consultations (any disagreement with the Pharmacy Consultation must be stated)
   4. Any other Consultations
   5. Labs and X-rays.
5. You acknowledge that any Discharged Charts are inspected, flagged and include a blank Discharge Summary sheet. These charts are placed in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility to designate area) within one week or less after the date of discharge. You agree to complete the Discharge Summary to include:
   1. A final diagnosis
   2. Summary remarks
   3. Signature.
6. You agree to provide advance written notification to the Director of Nursing or Administrator of your anticipated vacations or other extended absences and the covering physician contact information.
7. You hereby declare that you shall not, directly or indirectly, pay, solicit or receive remuneration for the referral of patients to the extent prohibited by federal and state law.

If you have any concerns regarding the overall operations of the Facility, or if you have any suggestions for clinical program development, please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once again, we look forward to working with you.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator

I, Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to comply with the policies and procedures of the Facility, including those policies and procedures referenced above.

**Physician credentialing checklist**

Copies of each document below are required for our files:

Physician’s Name:

|  |  |
| --- | --- |
|  | **Expiration Date** |
| Physician License |  |
| CDS Certificate |  |
| DEA Control Substance Certificate |  |
| Insurance Certificate |  |

Attach Current Resume or Curriculum Vitae

**Physician Credentialing Application**

**GENERAL INFORMATION**

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

*Last First Middle*

Degree: \_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_Social Security #\_\_\_\_\_\_\_\_\_\_\_\_

License#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_UPIN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare Provider#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Provider# (*if applicable*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Licenses (list all states in which previously or currently held): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEA #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State pharmacy certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current office address(es) and telephone number(s) (please list all offices):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pager #/Answering Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pager #/Answering Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List partners/associates (*if applicable*):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years in practice: \_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_Place of Birth: \_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_\_\_\_\_\_

Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_

Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIAL BOARD CERTIFICATION**

(For Board Certified practitioners, attach a copy of Certificate. For Board Eligible practitioners, attach a copy of the letter from the Board)

Certified by the American Board of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

Renewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eligible for Board Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

**Hospital Skilled Nursing and Sub-acute Affiliations**

List all present health care affiliations

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital & Address** | **To** | **From** | **Status** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Professional Memberships**

If you are presently a member of, or are applying for membership, in any county, state or national professional societies, boards, or specialty organizations, please list below:

|  |  |
| --- | --- |
| **Organization** | **Current Status** |
|  |  |
|  |  |
|  |  |
|  |  |

**Disciplinary Action**

Have any of the following ever been or are currently in the process of being investigated by pertinent regulatory authority, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished:

1. Medical license in any state Yes/No \_\_\_\_\_
2. Other professional registration or certification to practice profession Yes/No \_\_\_\_\_
3. DEA registration or state pharmacy registration or certification, if any Yes/No \_\_\_\_\_
4. Academic probation or other restriction Yes/No \_\_\_\_\_
5. Membership in any hospital medical staff Yes/No \_\_\_\_\_
6. Prerogatives/rights on the medical staff of any health care facility Yes/No \_\_\_\_\_
7. Clinical privileges in any facility Yes/No \_\_\_\_\_
8. Medicare or Medicaid enrollment and/or billing status Yes/No \_\_\_\_\_
9. Professional society membership, fellowship, or board certification Yes/No \_\_\_\_\_
10. Professional office Yes/No \_\_\_\_\_
11. Any other type of professional sanction(s) Yes/No \_\_\_\_\_

To your knowledge, has information pertaining to you ever been reported to the National Protection Data Bank or the Healthcare Integrity and Protection Data Bank?

Yes/No \_\_\_\_\_

If you answer “Yes” to any of these questions, please provide a detailed explanation on a separate piece of paper.

**Professional Liability Insurance**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Carrier Name Policy Number Amount of coverage*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Expiration Date*

During the past ten (10) years, have there been or are there currently pending any malpracticeclaims, suits, settlements, or arbitration proceedings involving your professional practice?

Yes/No \_\_\_\_\_

Have you even been denied Professional Liability Insurance or has any coverage ever beencanceled, restricted, or not renewed by your carrier based on your individual liability history?

Yes/No \_\_\_\_\_

Have you ever been assessed a surcharge or rated in a high-risk class by your carrier based on your individual liability history?

Yes/No \_\_\_\_\_

If you answered “Yes” to any of the questions, please provide a detailed explanation on a separate sheet of paper, including the name of carrier, nature of claim, the settlement, and other pertinent information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name (typed or printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Medical Director Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by Administrator Date

**Applicant’s Acknowledgement**

I fully understand that any misstatements or omissions from this application constitute cause for denial of appointment or cause for dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief. In making this application for appointment to the medical staff of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (the “Facility”), I acknowledge that I: (1) have received and read the requirements of the medical staff of the Facility; (2) am familiar with the principles, standards, and ethics of the National, State, and Local associationswhich apply to and govern my specialty and/or profession, and I agree to be bound by the termsthereof if l am granted privileges at the Facility. I further agree to be bound by the above terms in all matters relating to the consideration of my application or appointment to the medical staff.

**Consent for Release of Information**: By applying for appointment to the medical staff, I hereby signify my willingness to appear for interviews, if deemed necessary. I authorize the Facility medical staff and/or its representatives to consult with administrative personnel and/or members of the medical staff of other hospitals and/or institutions with which I have been associated and any past and present malpractice carriers who may have information regarding my professional competence, character, and ethics. I hereby further consent to the inspection by the Facility medical staff and its representatives of all records and documents, including medical records at other hospitals, which may be material to an evaluation of my professional qualifications and competence. I hereby release from liability all representatives of the Facility and its medical staff for acts performed in good faith and without malice while evaluating my application, credentials, and qualifications. I further hereby release from liability any individuals and organizations who provide information to the Facility or its medical staff, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications. I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information provided by me to the Facility and/or its medical staff to other hospitals, medical associations, and/or other interested persons/agencies who request such. A release of information must be done in good faith and without malice, and upon presentation to the staff of the Facility a release signed by me. I hereby release from liability this facility and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership of the Facility, have the burden of producing all of the information requested. I fully realize that there is a need for an adequate evaluation of my professional competence, ethics, and other qualifications. I recognizethat any doubts or other concerns expressed about my qualifications by anyone contacted inconnection with the facility’s exercise of due diligence must be resolved to the facility’s reasonable satisfaction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Medical Director

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by Administrator

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature

**{Facility}**

**Disability and Pregnancy Accommodations Policy And Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with the Americans with Disabilities Act (ADA), as amended by the ADA Amendments Act (ADAAA), the Pregnancy Disability Act (PDA), and all other applicable state and local fair employment practices laws.

**POLICY**

It is the Facility’s policy to provide a reasonable accommodation to disabled or pregnant, including those who suffer medical conditions related to pregnancy and childbirth, applicants and employees if the reasonable accommodation would allow the individual to perform the essential functions of the job, unless doing so would create an undue hardship on the Facility’s business. The Facility does not discriminate against an employee on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same as other persons not so affected but similar in their ability or inability to work.

**PROCEDURE**

1. Reasonable Accommodation
   1. An employee may be entitled to reasonable accommodation for limitations resulting from pregnancy-related conditions that constitute a disability or for limitations resulting from the interaction of the pregnancy with an underlying impairment. A reasonable accommodation is a change in the workplace or in the way things are customarily done that enables an individual with a disability to perform a job’s essential functions or enjoy equal benefits and privileges of employment.
2. Requesting a Reasonable Accommodation
   1. Employees may make a request for reasonable accommodations for a disability either orally or in writing.
   2. When making the request, the Facility will direct the employee to include relevant information, such as:
      1. A description of the accommodation the employee is requesting;
      2. The reason why the employee needs an accommodation;
      3. How the accommodation will help the employee perform the essential functions of the employee’s job.
   3. The Facility’s Compliance and Ethics Officer shall document in writing the receipt of any request for accommodation, shall provide a copy of the request to the individual, and retaining a copy for the Facility’s records.
3. After receiving an oral or written request, the Facility will engage in an interactive dialogue with the employee to determine the precise limitations of the employee’s disability and explore potential reasonable accommodations that could overcome those limitations.
   1. Examples of pregnancy related accommodations include, but are not limited to:
      1. bathroom breaks;
      2. breaks for increased water intake;
      3. periodic rest;
      4. assistance with manual labor;
      5. job restructuring or modified work schedules; and
      6. temporary transfers to less strenuous or hazardous work.
   2. The Facility shall be required to provide such accommodations to an employee affected by pregnancy, absent a showing by the Facility of undue hardship on the Facility’s business should such accommodations be required.
4. Medical Information
   1. If a disability or need for accommodation is not obvious, the Facility reserves the right to ask the employee to provide supporting documents showing that the employee has a disability within the meaning of the ADA and applicable state or local laws, and that the disability necessitates a reasonable accommodation.
      1. If the information provided in response to this request is insufficient, the Facility may require that the employee see a health care professional of the Facility’s choosing, at the Facility’s expense.
         1. In those cases, if the employee fails to provide the requested information or see the designated health care professional, the employee’s request for a reasonable accommodation may be denied.
   2. The Facility will keep confidential any medical information that it obtains in connection with your request for a reasonable accommodation.
5. Undue Hardship
   1. The Facility shall not be obligated to provide a requested accommodation, if such an accommodation would impose an “undue hardship” on the Facility’s business.
   2. The factors considered in the “undue hardship” analysis include:
      1. The overall size of the Facility’s business with respect to the number of employees, number and type of facilities, and size of budget;
      2. the Facility’s operations, including the composition and structure of the Facility’s workforce;
      3. the nature and cost of the accommodation needed, taking into consideration the availability of tax credits, tax deductions, and outside funding; and
      4. the extent to which the accommodation would involve waiver of an essential requirement of a job as opposed to a tangential or nonbusiness necessity requirement.
6. Determinations
   1. the Facility shall make determinations about reasonable accommodations and undue hardship on a case-by-case basis considering various factors and based on an individualized assessment in each situation.
   2. the Facility shall strive to make determinations on reasonable accommodation requests expeditiously, and will inform the individual once a determination has been made.
   3. the Facility shall document, in writing, the discussion about the requested accommodation and the final determination about how the accommodation request was resolved, including any undue hardship analysis.
7. No Retaliation or Intimidation
   1. Individuals will not be retaliated against for requesting an accommodation in good faith. The Facility expressly prohibits any form of discipline, reprisal, intimidation, or retaliation against any individual for requesting an accommodation in good faith.
8. Administration of this Policy
   1. The Compliance and Ethics Officer is responsible for the administration of this policy. Any questions regarding this policy should be directed to the Compliance and Ethics Officer.
9. Employees Covered under a Collective Bargaining Agreement
   1. The employment terms set out in this policy work in conjunction with, and do not replace, amend, or supplement any terms or conditions of employment stated in any collective bargaining agreement that a union has with the Facility.

**Disability and Pregnancy Accommodations**

**Acknowledgment of Receipt and Review**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I received a copy of the Facility’s Disability Accommodations Policy and Procedure and that I read it, understood it and agree to comply with it. I understand that the Facility has the maximum discretion permitted by law to interpret, administer, change, modify, or delete this policy at any time. No statement or representation by a supervisor or manager or any other representative of the Facility, whether oral or written, can supplement or modify this policy. Changes can only be made if approved in writing by the Compliance and Ethics Officer. I also understand that any delay or failure by the Facility to enforce any work policy or rule will not constitute a waiver of the Facility’s right to do so in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

**{Facility}**

**Prohibition of Unethical Relationships Between Staff and Residents Policy and Procedure**

**PURPOSE**

To provide guidelines requiring staff, contractors, and volunteers (“staff” or “employees”) to establish and maintain professional boundaries between themselves and residents.

**POLICY**

An environment of trust is an essential component to resident care. When relationships between staff and residents become poorly defined or compromised by the interests of a staff member, such interactions may result in a violation of a resident’s trust and the misuse of power by a staff member to the detriment of the resident. As such, it is the policy of {Facility} (the “Facility”) that professional boundaries must be established and maintained between the Facility’s employees and its residents. Relationships or activities that violate the staff-resident professional boundary will be considered unethical and are prohibited. All staff are responsible for ensuring that such relationships do not occur.

**PROCEDURE**

1. Prohibition of Unethical Relationships.
2. The Facility prohibits any and all unethical social, romantic, or business interactions between staff and residents. These interactions are presumed to interfere with or impact negatively on the resident, other residents, or other staff members.
3. This prohibition applies to the entire length of a resident’s stay at the Facility up to the resident’s discharge.
4. Examples of Unethical Relationships.
5. Romantic Relationships. Romantic and/or sexual relationships between staff and residents are considered to be an abuse of power by the staff member. Such relationships are prohibited and will be viewed as staff-resident boundary violations that have resulted in an unethical relationship.
6. Business Relationships. Any business relationship between staff and residents is presumed to violate the staff-resident boundary and is considered to be an unethical relationship.
7. Social Relationships. Social relationships that are more than incidental occurrences are presumed to conflict with staff- resident boundaries and should be avoided. Socialization with residents that is not formally sanctioned as a resident care activity can be viewed as compromising the staff-resident relationship. Examples of boundary problems that may occur in social relationships include, but are not limited, to:
   1. a staff member driving a resident in the staff member’s personal vehicle;
   2. a staff member taking a resident to a social event;
   3. a staff member inviting a resident to live in the staff member’s home post discharge of the resident;
   4. staff members and residents socializing outside of the Facility, both in public settings or in the home of the resident or staff member;
   5. any physical contact outside of contact during the provision direct care by the staff member;
   6. offering preferential treatment to a particular resident, i.e. additional smoke breaks, that is not offered to all residents.
8. Exceptions.
9. Pre-existing familial relationships. This policy does not apply to instances where the resident is the family member or spouse of the employee. If a staff member has a familial relationship with a resident, the staff member should provide a written notification to the Compliance and Ethics Officer at the start of the resident’s stay.
10. Pre-existing non-familial relationships. If a staff member has a non-familial previous personal relationship with a resident that has the potential to develop into an unethical relationship as described in this policy, the staff member should contact the Compliance and Ethics Officer for guidance.
11. Professional Ethics. In those cases where an employee is a member of a profession with its own code of ethics, the employee must also adhere to the standards of his/her profession. Where a conflict occurs between a relevant professional ethical standard of the employee’s occupation and the procedures in this policy, the employee must seek clarification from the Compliance and Ethics Officer.
12. Discipline.
13. Employees who violate this policy will be subject to disciplinary procedures up to and including termination, reporting and referral to relevant federal or state agencies, and/or criminal prosecution.
14. Reporting.
15. Any employee who has knowingly or inadvertently engaged in a relationship which violates this policy should report his/her activities to the Compliance and Ethics Officer.
16. Any employee having knowledge of a social, business, or romantic relationship between another staff member and a resident must report such behavior to the Compliance and Ethics Officer.
17. Unsolicited Attention from Residents. Employees receiving notes, expressions of affection, sexual interest, or provocation from a resident or who are having trouble managing a relationship with a resident must immediately report this in writing to the Compliance and Ethics Officer, along with any related documentation.

**{Facility}**

**Protected Health Information Policy and Procedure**

**POLICY**

Protected health information (“PHI”) is individually identifiable health information that is transmitted or maintained by electronic media or any other form or medium. PHI will be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Standards and other applicable laws.

**PROCEDURE**

1. PHI includes oral, written, or otherwise recorded information that is created or received by {Facility}.
2. PHI may relate to a resident’s physical or mental health, payment, or health care services provided to a resident.
3. PHI may pertain to a health condition or payment in the past, present, or future, and the resident who is the subject of the information may be alive or deceased.
4. PHI will be protected in any form, including, but not limited to, telephone conversations and voice mail, paper records, computers, transmissions over the Internet, dial-up lines, private networks, fax machines, electronic memory chips, magnetic tape, magnetic disk, external hard drives.

**{Facility}**

**Notice of Privacy Practices Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws that grant residents or a resident’s legal representative (collectively referred to herein as the “resident”) the right to adequate notice of the uses and disclosures of the resident’s protected health information (“PHI”).

**POLICY**

It is the policy of the Facility that individuals have the right to adequate notice of the uses and disclosures of their PHI, for as long as the PHI is maintained by the Facility.

**PROCEDURE**

1. Notice of Use and Disclosure
   1. Provision of Notice
      1. The Compliance and Ethics Officer shall approve a Notice of Privacy Practices (the “Notice”) acceptable under State and Federal law to be provided to each resident: (i) prior to the time of first service delivery when the individual executes the Notice of Privacy Practices Acknowledgment Form; (ii) in an emergency treatment situation, as soon as is reasonably practicable after the emergency treatment situation, or (iii) upon request of a resident.
   2. Web Site Notice
      1. If the Facility maintains a web site containing information about the Facility's customer service or benefits, it shall make the Notice available electronically through the web site.
   3. Posting of Notice
      1. The Facility shall post the Notice in a clear and prominent location where residents will be able to read the Notice. The Facility shall make copies of the Notice available for individuals to take with them.
2. Acknowledgement
   1. Except in an emergency, the Facility shall make a good faith effort to obtain a written acknowledgement of receipt of the Notice. If no acknowledgement can be obtained, the Facility shall document its efforts and the reasons why acknowledgement was not obtained. In emergency treatment situations, the acknowledgement shall be obtained from the individual as soon as reasonably practical.
3. Revisions to Notice
   1. The Compliance and Ethics Officer must promptly revise and distribute to residents the Notice whenever there is a material change to the uses and disclosures of PHI, changes in residents’ rights or the Facility’s duties, or other privacy practices stated in the Notice. Thereafter, the revised Notice shall be utilized when providing the Notice to an individual.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

It is important to read and understand this Notice of Privacy Practices before signing any Acknowledgment of Receipt of the Notice of Privacy Practices.

If you have any questions about this Notice or would like further information concerning your privacy rights, please contactour Compliance and Ethics Officer.

1. PURPOSE OF THE NOTICE OF PRIVACY PRACTICES  
    This Notice of Privacy Practices (the “Notice”) is meant to inform you of the uses and disclosures of protected health information (PHI) that we may make. It also describes your rights to access and control your PHI and certain obligations we have regarding the use and disclosure of your protected health information.

Your “protected health information” is information about you created and received by us, including demographic information, that may reasonably identify you and that relates to your past, present, or future physical or mental health or condition, or payment for the provision of your health care.

The Privacy Rule, a federal law, gives you rights over your PHI and sets rules and limits as to who can look at and/or receive your PHI. The Privacy Rule applies to all forms of individuals’ PHI, whether electronic, written or oral. The Security Rule is a federal law that requires security for PHI in electronic form. This Notice describes how we may use or disclose your PHI to carry out treatment, payment, or health care operations, as well as other purposes permitted or required by law.

We are required by law to maintain the privacy of your protected health information. We are also required by law to provide you with this Notice of our legal duties and privacy practices with respect to your protected health information, to notify you following a breach of your unsecured protected health information, and to abide by the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice, at which time, the provisions of the newer Notice will be effective for all PHI that we maintain. If this Notice is revised at any time, we will provide all residents with a revised copy, in accordance with the Privacy Rule.

1. UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time we provide care to you, a record is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information:

* 1. to plan your care and treatment
  2. to communicate with other health professionals involved in your care
  3. to document the care you receive
  4. to educate health professionals
  5. to provide information for medical research
  6. to provide information to public health officials
  7. to evaluate and improve the care we provide
  8. to obtain payment for the care we provide
  9. for administrative purposes

1. UNDERSTANDING WHAT IS IN YOUR RECORD AND HOW YOUR PHI IS USED HELPS YOU TO:
   1. ensure it is accurate
   2. better understand who may access your PHI
   3. make more informed decisions when authorizing disclosure to others
2. HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe some of the different ways that we may use or disclose your PHI. Even if not specifically listed below, {Facility} (the “Facility”) may use and disclose your PHI as permitted or required by law or as authorized by you. We will make reasonable efforts to limit access to your PHI to those persons or classes of persons, as appropriate, in our workforce who need access to carry out their duties. In addition, if required, we will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of any use or disclosure and to the extent such use or disclosure is limited by law.

1. USES AND DISCLOSURES OF YOUR PHI THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT
   1. For Treatment—We may use and disclose your PHI to provide you with medical treatment and related services. For example, we may also use or disclose PHI about you in order to coordinate your care and provide you with medication, lab work, and x-rays. If we are permitted to do so, we may also disclose your PHI to individuals or facilities that will be involved with your care after you leave the Facility and for other treatment reasons. We may also use or disclose your PHI in an emergency situation.
   2. For Payment—We may use and disclose your PHI so that we can bill and receive payment for the treatment and related services you receive. For billing and payment purposes, we may disclose your health information to your payment source, including an insurance or managed care company, Medicare, Medicaid or another third-party payor. For example, we may need to give your health plan information about the treatment you received so your health plan will pay us or reimburse us for the treatment, or we may contact your health plan to confirm your coverage or to request prior authorization for a proposed treatment.
   3. For Health Care Operations— We may use and disclose your PHI for our day-to-day health care operations. This is necessary to ensure that you receive quality care. For example, we may use PHI for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine PHI about many residents to help determine what additional services we should offer, what services should be discontinued, and whether certain new treatments are effective. PHI about you may be used for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your PHI include accreditation, certification, licensing and credentialing activities, review and auditing, including Compliance and Ethics reviews, medical reviews, legal services, and Compliance and Ethics programs. Your PHI may be used and disclosed for the business management and general activities of our Company including resolution of internal grievances, customer service, and due diligence in connection with a sale or transfer of our Company. In limited circumstances, we may disclose your PHI to another health care provider subject to HIPAA for its own health care operations. We may remove information that identifies you so that the PHI may be used to study health care and health care delivery without learning your identity.
   4. Business Associates—There may be some services provided by our business associates, such as a billing service, transcription company or legal or accounting consultants. We may disclose your PHI to our business associate so that they can perform the job we have asked them to do. To protect your health information, we require our business associates to enter into a written contract that requires them to appropriately safeguard your information.
   5. Providers—Many services provided to you, as part of your care at the Facility are offered by participants in one of our organized healthcare arrangements. These participants may include a variety of providers such as physicians, therapists, psychologists, social workers, and suppliers. We may use and disclose PHI to contact you as a reminder that you have an appointment at a provider.
   6. As Required by Law—We will disclose PHI about you when required to do so by federal, state, or local law. The use or disclosure will be made in Compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.
   7. Public Health Activities—We may disclose your PHI to prevent a serious threat to your health and safety or the health and safety of the public or another person to a public health authority that is authorized by law to collect or receive such information, such as for the purpose of preventing or controlling disease, injury or disability; reporting births, deaths or other vital statistics; reporting child abuse or neglect; notifying individuals of recalls of products they may be using; notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
   8. Risk of Contracting a Communicable Disease—We may use or disclose PHI about you if you may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, so long as we are authorized by law to notify you as necessary in the conduct of a public health intervention or investigation.
   9. To Avert a Serious Threat to Health or Safety—We may use and disclose your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.
   10. Coroners, Medical Examiners, Funeral Directors— We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties, as authorized by law.
   11. Organ and Tissue Donation—If you are an organ donor, we may disclose PHI to organizations that handle organ procurement to facilitate donation and transplantation.
   12. Military and National Security—If required by law, if you are a member of the armed forces, we may (1) use and disclose your PHI as required by military command authorities or the Department of Veterans Affairs; (2) disclose your PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by law (3) disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations; (4) use and disclose your PHI for the purpose of a determination by the Department of Veterans Affairs, and/or to foreign military authorities if you are a member of that foreign military service, of your eligibility for benefits.
   13. Research Purposes—Your PHI may be used or disclosed for research purposes, but only if the use and disclosure of your information has been reviewed and approved by a special Privacy Board or Institutional Review Board, or if you provide authorization.
   14. Workers’ Compensation—We may use or disclose your PHI as permitted by laws relating to workers' compensation or related programs.
   15. Health Oversight Activities—We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, accreditation, licensure, and disciplinary actions.
   16. Reporting Abuse, Neglect, or Domestic Violence—We may disclose your PHI to an appropriate government agency if we believe you may have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
   17. Criminal Activity—We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety of you, another person or the public. We may also disclosure PHI if it is necessary for law enforcement officials to identify or apprehend an individual.
   18. Legal Proceedings—If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
   19. Law Enforcement—We may disclose PHI when requested by a law enforcement official:
   20. In response to a court order, subpoena, warrant, summons or similar process, or otherwise as required by law;
       1. To identify or locate a suspect, fugitive, material witness, or missing person;
       2. To report gunshot wounds;
       3. To report emergencies or suspicious deaths;
       4. About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
       5. About a death we believe may be the result of criminal conduct;
       6. About criminal conduct at our Company;
       7. In emergency circumstances to report a crime; the location of the crime or victims; and/or the identity, description or location of the person who committed the crime; and
       8. Where there is a medical emergency (not on our Company’s premises) and it is likely that a crime has occurred.
   21. National Security and Intelligence Activities—We may disclose PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
   22. Food and Drug Administration—We may disclose PHI to a person or company required by the Food and Drug Administration (“FDA”) for the purpose of quality, safety or effectiveness of FDA-regulated products or activities including, without limitation, to report adverse events, product defects or problems, or biologic product deviations; to track products; to enable product recalls; to make repairs or replacement; or to conduct post marketing surveillance, as required.
2. USES AND DISCLOSURES THAT REQUIRE PROVIDING YOU THE OPPORTUNITY TO AGREE OR OBJECT
   1. Treatment Alternatives and Other Health-Related Benefits and Services—We may use and disclose PHI to tell you about or recommend possible treatment options or alternatives and to tell you about health-related benefits, services, or medical education classes that may be of interest to you.
   2. Fundraising Activities—We may use information about you to contact you in an effort to raise money for the Facility and its operations. For the same purpose, we may share your information with our institutionally related foundation. The information we use or share will be limited to your name, address, other contact information, age, gender, date of birth, dates that you received health care, department of service information, treating physician, outcome information, and health insurance status. You have the right to opt out of receiving such communications. A description of how to opt out of any fundraising communications will be included in any fundraising materials or communications that you receive. If you request that your information not be used or disclosed for fundraising purposes, we will make sure that you do not receive future fundraising communications. We may provide with you a method to opt back in to receive such communications.
   3. Facility Directory—Except for individuals admitted to a hospital for psychiatric disabilities or to a substance abuse treatment program, unless you object, we may include limited information about you in our facility directory while you are a resident at the facility, including your name, location in the facility, your general condition (e.g. fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your information and religious affiliation may also be given to a member of the clergy, even if the clergy member does not ask for you by name.
   4. Individuals Involved in Your Care or Payment of Your Care—Unless you object, we may disclose your PHI to a family member, a relative, a close friend or any other person you identify, if the information relates to the person’s involvement in your health care to notify the person of your location or general condition or payment related to your health care. In addition, we may disclose your PHI to a public or private entity authorized by law to assist in a disaster relief effort. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment or if we reasonably infer that you would not object.
3. USES AND DISCLOSURES OF PHI BASED UPON YOUR WRITTEN AUTHORIZATION
   1. All other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke your written authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your authorization.
   2. Uses and Disclosures of Psychotherapy Notes—Psychotherapy notes are notes (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and a summary of the following: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes will not be used or disclosed without a valid, written authorization, except in the following circumstances:
      1. To carry out the following Treatment, Payment, or Health Care Operations:
      2. Use by the originator of the psychotherapy notes for treatment;
      3. Use or disclosure by the Facility 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; or
      4. Use or disclosure by the Facility to defend itself in a legal action or other proceeding brought by the patient; and
      5. 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.
   3. Use and Disclosure of Substance Abuse and HIV-Related Information—For disclosures concerning PHI relating to care for substance abuse or HIV-related testing and treatment, special restrictions apply. For example, we generally may not disclose this specially protected information in response to a subpoena, warrant, or other legal process unless you sign a special authorization, or a court orders the disclosure.
      1. Substance abuse treatment information. If you are treated in a specialized substance abuse program, the confidentiality of alcohol and drug abuse patient records is protected by federal and state laws and regulations. Generally, we may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, unless:
      2. You consent in writing;
         1. The disclosure is allowed by a court order; or
         2. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
         3. Marketing—A signed authorization is required for the use or disclosure of your PHI for a purpose that encourages you to purchase or use a product or services except for certain limited circumstances, such as when the marketing communication is face-to-face or when marketing includes the distribution of a promotional gift of nominal value provided by the Facility. An authorization is not required to describe a health-related product or service provided by use; to make communications to you regarding your treatment; or to direct or recommend alternative treatments, therapies, providers, or settings of care for you.
   4. Disclosures that Constitute a Sale of PHI—A signed authorization is required for the use or disclosure of your PHI in the event that the Facility directly or indirectly receives remuneration for such use or disclosure, except under certain circumstances as allowed by federal or state law. For example, authorization is not needed if the purpose of the use or disclosure is for your treatment, public health activities, or providing you with a copy of your PHI.
4. WHEN WE MAY NOT USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION
   1. Except as described in this Notice, or as permitted by state or federal law, we will not use or disclose your PHI without your written authorization.
   2. Your written authorization will specify particular uses or disclosures that you choose to allow. Under certain limited circumstances, the Facility may condition treatment on the provision of an authorization, such as for research related to treatment. If you do authorize us to use or disclose your PHI for reasons other than treatment, payment, or health care operations, you may revoke your authorization in writing at any time by contacting the Facility’s Compliance and Ethics Officer. If you revoke your authorization, we will no longer use or disclose your PHI for the purposes covered by the authorization, except where we have already relied on the authorization.
5. YOUR HEALTH INFORMATION RIGHTS REGARDING YOUR PHI
   1. You have the following rights with respect to your PHI. The following briefly describes how you may exercise these rights.
   2. Right to Request Restrictions of Your PHI— You have the right to request a restriction or limitation on the PHI we use or disclose about you, including information used or disclosed for the purposes of treatment, payment, or health care operations. You may also request that your PHI not be disclosed to family members or friends who may be involved in your care.
   3. You may request a restriction on the use or disclosure of your PHI by submitting a written request to the Facility stating (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.
   4. We are not required to agree to your requested restriction, unless it involves the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations that pertains solely to a health care item or service for which the Facility has been paid out of pocket in full by you or a third party (other than the health plan) on your behalf.
   5. If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you with emergency treatment. If restricted PHI is disclosed to a health care provider for emergency treatment, we will request that such health care provider not further use or disclose the information. In addition, you and the Facility may terminate the restriction if the other party is notified in writing of the termination.
6. RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS AND/OR ALTERNATE COMMUNICATIONS—

You have the right to request a reasonable accommodation regarding how you receive communications of PHI. You have the right to request an alternative means of communication or an alternative location where you would like to receive communications. For example, you may ask that we only contact you via mail to a post office box. We will not request an explanation from you as to the basis for the request. You must submit your request in writing to our office. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

1. RIGHT TO ACCESS, INSPECT, AND COPY YOUR PHI—You have the right to access, inspect, and obtain a copy of your PHI that is used to make decisions about your care for as long as the PHI is maintained by the Facility. You may not be permitted to inspect or copy the following: psychotherapy notes, or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. If we maintain your information electronically in a designated record set, then you have the right to request an electronic copy of such information. To access, inspect, and copy your PHI that may be used to make decisions about you, you must submit your request in writing to the Facility. If you request a copy of the information, we may charge a fee for the costs of preparing, copying, mailing, or other supplies associated with your request. We may deny, in whole or in part, your request to access, inspect, and copy your PHI under certain limited circumstances. If we deny your request, we will provide you with a written explanation of the reason for the denial. You may have the right to have this denial reviewed by an independent health care professional designated by us to act as a reviewing official. This individual will not have participated in the original decision to deny your request. You may also have the right to request a review of our denial of access through a court of law. All requirements, court costs, and attorneys' fees associated with a review of denial by a court are your responsibility. You should seek legal advice if you are interested in pursuing such rights.
2. RIGHT TO AMEND YOUR PHI—You have the right to request an amendment to your PHI for as long as the information is maintained by or for the Facility. Your request must be made in writing to the Facility and must state the reason for the requested amendment. We may deny your request for an amendment if the request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the PHI kept by or for the Facility; or (3) is accurate and complete.
   1. If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial. We may rebut your statement of disagreement. If you do not wish to submit a written statement disagreeing with the denial, you may request that your request for amendment and your denial be disclosed with any future disclosure of your relevant information.
3. RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PHI—You have the right to receive an accounting of certain disclosures of your PHI by the Facility or by others on our behalf. To request an accounting of disclosures, you must submit a request in writing, stating a time period that is within six (6) years from the date of your request. The first accounting provided within a twelve-month period will be free. We may charge you a reasonable, cost-based fee for each future request for an accounting within a single twelve-month period. However, you will be given the opportunity to withdraw or modify your request for an accounting of disclosures in order to avoid or reduce the fee. In the event the Facility maintains an electronic health record, an accounting of disclosures from the electronic health record related to treatment, payment or health care operations will be made only for the three (3)-year period preceding the request.
4. RIGHT TO BE NOTIFIED FOLLOWING A BREACH OF UNSECURED PHI—If there is a breach to your PHI, you will be notified within a reasonable amount of time, as required by law.
5. RIGHT TO A REVISED COPY OF THIS NOTICE—You have the right to receive a copy of this Notice upon request when it is revised on or after the effective date of its revision. Additionally, the revised Notice will be posted in a clear and prominent location.
6. RIGHT TO OBTAIN A PAPER COPY OF NOTICE—You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting CLENT. In addition, you have the right to receive a copy of this Notice when the Facility seeks additional consent.
7. RIGHT TO COMPLAIN—You may file a complaint with us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may also file a complaint with us by notifying our Compliance and Ethics Officer in writing of your complaint. You will not be penalized or retaliated against for filing a complaint and we will make every reasonable effort to resolve your complaint with you.

*ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE*

Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been given a copy of the Facility’s *Notice of Privacy Practices (“Notice*”), which describes how my PHI is used and shared. I understand that the Facility has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility, or by visiting their website, if any.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Resident or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the Resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the steps taken to obtain the resident’s or personal representative’s signature on the *Acknowledgement:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Completed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

File original in resident’s Business Office Record

**{Facility}**

**Compliance and Ethics Evaluation Policy and Procedure**

**PURPOSE**

The purpose of this policy is to ensure that {Facility} (the “Facility”) complies with applicable laws regarding Compliance and Ethics evaluation.

**POLICY**

The Facility will review all HIPAA Security Policies and Procedures for technical and non-technical viability, effectiveness, and Compliance and Ethics with the HIPAA regulations on annual basis or more frequently as per the Compliance and Ethics Officer. Additionally, the Facility will evaluate its overall HIPAA Compliance and Ethics plan on an annual basis.

**PROCEDURE**

1. The Compliance and Ethics Officer will schedule periodic reviews of the Facility’s policies and procedures.
2. The Compliance and Ethics Officer will schedule additional reviews if one or more of the following events occur:
   1. Changes in the HIPAA Security or Privacy Regulations;
   2. New federal, state, or local laws and regulations affecting HIPAA;
   3. Changes in the risk management process;
   4. Changes in the Facility's IT environment;
   5. Changes in the Facility's business processes with respect to IT; and
   6. A significant security incident occurs.
3. The Compliance and Ethics Officer will either perform a formal HIPAA audit on an annual basis, or obtain the services of a consultant to perform that service.
4. Based upon the above procedures, the Compliance and Ethics Officer will develop, recommend, and implement changes to the HIPAA Policies and Procedures. The following steps shall be followed as part of this process:
   1. All recommended changes will be communicated to the Compliance and Ethics Officer for final approval; and
   2. Upon approval, all changes will be communicated to the work force members via the Compliance and Ethics Officer.

**{Facility}**

**Breach of Protected Health Information Notification  
 Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with all applicable federal and state statutes and regulations with regard to notification of the proper parties in the event of a breach of Unsecured Protected Health Information (PHI).

**POLICY**

To establish and consistently use criteria to identify, track, and make appropriate notifications in the event of a breach of Unsecured PHI.

**PROCEDURE**

1. Definition of PHI
   1. PHI is defined as individually identifiable health information which can be linked to a resident. Specifically, PHI can relate to the resident’s past, present, or future physical or mental health or condition, the provision of health care to the resident, or, the past, present, or future payment for the provision of health care to the resident. Common PHI identifiers include names, social security numbers, addresses, and birth dates.
2. Definition of Breach
   1. A breach of PHI is the impermissible use or disclosure of unsecured PHI that compromises the security or privacy of the PHI. Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology as specified by the applicable regulations. The impermissible use or disclosure of unsecured PHI will be presumed to be a breach unless the Facility can demonstrate that there is a low probability that the PHI was compromised. Such a determination will be based on a risk assessment of the following factors:
      1. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
      2. The unauthorized person who used PHI or to whom the disclosure was made;
      3. Whether the PHI was actually acquired or viewed; and
      4. The extent to which the risk to PHI has been mitigated.
      5. The Facility, however, shall have the discretion to provide the required breach notifications following an impermissible use or disclosure without performing a risk assessment to determine the probability that the protected health information has been compromised.
3. Exceptions to Breach
   1. The definition of breach does not include:
      1. the unintentional acquisition, access, or use of PHI by an employee or person acting under the Facility’s or business associate’s authority, if such acquisition, access, or use of the PHI was made in good faith and within the scope of authority,
      2. the inadvertent disclosure of PHI by a person authorized by the Facility or a business associate to access PHI to another person authorized by the Facility or a business associate to access PHI, or
      3. scenarios where the Facility or a business associate believe in good faith that the unauthorized person to whom the impermissible disclosure was made, would not have been able to retain the information.
4. Notification
   1. Following a breach of unsecured PHI, the Facility will provide notification of the breach to affected individuals, the Secretary of the Department of Health and Human Services (HHS), and, in certain circumstances, to the media.
5. Notification Requirements – Notice to Affected Individuals
   1. Following the discovery of a breach of unsecured PHI, the Facility will notify each affected resident by providing them with written notice of the breach by first-class mail, or alternatively, by e-mail if the affected resident had agreed to receive such notices electronically. If the Facility has insufficient or out-of-date contact information for 10 or more residents, the Facility will provide substitute individual notice by either posting the notice on the home page of the Facility’s website for at least 90 days or by providing the notice in major print or broadcast media where the affected residents likely reside. The Facility will include a toll-free phone number that will remain active for at least 90 days where residents can learn if their information was involved in the breach. If the Facility will have insufficient or out-of-date contact information for fewer than 10 residents, the Facility may provide substitute notice by an alternative form of written notice, by telephone, or other means.
   2. The Facility will provide these individual notifications without unreasonable delay and in no case later than 60 days following the discovery of the breach. The notifications will include, to the extent possible, (i) a brief description of the breach, (ii) a description of the types of information that were involved in the breach, (iii) the steps affected residents should take to protect themselves from potential harm, (iv) a brief description of what the Facility is doing to investigate the breach, mitigate the harm, and prevent further breaches, and (v) the Facility’s contact information.
6. Breach by a Business Associate
   1. In cases where the Facility’s business associate caused the breach, notwithstanding the fact that the Facility is still ultimately responsible for ensuring that the affected residents are notified, the Facility will delegate the responsibility of providing individual notices to the business associate if the Facility determines that the business associate will be in a better position to provide notice to the affected residents. To make this determination, the Facility will take into account various circumstances, such as the functions that the business associate performs on behalf of the Facility and which entity has the relationship with the affected resident.
7. Media Notice in Circumstances where the Breach Affects more than 500 Residents
   1. In cases where a breach affects more than 500 residents, in addition to notifying the affected residents, the Facility will also provide notice of the breach to prominent media outlets located in the area where the affected residents reside. This media notification will be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and will include the same information required for the individual notice.
8. Notice to the Secretary of HHS
   1. In addition to notifying affected individuals and the media (where appropriate), the Facility will also notify the Secretary of HHS of any breaches of unsecured PHI. The Facility will notify the Secretary by visiting the HHS web site (http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html) and filling out and electronically submitting a breach report form. If a breach affects 500 or more residents, the Facility will notify the Secretary without unreasonable delay and in no case later than 60 days following the breach. If, however, the breach affects fewer than 500 individuals, the Facility may notify the Secretary of such breaches on an annual basis. Reports of breaches affecting fewer than 500 individuals will be due to the Secretary no later than 60 days after the end of the calendar year in which the breaches are discovered.
9. Notification by a Business Associate
   1. If a breach of unsecured PHI occurs at or by a business associate, the business associate will have the duty to notify the Facility following the discovery of the breach. The Facility will require the business associate to provide notice to the Facility without unreasonable delay and no later than 60 days from the discovery of the breach. To the extent possible, the Facility will require the business associate to provide the Facility with the identification of each resident affected by the breach as well as any other available information required to be provided by the Facility in its notification to affected residents.
10. Documentation
    1. The Facility will maintain documentation showing that all required notifications were made. Alternatively, if the Facility determines that notification is not required, the Facility will maintain documentation that notification was not required. The Facility will determine that notification is not required based on (1) the Facility’s risk assessment demonstrating a low probability that the PHI was compromised by the impermissible use or disclosure; or (2) the application of any exception to the definition of “breach,” as stated above.
11. Staff Training
    1. The Facility will periodically train its employees on these policies and procedures, and will apply appropriate sanctions against workforce members who do not comply with these policies and procedures.

**{Facility}**

**Workforce Clearance Procedure Policy and Procedure**

**PURPOSE**

To ensure that all {Facility} (the “Facility”) workforce members have appropriate authorization to access the Facility’s information systems containing electronic protected health information (e-PHI).

**POLICY**

The background of all the Facility workforce members will be adequately reviewed during the hiring process. The Facility’s Human Resources department and the hiring supervisor will work to identify and define both the security responsibilities and the necessary level of supervision required for the position. This policy is applicable to all departments that use or disclose e-PHI for any purposes.

**PROCEDURE**

1. The background of all the Facility workforce members will be adequately reviewed during the hiring process, and verification checks will be made, as appropriate. Verification checks include, but are not limited to:
   1. Professional references
   2. Professional license validation
   3. Criminal background check
2. The type and number of verification checks conducted will be based on the employee’s probable access to information systems containing e-PHI and their expected ability to modify or change such e-PHI.
3. The extent and type of screening will be based on the Facility’s risk analysis process.
4. When defining a position, the Facility’s Human Resources department and the hiring supervisor will identify the security responsibilities and  supervision required for the position. Security responsibilities include general responsibilities for implementing or maintaining security.

**{Facility}**

**Designated Record Set Policy and Procedure**

**PURPOSE**

To describe the documents that comprise the Designated Record Set.

**POLICY**

The HIPAA Privacy Rule requires that residents be permitted to request access and amend their Protected Health Information (“PHI”) that is maintained in a Designated Record Set. This policy documents the contents of the Designated Record Set.

**PROCEDURE**

1. The Designated Record Set is a group of records maintained by or for {Facility} (the “Facility”) that consists of the Medical Records and billing records about a resident and is used, in whole or in part, by or for the Facility to make decisions about the resident. The term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for the Facility.
2. The Facility maintains the following as the Designated Record Set:
   1. The resident’s medical record,
   2. The resident’s business office file, and
   3. The resident’s personal health records.
3. The Resident Medical Record includes, at a minimum, the following:
   1. Activity documentation
   2. Admission/readmission documentation
   3. Advance directives
   4. Assessments, flow sheets
   5. Care plan
   6. Informed consent
   7. History and physical exams and other related hospital records
   8. Minimum Data Set
   9. Medication and treatment records
   10. Nursing documentation/progress notes
   11. Nutritional services documentation
   12. Physician and professional consultant progress notes
   13. Physician’s orders
   14. Rehabilitative and restorative therapy records
   15. Reports from lab, x-ray and other diagnostic tests
   16. Face sheet
   17. Social service documentation
4. The following is excluded from the Medical Record
   1. source data, including photographs,
   2. films,
   3. monitoring strips,
   4. videotapes,
   5. slides,
   6. worksheets and daily communication sheets, and
   7. shadow files or charts, unless such data is used to make decisions related to the resident’s care.
5. If records from other providers are used by the Facility to make decisions related to the care and treatment of the resident, then these records are considered part of the Designated Record Set as well as the medical record, e.g., history and physical, discharge summary and labs from previous acute care hospitalization.
6. The resident’s business office file shall include, at a minimum, the following:
   1. Admission documents
   2. Acknowledgement of receipt of the Facility’s Notice of Privacy Practices
   3. Correspondence relating to coverage and payment from insurance companies, health plans, Medicare, Medicaid, and other payor sources
   4. Resident claim information, including claim, remittance, eligibility response, and claim status response
   5. Statements of account balance
   6. Collection activity documents and correspondence
7. Personal health records consist of the resident’s personal health information provided to the Facility by the resident. If such records are used by the Facility to make health care related decisions, provide care services, or document observations, actions or instructions, then the records will be considered part of the Designated Record Set.
8. The following are excluded from the Designated Record Set:
   1. Administrative data, such as audit trails,
   2. Appointment schedules and practice guidelines that do not imbed PHI
   3. Incident reports,
   4. Quality assurance data,
   5. Vital certificate worksheets, and derived data such as accreditation reports,
   6. Anonymous resident data for research purposes,
   7. Public health records and
   8. Statistical reports.
9. The Facility shall document and retain
   1. The Designated Record Sets that are subject to access by residents; and
   2. The titles of the persons or offices responsible for receiving and processing requests for access by residents.
10. The Designated Record Set is to be retained according to state and federal regulations and following the Facility retention procedures.
11. See the Facility’s Right to Access Protected Health Information Policy and Procedure for specifics on a resident’s right to access a Designated Record Set.

**{Facility}**

**Workstation Use Policy and Procedure**

**Purpose**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) minimize the risk of unauthorized access to or disclosure of electronic protected health information (“ePHI”), and to prevent the compromise of the Facility's desktop, workstation, and notebook computers that are used to create, store, access, receive, or transmit ePHI.

**Policy**

It is the policy of the Facility to implement proper workstation use procedures that ensure the security of ePHI.

**Procedure**

1. Proper workstation use will be a key element in the awareness and training program for all new and existing users.
2. All users will log off their system if they leave the system for 10 minutes.
   1. The Compliance and Ethics Officer may determine what timeframe is reasonable for each employee or system and will notify work force members accordingly.
3. Users must not load unauthorized software onto any of the Facility’s desktop, workstation, or notebook computers without express permission of the Compliance and Ethics Officer.
4. Users will not store ePHI on a local hard drive without the express permission of the Compliance and Ethics Officer.
5. Users will store ePHI on a network drive whenever one is available, or as directed by the Compliance and Ethics Officer.
6. In the event the Compliance and Ethics Officer permits ePHI on a local hard drive, users will back-up all ePHI stored on their local hard drive in accordance with the Facility’s data back-up policies.
7. Users will use the Facility's desktops, workstation, or notebook computers for the Facility business only to perform the user’s job junction.
8. Users will not use the Facility‘s desktop, workstation, or notebook computers for personal gain.
9. Users will not use the Facility’s desktop, workstation, or notebook computers to access ePHI for which they are not authorized.

**{Facility}**

**Workstation Security Policy and Procedure**

**PURPOSE**

To ensure that the {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) minimize the risk of unauthorized access to or disclosure of electronic protected health information (ePHI), and to prevent the compromise in any way of the Facility’s desktop, workstation, and notebook computers that are used to create, store, access, receive, or transmit ePHI.

**POLICY**

It is the policy of the Facility to implement procedures that ensure the security of ePHI 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 logoff or secure Screensaver). The Facility will also ensure 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 ePHI and the installation of unauthorized software.

**PROCEDURE**

1. Proper workstation security will be a topic in the Facility training program.
2. The Compliance and Ethics Officer will 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.
3. The Compliance and Ethics Officer will periodically 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 ePHI on their hard drives;
   3. They are situated such that casual observance of ePHI on their screens/monitors is minimized; and
   4. They are connected to an uninterruptible power supply (UPS).
4. The Compliance and Ethics Officer will periodically assess the desktop, workstation, and notebook computers to ensure that:
   1. They are running an operating system that allows for:
      1. Secure login,
      2. Automatic logoff or secure screensaver, and
      3. Encryption where required;
   2. They have had all non-essential devices removed or disabled;
   3. They have had all necessary operating system patches, updates, and service packs applied;
   4. They are running appropriate anti-virus and anti-spyware software;
   5. They are free from all forms of malware;
   6. No unauthorized software is installed on them;
   7. Any ePHI that is stored on them is backed up in accordance with the Facility's back-up policies;
   8. Any ePHI that is stored on them is encrypted in accordance with the Facility's encryption policies; and
5. In situations where ePHI resides on local hard drives, those drives must be backed up in accordance with the Facility's Back-up Policy.
6. Desktops, workstations, and notebooks that are not owned by the Facility will not be used to create access, receive, store, or transmit ePHI, and will not be placed on the Facility's network for any purpose.
7. The Compliance and Ethics Officer will periodically review desktop, workstation, and notebook computer systems activity logs and audit trails to ensure Compliance and Ethics with this Policy.

**{Facility}**

**Physical Access and Environmental Security Policy And Procedure**

**PURPOSE**

To establish procedures for protecting the safety of Client’s (the “Facility”) electronic and paper information systems, including such information systems (as defined herein) containing Protected Health Information (“PHI”) and electronic PHI (ePHI), and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

**POLICY**

It is the Facility’s policy to limit physical access to its electronic and paper information systems containing PHI and ePHI as well as other sensitive information, including, but not limited to, any and all computers, copy machines, fax machines, mobile devices of any sort, computer printouts, online display devices, magnetic storage media, and all computer-related activities involving any device capable of receiving email, browsing Web sites, or otherwise capable of receiving, storing, managing, or transmitting electronic data; including, but not limited to servers, personal computers, notebook computers, hand-held computers, personal digital assistant (PDA), pagers, telecommunication resources, network environments, telephones, fax machines, printers, or any other device, equipment, facilities, software, and data that are designed, built, operated, and maintained to create, collect, record, process, store, retrieve, display, and transmit information, and the facility or facilities in which they are housed(collectively “Information Systems”), while ensuring that properly authorized access is allowed.

**PROCEDURE**

1. All outside doors of the Facility’s building shall be kept locked during non-business hours. All visitors shall be required to sign in at the front desk.
2. The Facility shall identify and make an inventory of all facility locations and Information Systems that it owns, rents, or occupies, where ePHI is collected, created, processed, or stored in order to ensure the security of, and limit access to, its PHI and ePHI. (See CCG 00408b Inventory of Locations, Physical Systems, Devices, and Media Containing Protected Health Information.)
3. The doors and windows to the Facility’s business offices located in the Facility’s building shall be kept locked during non-business hours or when unoccupied by authorized personnel. Only those the Facility employees that have a need to access the business offices shall be provided with access (e.g. keys or combination code) to the business offices. The Facility may choose to install a video recorder system to record a video of anyone who enters the business offices.
4. All access points to any of the Facility’s workstations shall be secured via physical safeguards such as locked doors and windows as well as secure passwords pursuant to the Facility’s Password Policy and Procedure (see CCG 00410 Password Policy and Procedure).
5. The Facility shall develop and maintain a list of individuals with authorized access to its Information Systems and residents’ PHI and ePHI and validate access authorizations prior to granting such access. Only authorized personnel requiring access, as determined by the Compliance and Ethics Officer or the Governing Body, shall have access to the Facility’s business offices, workstations, and Information Systems.
   1. The Facility shall validate access upon the initial granting of aces to an individual and thereafter the Facility shall validate each individual’s access, at a minimum, annually.
6. The Facility’s physical security systems shall comply with all applicable regulations such as, but not limited to, building codes and fire prevention codes.
7. The Facility shall put in place safeguards, e.g. locks and fire safety equipment, to protect its business offices and Information Systems from theft and fire.
8. The Facility shall put in place safeguards and ongoing monitoring to maintain temperature and humidity levels within its business offices and locations where its Information Systems are stored.
9. The Facility shall put in place safeguards to protect against power surges and outages of heating, air conditioning, and air filtration systems, which can enable humidity and dust to compromise the functional integrity and performance of the Facility’s Information Systems.
10. The Facility shall protect its business offices and Information Systems from damage resulting from water leakage by providing master shutoff valves that are accessible, working properly, and known to key personnel.
11. The Facility will ensure that security awareness of all personnel be continually emphasized, reinforced, updated, and validated.
12. Upon the transfer or termination of an employee with prior access to the business offices and/or computer systems, the Facility shall ensure that all keys are accounted for and surrendered to the Facility and that all applicable passwords and combinations are immediately changed.
13. The Facility shall maintain maintenance records that include the history of physical changes, upgrades, and other modifications to the Facility’s facilities and the rooms where information systems and ePHI are kept.
14. The Facility shall document the repairs and modifications made to any of the Facility’s physical security features that protect the facility, administrative offices, and treatment areas.
    1. The Compliance and Ethics Officer shall be responsible for maintaining a list of all repairs and modifications.

**Inventory of Locations, Physical Systems, Devices, and Media Containing Protected Health Information**

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**{Facility}**

**Safeguarding Mobile Data and Portable Devices  
Policy and Procedure**

# PURPOSE

Portable computing and storage devices are susceptible to loss, theft, and other hazards to a greater degree than stationary desktop equipment or equipment situated in a hardened data center. The purpose of this policy is to describe the administrative, physical, and technical safeguards that managers and system administrators should consider before permitting workforce members to utilize mobile data devices for work purposes.

**POLICY**

It is the policy of {Facility} (the “Facility”), and is applicable to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”), to implement reasonable and appropriate safeguards to protect against the risks and vulnerabilities unique to mobile data and portable data devices. Portable data devices include, but are not limited to laptop computers, tablets, portable electronic devices (PEDs), personal digital assistants (PDAs), wireless keyboards and mic, USB flash drive, and mobile phones (“Portable Device”).

**PROCEDURE**

# The Facility supported Portable Devices shall be configured according to configuration standards approved by the Compliance and Ethics Officer.

# Mobile Data Safeguards

## Mobile data and Portable Devices should be protected through a combination of the following safeguards.

### Identify the data that is at risk.

#### This involves compiling a description of the anticipated uses of the Portable Device, and types of information that will be created or maintained on it, or transmitted to or from the Portable Device.

### End user education.

#### Users of Portable Device and mobile data should receive education on the security safeguards associated with such devices and data.

### Configuration standards.

#### Portable Device should be standardized to the extent possible at the vendor or hardware, tools, or platform level to help to maximize stability and predictability of the mobile/handheld environment.

### Track and monitor all Portable Devices

### Password protection

#### All Portable Devices must be password or passcode protected. Passwords or passcodes should be required after ten (10) minutes of non-use.

### Workforce termination procedures.

#### Implement steps to ensure the return and/or proper wiping of data on Portable Devices.

### Remote erasing or wiping of date should be implemented as practicable.

### Inventory of mobile data.

#### The Facility should maintain an up-to-date inventory of Portable Devices containing information relating to work at the Facility.

### Education and training of Portable Device users on the following topics:

#### Care and use of the Portable Device in accordance with manufacturer's instructions and the Facility’s standards;

#### Instructions for connecting to and using wireless networks;

#### Instructions for using encryption features, if equipped;

#### Instructions for backing up data;

#### The Facility’s policies for removal of e-PHI and other sensitive data from the work place;

#### Procedures for backup data and restoring it in case of loss or other calamity;

#### Procedures for reporting loss or theft

### Management oversight.

#### The Facility staff members shall not be permitted to remove e-PHI offsite without the Compliance and Ethics Officer’s knowledge and express written permission.

### Promptly remove e-PHI that is no longer needed from Portable Devices.

### All Associates should keep their Portable Devices with them at all times.

#### Portable Devices should not be checked in with luggage

#### Portable Devices should not be left unattended during meal times, conferences, or trade shows. Portable devices should never be left unattended in automobiles.

#### Downplay or disguise the Portable Device

## Do not disable or modify IT-installed safeguards.

* 1. The Facility’s IT Department has configured the Facility devices with certain safeguards and security settings. Do not interfere with, remove or disable any IT-installed safeguards, even if you are able to do so.

## Responding to a lost or stolen device

### Associates must *immediately* report the loss or theft of a Portable Device to the Compliance and Ethics Officer.

### If individually identifiable e-PHI was on the Portable Device, the Facility will comply with all breach notification requirements as promulgated by any state or federal government law or regulation (See Breach Notification Policy and Procedure #CCG 00404).

**{Facility}**

**Password Policy and Procedure**

**Purpose**

To establish a standard for creation of strong passwords, the use and ownership of those passwords, the protection of those passwords, and the frequency of change.

**Policy**

Passwords are an important component of computer security, and often times they serve as the only way to authenticate a user. Lax password procedures can compromise {Facility}’s (the “Facility”) entire information systems environment.

The Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) are responsible for taking the appropriate steps, as outlined below, to select, use, and secure their passwords.

To the extent possible, the Facility 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 Facility and must be given to the Compliance and Ethics Officer upon request.

**Procedure**

1. The scope of this policy includes all work force 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 either: (i) resides at the Facility; (ii) is hosted by an application service provider; (iii) has access to the Facility network; or (iv) stores any nonpublic the Facility information.
   1. All system-level passwords (e.g. admin or application administration accounts, etc.) should be changed at least once every quarter. Whenever the system or the application supports it, this change should be prompted by the system or application, itself, on an automated basis.
   2. All user-level passwords (e.g. e-mail, web, desktop computer, etc.) should be changed at least every year, or based on circumstances.
   3. The re-use of passwords will not be allowed.
   4. Users must not use the same password for gaining access to informational web sites as they do for gaining access to the Facility’s systems or applications.
   5. Passwords must not be inserted into e-mail messages or other forms of electronic communication.
   6. All system-level and user-level passwords must conform to the guidelines described below.
   7. Default administration-level passwords that come with systems, applications, or devices must be changed immediately.
   8. Passwords must never be written down or stored online.
   9. Passwords must not be revealed to anyone including family members, coworkers, and supervisors, except when requested by the Compliance and Ethics Officer.
2. Password Guidelines
   1. General Password Construction Guidelines
   2. The use of strong passwords is required by the Facility work force members.
   3. Poor or weak passwords have the following characteristics:
   4. The password contains less than eight characters
   5. The password is a common usage word such as:
   6. Names of family, pets, friends, coworkers, fantasy characters, etc.
   7. Computer terms and names, commands, sites, companies, hardware, software.
   8. Birthdays and other personal information, such as addresses and phone numbers.
   9. Word or number patterns such as qwerty, zyxwvuts, 123321, etc.
   10. Any of the above spelled backward.
   11. Any of the above preceded or followed by a digit (e.g., secret1, 1secret).
   12. Strong passwords have the following characteristics:
   13. Contain both upper and lowercase characters (e.g., a-z, A-Z).
   14. Have digits and punctuation characters as well as letters (e.g., 0-9, !@#$%^&\*()\_+|˜‐=/'{}[]:“;’<>?,./).
   15. Are at least eight alphanumeric characters long.
   16. Are not a word in any language, slang, dialect, jargon, etc.
   17. Are not based on personal information, names of family, etc.
3. Other
   1. If someone demands access to a password, refer him or her to the Compliance and Ethics Officer.
   2. Create passwords that can be easily remembered by you. One way to do this is to create a password based on a song title, affirmation, or other phrase. For example, the phrase might be, "The HIPAA Security Rule Is The One For Me" and the password could be: “ThsRiT14M.”
   3. Do not use the “Remember Password” or “Store Password” feature of system, application, device, or equipment.
   4. Use a different password for systems-level access and applications-level access.
   5. Do not write passwords down and store them anywhere in your office. Do not store passwords in a file on ANY computer system or device (including tablets or lab equipment) without encryption.
   6. Change passwords at least once every three months.
   7. If you feel that an account or password has been compromised, report the incident to the security officer and change all passwords.
   8. Work force members' adherence to this policy will be monitored, and periodic random testing of passwords may be performed by the Compliance and Ethics Officer 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 sanctions may apply.
4. Any Associate found to have violated this policy may be subject to sanctions, up to and including termination of employment.

**{Facility}**

**Emailing Protected Health Information Policy And Procedure**

**Purpose**

To ensure the appropriate use of the email system when transmitting Protected Health Information (“PHI”).

**Policy**

It is the policy of {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) to protect the electronic transmission of PHI as well as to fulfill our duty to protect the confidentiality and integrity of resident PHI as required by law, professional ethics, and accreditation requirements. The information released will be limited to the minimum necessary to meet the requestor’s needs. Whenever possible, de-identified information will be used.

**Procedure**

1. E-mail users will be set up with a unique identity complete with unique password and file access controls.
2. E-mail users may not intercept, disclose, or assist in intercepting and disclosing e-mail communications.
3. Resident specific information regarding highly sensitive health information must not be sent via e-mail, even within the internal email system (i.e. information relating to AIDS/HIV, drug and alcohol abuse, and psychotherapy notes).
4. Users will restrict their use of email for communicating normal business information such as information about general care and treatment of residents, operational and administrative matters, such as billing.
5. Users should verify the accuracy of the email address before sending any PHI and, if possible, use email addresses loaded in the system address book.
6. PHI may be sent unprotected via e-mail within a properly secured, internal network of the organization. When sending PHI outside of this network, such as over the Internet, every effort should be made to secure the confidentiality and privacy of the information. Sample security measures include password protecting the document(s) being sent or encrypting the message.
7. All e-mail containing PHI will contain a confidentiality statement (see sample below).
8. Users should exercise extreme caution when forwarding messages. Sensitive information, including resident information, must not be forwarded to any party outside the organization without using the same security safeguards as specified above.
9. Users should periodically purge e-mail messages that are no longer needed for business purposes, per the Facility’s records retention policy.
10. Employee e-mail access privileges will be removed promptly following their departure from the Facility.
11. Email messages, regardless of content, should not be considered secure and private. The amount of information in any email will be limited to the minimum necessary to meet the needs of the recipient.
12. Employees should immediately report any violations of this guideline to their supervisor, Administrator or Privacy Officer.

Sample Confidentiality Statement

The information contained in this e-mail is legally privileged and confidential information intended only for the use of the individual or entity to whom it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any viewing, dissemination, distribution, or copy of this e-mail message is strictly prohibited. If you have received and/or are viewing this e-mail in error, please immediately notify the sender by reply e-mail, and delete this e-mail from your system. Thank you.

**{Facility}**

**Faxing protected health information policy and procedure**

**Purpose**

To ensure that Protected Health Information (“PHI”) is appropriately safeguarded when it is sent or received via facsimile (fax) machine or software.

**Policy**

It is the policy of {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) to allow the use of facsimile machines to transmit and receive PHI. The information released will be limited to the minimum necessary to meet the requestor’s needs.

**Procedure**

1. The fax machine should be located in an area that is not easily accessible to unauthorized persons. Examples include the business office, medical record office, or nurse’s station. If possible, the fax machine should not be located in a public area where confidentiality of PHI might be compromised. If this is not possible, a sign should be posted regarding access to the documents. (See sample sign following this Policy.)
2. The Facility shall ensure that only authorized individuals have access to its fax machines.
3. Received documents will be removed promptly from the fax machine. To promote secure delivery, instructions on the cover page will be followed.
4. Unless otherwise prohibited by state law, information transmitted via facsimile is acceptable and may be included in the resident’s Medical Record.
5. Steps should be taken to ensure that the fax transmission is sent to the appropriate destination. These include:
   1. Pre-programming and testing destination numbers whenever possible to eliminate errors in transmission due to misdialing.
   2. Asking frequent recipients to notify the Facility of a fax number change.
   3. Confirming the accuracy of the recipient’s fax number before pressing the send/start key.
   4. If possible, printing a confirmation of each fax transmission.
6. A cover page should be attached to any facsimile document that includes PHI. The cover page should include:
   1. Destination of the fax, including name, fax number and phone number;
   2. Name, fax number and phone number of the sender;
   3. Date;
   4. Number of pages transmitted; and
   5. Confidentiality Statement (See sample below).
7. If a fax transmission fails to reach a recipient or if the sender becomes aware that a fax was misdirected, the internal logging system should be checked to obtain the incorrect recipient’s fax number. The Facility will follow its policies with regard to PHI breaches. See breach of protected of PHI policy and procedure.
8. The Facility will obtain a written authorization for any use or disclosure of PHI when the use or disclosure is not for treatment, payment, or healthcare operations or required by federal or state law or regulation.
9. The PHI disclosed will be the minimum necessary to meet the requestor’s needs.

Sample Confidentiality Statement

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***Confidential and Protected Communication***

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**{Facility}**

**Login Monitoring Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with applicable laws regarding the security of electronic protected health information (ePHI) through login monitoring.

**POLICY**

It is the policy of the Facility to monitor login attempts in order to detect and report login discrepancies, such as unauthorized and/or failed login attempts and dual login attempts.

**PROCEDURE**

1. The Compliance and Ethics Officer will monitor and review login activity.
2. The Compliance and Ethics Officer will ensure that the Facility's systems have login monitoring and reporting functionality.
3. The Compliance and Ethics Officer will 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 Policy.
4. The Compliance and Ethics Officer will establish a review process whereby systems login logs, reports, or other mechanisms that document login activity are reviewed by the Compliance and Ethics Officer at intervals commensurate with their risk level.
5. The Compliance and Ethics Officer will be alerted by work force members and the Facility’s systems to login attempts deemed reasonably “suspect” by the work force members or the system within a reasonable period of time.
6. The Compliance and Ethics Officer will determine and set a reasonable time of inactivity that will terminate a work force member's workstation by automatic logoff.
7. The Compliance and Ethics Officer must consider a system's login monitoring and reporting functionality as a factor in the Facility's systems purchase decisions for those systems that require it.
8. Work force members will receive training and reminders about login monitoring and reporting of discrepancies as per the Facility's Employee Education and Training Policy and Procedure.

**{Facility}**

**Privacy for Verbal, Telephone, and Other Types of Communications Policy and Procedure**

**PURPOSE**

To ensure that Protected Health Information (“PHI”) is appropriately safeguarded when it is verbally communicated.

**POLICY**

It is the policy of {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) to ensure that appropriate safeguards are in place to ensure the confidentiality of verbally communicated PHI.

**PROCEDURE**

1. Verbal and Substitute Communications in Healthcare Areas
2. All Employees and individuals involved in a resident’s care shall be required to speak quietly when discussing a resident’s PHI and avoid the use of residents’ names or other identifiers in conversations whenever possible.
3. All Employees and individuals involved in a resident’s care shall not discuss PHI in public areas, either verbally or by sign-language.
4. Telephone Use in Healthcare Areas
5. All Employees and individuals involved in a resident’s care shall:
   1. Conduct telephone conversations that include PHI in private areas, if possible.
   2. Make reasonable efforts to verify the identity of the other person(s) before proceeding with a telephone conversation.
6. Answering Machines: Employees and individuals involved in a resident’s care must never leave PHI in a message (diagnoses, lab test names or lab results, surgical procedures, etc.) on an answering machine, voicemail system, or with an unknown person who takes a message for a resident.

**{Facility}**

**Audit Controls Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) has the technical capabilities to record and examine systems that contain or use electronic protected health information (ePHI).

**POLICY**

It is the policy of the Facility to implement and utilize 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 ePHI. It is also the policy of the Facility to examine and review that recorded activity on a periodic basis, and to maintain and store such recorded activity for a reasonable amount of time.

**PROCEDURE**

1. The Compliance and Ethics Officer will be educated about the audit control features and functionality of the systems, applications, and devices that receive, store, transmit, or otherwise access ePHI that are in use by the Facility.
2. The Compliance and Ethics Officer will educate the appropriate work force members in charge of systems, applications, or devices that receive, store, transmit, or otherwise access ePHI about the audit control features and functionality of their systems.
3. The Compliance and Ethics Officer will 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 ePHI.
4. In the event audit control features will not become available, the Compliance and Ethics Officer will find an alternate audit control feature and/or temporarily refrain from using the device from receiving, storing, or otherwise transmitting ePHI. The Compliance and Ethics Officer will also attempt 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.
5. The Compliance and Ethics Officer will consider audit control features and functionality in purchase decisions for systems, applications, and devices that receive, store, transmit, or otherwise access ePHI.
6. The Compliance and Ethics Officer will ensure that adequate systems storage is available for the storage of audit control information.
7. The Compliance and Ethics Officer will determine:
   1. What information needs to be captured by audit control features and functionality within each system, application, and device.
   2. Which audit control reports must be generated from each system, application, and device.
   3. How often audit control reports should be generated and in what manner.
   4. Who will receive and review the audit control information.
   5. Procedures for documenting and reporting audit control discrepancies.
   6. The length of time, and manner in which, to store the generated audit control information.

**{Facility}**

**Disclosures for Law Enforcement Purposes   
Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with HIPAA Privacy Rule requirements when law enforcement officials request a resident’s Protected Health Information (“PHI”).

**POLICY**

PHI may be disclosed pursuant to judicial or administrative process without the written authorization of the resident, or the opportunity for the resident to agree or object, subject to certain conditions. The Facility will disclose PHI in the course of judicial or administrative process in response to a court or administrative tribunal order. The Facility will disclose PHI in response to a subpoena, discovery request, or other lawful process that is not accompanied by a court order, subject to the conditions set forth in this procedure. In either case, the Facility will disclose only that PHI expressly authorized by the subpoena, discovery request, other lawful process, or court order. (The Facility may contact its legal counsel to review and verify the legality of a subpoena requesting PHI served.)

**PROCEDURE**

The Facility may disclose a resident’s PHI for a law enforcement purpose to a law enforcement official in the following scenarios:

1. Where required by laws that require the reporting of certain types of wounds or other physical injuries; or
2. In Compliance with, and as limited by, the relevant requirements of:
   1. A court order or court-ordered warrant, or a subpoena, or summons issued by a judicial officer;
   2. A grand jury subpoena; or
   3. An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
      1. The information sought is relevant and material to a legitimate law enforcement inquiry;
      2. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
      3. De-identified information could not reasonably be used.
3. In response to a law enforcement official’s request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. In such cases, the Facility may disclose only the following information:
   1. Name and address;
   2. Date and place of birth;
   3. Social security number;
   4. ABO blood type and RH factor;
   5. Type of injury;
   6. Date and time of treatment;
   7. Date and time of death, if applicable; and
   8. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.
4. In response to a law enforcement official’s request for such information about a resident who is or is suspected to be a victim of a crime, if:
   1. The resident agrees to the disclosure; or
   2. The Facility is unable to obtain the resident’s agreement because of incapacity or other emergency circumstance, provided that:
      1. The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;
      2. The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the resident is able to agree to the disclosure; and
      3. The disclosure is in the best interests of the resident as determined by the Facility, in the exercise of its professional judgment.
5. About a resident who has died for the purpose of alerting law enforcement of the death of the resident if the Facility has a suspicion that such death may have resulted from criminal conduct.
6. In cases where the Facility believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Facility’s premises.

**{Facility}**

**Contingency Plan Testing and Revision Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with applicable laws regarding responding to an emergencies or other occurrences.

**POLICY**

The Facility shall establish a plan for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic protected health information (ePHI).

**PROCEDURE**

The Facility shall implement a contingency plan in the following risk areas:

1. Data backup plan.
   1. Establish and implement procedures to create and maintain retrievable exact copies of ePHI.
2. Disaster recovery plan.
   1. Establish procedures to restore any loss of data.
3. Emergency mode operation plan.
   1. Establish procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in emergency mode.
4. Applications and data criticality analysis (Addressable). Assess the relative criticality of specific applications and data in support of other contingency plan components.

**{Facility}**

**Security Officer Job Description**

**PURPOSE**

{Facility}’s (the “Facility”) Compliance and Ethics Officer shall also serve as the Facility’s Information Security Officer.

The Information Security Officer shall be responsible for all ongoing activities related to the availability, integrity, and confidentiality of residents’ protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996, and in Compliance with the Facility’s security policies and procedures as well as other applicable regulations and laws.

**RESPONSIBILITIES**

1. Develops in association with the Facility’s Compliance and Ethics Committee the information security policies and procedures.
2. Implements the Facility’s information security policies and procedures.
3. Coordinates the information security Compliance and Ethics activities.
4. Provides direct information security training to the Facility Associates (includes any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility).
5. Monitors Compliance and Ethics with the Facility’s security policies and procedures among Associates and takes corrective action.
6. Manages information security incident response.
7. Monitors internal control systems to ensure that appropriate information access levels and security clearances are maintained.
8. Performs information security risk analysis and periodic information system activity reviews for information security processes.
9. Coordinates the development of the Facility’s disaster recovery and business continuity plans for information systems, and tests readiness.
10. Monitors advancements in information security technologies.
11. Monitors changes in legislation and accreditation standards that affect information security.
12. Initiates, facilitates, and promotes activities to foster information security awareness within the Facility.

**QUALIFICATIONS**

1. Baccalaureate or Associate’s degree from an accredited institute of higher education.
2. Experience in project management and change management.
3. Knowledge of network infrastructure.
4. Knowledge of database applications.
5. Good presentation and communication skills.

**{Facility}**

**Risk Management Policy and Procedure**

**PURPOSE**

The purpose of this policy is to ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws regarding security risk management.

**POLICY**

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

**PROCEDURE**

1. The Security Officer will form a risk analysis and mitigation committee, which will be responsible for all tasks related to risk management, as assigned by the Security Officer in accordance with the policies of the Facility. Such risk management tasks shall include, but not be limited to:
   1. Reducing identified risks to reasonable and appropriate levels;
   2. Monitoring security risks to all ePHI systems throughout the year, including information systems security reviews, and providing feedback to the appropriate work force members;
   3. Auditing and updating the risk assessment no less than once per year; and
   4. In coordination with human resources, enforcing sanctions of violations of HIPAA security policies.

**{Facility}**

**Risk Analysis Policy and Procedure**

**PURPOSE**

To ensure that Client (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws regarding security risk analysis.

**POLICY**

The Security Officer shall be responsible for conducting an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of PHI that the Facility holds.

**PROCEDURE**

1. The Facility shall conduct a comprehensive risk analysis of security threats conducted at least once every three years. The analysis should be reviewed annually and updated as needed.
2. The Facility shall conduct an additional comprehensive risk analysis upon the occurrence of a significant event or change in the Facility’s organization or environment.
   1. A significant event includes, but is not limited to:
      1. A security incident;
      2. Notification by Community Emergency Response Team (CERT) or other authority of a weakness and a threat that might act upon it; and
      3. Information about risk received from a whistleblower
3. The risk analysis should comprehensively describe the Facility’s information system, including the following components:
4. The computer hardware and software that make up the Facility’s information system.
5. The categories and qualifications of Associates who use the system.
6. The functions and activities supported by the information system.
7. The data and information the information system collects, processes, and stores.
8. The physical environment that houses the information system components.
9. On-site and off-site storage of information.
10. The entities to which information is transmitted.
11. The data and information transmitted to other organizations.
12. The internal and external connections between the Facility’s information system and the information systems of other organizations.
13. The risk analysis will identify threats to the security of the Facility’s PHI, including natural, human, and environmental threats. It shall also identify the nature of each threat or vulnerability and how each may damage information security.
14. The risk analysis shall indicate the preventive measures that the Facility has implemented (or is planning to implement) to limit the damage that might be caused by each threat or vulnerability and evaluates the likelihood that each security threat or vulnerability might occur.
15. The risk analysis shall describe the nature and extent of the damage each threat might cause to the integrity, availability, and confidentiality of the Facility’s information resources. It shall also identify high-priority threats that are the focus of risk management efforts and recommends controls or actions to lessen the risk associated with high-priority threats. The Security Officer shall review and approve the risk analysis, and the results shall be shared with other members of the Facility’s management team and presented to the Facility’s Governing Body.
16. The risk analysis shall categorize the facility’s information systems (see II above) based on the potential impact to the facility should such systems become unavailable.
    1. The information systems shall be classified as high, moderate or low impact systems to assist the facility in setting the scope of its audits and to prioritize investments for security mitigation.
    2. The Facility shall document the security categorization results, including supporting rationale.
    3. The security categorization decision shall be reviewed and approved by the Governing Body or the Governing Body’s designated representative (i.e. the Compliance and Ethics Officer/Security Officer).
17. Security Plan Documentation System
    1. The Facility implement shall implement a Security Plan Documentation System (“Security Plan”) for managing identified risks.
    2. The Security Plan shall document the controls and methods in place or planned to mitigate the threats and vulnerabilities to ePHI identified as a result of conducting the risk analysis and shall rely on the findings included in the Facility’s risk assessment to identify the appropriate management and operational or technical safeguards to manage risk to an acceptable level.
    3. In order to be able to implement effective safeguards to protect ePHI, the Facility shall document and share the results of the risk analysis with the staff responsible for making risk management decisions, developing risk-related policies, and implementing risk mitigation safeguards for ePHI. The Facility shall document the results of its risk analysis and assure the results are distributed to appropriate members of its workforce who are responsible for mitigating the threats and vulnerabilities to ePHI identified through the risk analysis.

**{Facility}**

**Security Management Processes Policy And Procedure**

**PURPOSE**

To ensure the safeguarding of the confidentiality, integrity, and availability of electronic Protected Health Information (ePHI), applications, systems, and networks pursuant to the Health Insurance Portability and Accountability Act of 1996.

**POLICY**

It is {Facility}’s (the “Facility”) policy to ensure that appropriate safeguards are in place and effective. The Facility shall review logs of access and activity to detect, report, and guard against:

* Network vulnerabilities and intrusions.
* Breaches in confidentiality and security of patient protected health information.
* Performance problems and flaws in applications.
* Improper alteration or destruction of ePHI (information integrity).

This policy applies to organizational information applications, systems, networks, and any computing devices, regardless of ownership (e.g., owned, leased, contracted, and/or stand-alone).

This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”).

The Facility shall review logs of access and activity of ePHI applications, systems, and networks and address standards set forth by the HIPAA Security Rule to ensure Compliance and Ethics to safeguarding the privacy and security of ePHI. The Security Rule requires the Facility to implement reasonable hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use ePHI. It does not describe in detail the data that should be gathered in system logs or the length of time these must be kept. Review activities may be limited by application, system, and/or network reviewing capabilities and resources. The Facility shall make reasonable and good-faith efforts to safeguard information privacy and security through a well-thought-out approach to reviewing of logs which is consistent with available resources. The Compliance and Ethics/Security and Privacy Officer together with the facility administration are responsible for the implementation of the procedures in this policy.

Violation of this policy by workforce members may result in corrective disciplinary action, up to and including termination of employment. Violation of this policy by other Associates may result in termination of the relationship and/or associated privileges. Violation may also result in civil and criminal penalties as determined by federal and state laws and regulations.

**PROCEDURE**

1. Key Definitions
2. Log Review: The internal process of reviewing information system access and activity (e.g., log-ins, file accesses, and security incidents). A review may be done as a periodic event, as a result of a resident complaint, or suspicion of Associate wrongdoing. Review activities shall also take into consideration the Facility’s information system risk analysis results.
3. System Logs: Records of activity maintained by the system which provide: 1) date and time of activity; 2) origin of activity; 3) identification of user performing activity; and 4) description of attempted or completed activity.
4. Review Trail: A means to monitor information operations to determine if a security violation occurred by providing a chronological series of logged computer events (review logs) that relate to an operating system, an application, or user activities. Review trails provide: (1) Individual accountability for activities such as an unauthorized access of ePHI; (2) Reconstruction of an unusual occurrence of events such as an intrusion into the system to alter information; (3) Problem analysis such as an investigation into a slowdown in a system’s performance, and (4) Other data as needed based on the Facility objectives.
   1. *A review trail identifies who (login) did what (create, read, modify, delete, add, etc.) to what (data) and when (date, time).*
5. Electronic Protected Health Information (ePHI): Electronic protected health information means individually identifiable health information that is: transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.
6. Trigger Event: Activities that may be indicative of a security breach that require further investigation (See Appendix A).
7. General
8. Responsibility for reviewing information system access and activity is assigned to the Facility’s Information Systems (IS) Department Leader, Compliance and Ethics/Security Officer, departmental Security or Privacy coordinator, or other designee as determined by the Facility’s administration. The responsible individual shall:
   1. Assign the task of generating reports for review activities to the individual responsible for the application, system, or network.
   2. Assign the task of reviewing the logs to the individual responsible for the application, system, or network, the Compliance and Ethics/Privacy Officer, or any other individual determined to be appropriate for the task.
   3. Organize and provide oversight to a team structure charged with review Compliance and Ethics activities (e.g., parameters, frequency, sample sizes, report formats, evaluation, follow-up, etc.).
9. The Facility’s reviewing processes shall address access and activity at the following levels listed below. Reviewing processes may address the date and time of each log-on attempt, date and time of each log-off attempt, devices used, functions performed, etc.
   1. User: User level review trails generally monitor and log all commands directly initiated by the user, all identification and authentication attempts, and files, patients, and resources accessed.
   2. Application: Application level review trails generally monitor and log user activities, including data files opened and closed, patients accessed, specific actions, and printing reports.
   3. System: System level review trails generally monitor and log user activities, applications accessed, and other system defined specific actions.
   4. Network: Network level review trails generally monitor information on current operations, penetrations, and vulnerabilities.
10. The Facility shall determine the systems or activities that will be tracked or reviewed by:
    1. Focusing efforts on areas of greatest risk and vulnerability as identified in the information systems risk analysis and ongoing risk management processes.
    2. Maintaining confidentiality, integrity, and availability of ePHI applications and systems.
    3. Assessing the appropriate scope of system reviews based on the size and needs of the Facility by determining:
       1. information/ePHI at risk,
       2. systems, applications or processes which are vulnerable to unauthorized or inappropriate access,
       3. activities that should be monitored (create, read, update, delete = CRUD),
       4. information to be included in the review record,
       5. Assessing available organizational resources.
11. The Facility shall identify “trigger events” or criteria that raise awareness of questionable conditions of viewing of confidential information. The “events” may be applied to the entire facility or may be specific to a department, unit, or application (See Appendix – Listing of Potential Trigger Events). At a minimum, the Facility shall provide immediate reviewing in response to:
    1. Resident complaint.
    2. Employee complaint.
    3. Suspected breach of resident confidentiality.
    4. High risk or problem prone event (e.g., VIP admission).
    5. External report, such as from credit bureau or law enforcement.
12. The Facility shall determine review criteria with a risk based approach. This may include but is not limited to reviewing security risk analysis findings, past experience, current and projected future needs, and industry trends and events. The Facility will determine its ability to generate, review, and respond to review reports using internal resources. The Facility may determine that external resources are also appropriate. The Facility recognizes that failure to address automatically generated review logs, trails, and reports through a systematic review process may be more detrimental to the facility than not reviewing at all.
13. The Facility shall designate the Associates who are authorized to use security testing and monitoring tools. Such tools may not be used by anyone not specifically authorized. These tools may include, but are not limited to:
    1. Scanning tools and devices.
    2. War driving software.
    3. Password cracking utilities.
    4. Network or wireless packet capture utilities.
    5. Passive and active intrusion detection systems.
    6. Other devices as determined by the Facility.
14. Review documentation/reporting tools shall address, at a minimum, the following data elements:
    1. Authorizing official or policy, Application, System, Network, Department, and/or User Reviewed.
    2. Review Type.
    3. Individual/Department Responsible for Review.
    4. Date(s) of Review.
    5. Reporting Responsibility/Structure for Review Results.
    6. Conclusions.
    7. Recommendations.
    8. Actions.
    9. Assignments.
    10. Follow-up.
15. The process for review of logs, trails, and reports shall include:
    1. Description of the activity as well as rationale for performing review.
    2. Identification of which workforce members or department/unit will be responsible for review (workforce members should not review logs which pertain to their own system activity unless there is no alternative or an inherent conflict of interest).
    3. Frequency of the reviewing process.
    4. Determination of significant events requiring further review and follow-up.
    5. Identification of appropriate reporting channels for review of results and required follow-up.
16. Vulnerability testing software may be used to probe the network. This may be to identify what is running (e.g., operating system or product versions in place). Any publicly-known vulnerabilities should be corrected. Re-evaluate whether the system can withstand attacks aimed at circumventing security controls.
    1. Testing may be carried out internally or provided through an external third-party vendor. Whenever possible, a third party reviewing vendor should not be providing the organization IT oversight services (e.g., vendors providing IT services should not be reviewing their own services – separation of duties).
    2. Testing shall be done on a routine basis (e.g., annually).
17. Review Requests for Specific Cause
18. A request may be made for review for a specific cause. The request may come from a variety of sources including, but not limited to, a resident, Human Resources, Risk Management, the Compliance and Ethics/Privacy/Security Officer, and/or a member of the Facility’s administration.
19. A request for a review for specific cause must include time frame and nature of the request. The request must be reviewed and approved by the Facility’s Compliance and Ethics/Privacy/Security Officer.
20. A request for a review as a result of a resident concern shall be initiated by the Facility’s Compliance and Ethics/Privacy/Security Officer. Detailed review may be shared with the resident. If this is done, a careful explanation must be given to the resident concerning the need for many individuals to have access to records.
    1. Should the review disclose that an Associate accessed a resident’s PHI inappropriately, the information shall be shared with the Associate’s supervisor/and or Human Resources Department to determine appropriate sanction/corrective disciplinary action.
    2. The Facility may, but is not obligated to share details of the logs with the resident. Prior to communicating with the resident, the Facility will consider the need to collaborate with risk management and/or legal counsel for incidents of a more sensitive nature.
21. Evaluation and Reporting of Review Findings
22. The Facility shall ensure that system logs that are routinely gathered shall be reviewed in a timely manner.
23. The Facility shall ensure that a report of review of results will be limited on a minimum necessary/need to know basis. Review of results will only be disclosed as deemed necessary, with legal or administrative counsel to be consulted as needed.
24. There is no legal requirement to disclose the name of an individual who breached a resident’s record. There is also no obligation to share the name of every individual that was involved in processing a resident record. The Facility may choose to disclose this information. If the organization chooses to provide a complete list of everyone that accessed a record, it must be done with a careful explanation to the patient. Most patients do not know how many individuals are involved in processing their records. When a patient asks if a specific individual has accessed records, only that name should be disclosed.
25. The reporting process shall allow for meaningful communication of the review findings to the appropriate departments/units.
26. Security reviews constitute an internal, confidential monitoring practice that may be included in the Facility’s performance improvement activities and reporting.
27. Whenever indicated through evaluation and reporting, appropriate corrective actions must be undertaken. These actions shall be documented and shared with the responsible and sponsoring departments/units.
28. If criminal activity is discovered during a review, it will be reported to appropriate law enforcement.
29. Reviewing Business Associate and/or Vendor Access and Activity
30. Periodic monitoring of business associate and vendor information system activity shall be carried out to ensure that access and activity is appropriate for privileges granted and necessary to the arrangement between the Facility and the external agency.
31. If it is determined that the business associate or vendor has exceeded the scope of access privileges, the Facility’s leadership will reassess the business relationship.
32. If it is determined that a business associate has violated the terms of the Facility’s HIPAA business associate agreement, the Facility shall take immediate action to remediate the situation. Continued violations may result in discontinuation of the business relationship.
33. Review Log Security Controls and Backup
34. Review logs shall be protected from unauthorized access or modification, so the information they contain will be available if needed to evaluate a security incident.
35. Whenever possible, audit trail information shall be stored on a separate system. This is done to apply the security principle of “separation of duties” to protect audit trails from hackers. Audit trails maintained on a separate system would not be available to hackers who may break into the network and obtain system administrator privileges. A separate system would allow the Facility to detect hacking security incidents.
36. Review logs maintained within an application shall be backed-up as part of the application’s regular backup procedure.
37. The Facility shall review internal back-up, storage and data recovery processes to ensure that the information is readily available in the manner required.
38. Workforce Training, Education, Awareness and Responsibilities
39. The Facility shall provide Associate’s training, education, and awareness on safeguarding the privacy and security of resident protected health information.
40. The Facility’s commitment to reviewing access and activity of the information applications, systems, and networks is communicated through new employee orientation, ongoing training opportunities and events, and applicable policies.
41. Associates shall be made aware of responsibilities with regard to privacy and security of information as well as applicable sanctions/corrective disciplinary actions should the reviewing process detect an Associate’s failure to comply with organizational policies.
42. External Reviews of Information Access and Activity
43. Information system review information and reports gathered from contracted external review firms, business associates, and vendors shall be evaluated and appropriate corrective action steps taken as indicated.
44. Prior to contracting with an external review firm, the Facility shall:
    1. Outline the review responsibility, authority, and accountability.
    2. Choose a review firm that is independent of other organizational operations.
    3. Ensure technical competence of the review firm staff.
    4. Require the review firm’s adherence to applicable codes of professional ethics.
    5. Obtain a signed HIPAA-compliant business associate agreement.
    6. Assign organizational responsibility for supervision of the external review firm.
45. Retention of Review Information
46. Review logs and audit trail report information shall be maintained based on organizational needs. Retention of this information shall be based on:
    1. Organizational history and experience.
    2. Available storage space.
    3. Reports summarizing review activities shall be retained for a period of six years

**APPENDIX A – TRIGGER EVENTS**

**POTENTIAL TRIGGER EVENTS THAT MAY REQUIRE FURTHER INVESTIGATION/REVIEWING**

Examples include:

* High risk or problem prone incidents or events.
* Resident and/or employee complaints.
* High profile resident/event (e.g., accident, homicide, assault, etc.).
* Requests by law enforcement or other outside agency with proper subpoena if applicable.
* Atypical patterns of activity.
* Failed authentication attempts.
* Users that have the same last name, address, or street name as in the patient file being viewed.
* VIPs encounters (board members, celebrities, governmental or community figures, authority figures, physician providers, management staff, or other highly publicized individuals).
* Resident files with no activity for XX days.
* Employees viewing other employee records.
* Diagnosis related (e.g., STD, HIV, pregnancy, AODA, mental health, etc.).
* Remote access use and activity.
* After-hours activity if applicable.
* Activity post termination.
* Department- or unit-specific circumstances – risk areas to be determined by individual departments/business units:
  + Providers viewing files of patients on other units (e.g., medical and surgical nurses viewing files of patients treated only in emergency services or psychiatric services).
  + Transcriptionists viewing files of services or patients for whom they did not transcribe reports.
  + Medicare billers viewing insurance categories they do not process.

**{Facility}**

**Use and Disclosure of Protected Health Information   
Policy and Procedure**

**POLICY**

It is the policy of {Facility} (the “Facility”) to protect the privacy and confidentiality of protected health information (PHI). Both state and federal laws impose requirements on how protected health information created or maintained by the Facility may be used and disclosed. The Facility intends to comply with all applicable laws protecting the privacy and confidentiality of PHI, including, but not limited to, the Privacy Rules established under HIPAA.

**PROCEDURE**

1. Generally

The Facility shall not use or disclose PHI unless it is permitted or required by state or federal law before permitting the use or disclosure of PHI.

1. Commitment to Privacy and Confidentiality of Health Information
   1. The Facility shall maintain policies and procedures regarding PHI that workforce members shall be required to comply with, including, but not limited to, the following:
   2. Use and disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations Policy and Procedure
   3. Right to Access to Protected Health Information
   4. Right to Amendment of Protected Health Information Policy and Procedure
   5. Right to Accounting of Disclosures of Protected Health Information Policy and Procedure
   6. Right to Request Restrictions on Use or Disclosure of Protected Health Information Policy and Procedure
   7. Right to Request Confidential Communication of Protected Health Information Policy and Procedure
   8. Right to Request Alternative Communication of Protected Health Information Policy and Procedure
   9. Use and Disclosure of PHI Subject to an Authorization
   10. Use and Disclosure of Protected Health Information Subject to the Minimum Necessary Standard Policy and Procedure
   11. Use and Disclosure of Protected Health Information for Fundraising Purposes Policy and Procedure
   12. Use and Disclosure of Protected Health Information in the Facility Directory
   13. Personal Representation of Residents Policy and Procedure
   14. Use and Disclosure of Protected Health Information Not Subject to Permission of Resident
   15. Use and disclosure of Protected Health Information for Research purposes
   16. Use and Disclosure of Protected Health Information to Persons Involved in the Resident's Care and Notification Purposes Policy
   17. Use and Disclosure of De-Identified Protected Health Information
   18. Use and Disclosure of Protected Health Information Located Within a Limited Data Set
   19. Safeguarding Against Wrongful Uses and Disclosures of Protected Health Information Policy and Procedure
   20. Employee Sanctions for HIPAA Violations Policy and Procedure
   21. Complaints to the Facility Regarding the Facility Privacy Practices Policy and Procedure
   22. HIPAA Recordkeeping Policy and Procedure
   23. Verification of Entities or Persons to Whom Protected Health Information May Be Disclosed
   24. Use and Disclosure of Protected Health Information by Business Associates

**{Facility}**

**Use and Disclosure of Protected Health Information—Treatment, Payment, and Health Care Operations**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws that set forth rules regarding use and disclosure of protected health information (“PHI”) for treatment, payment, and health care operations.

**POLICY**

It is the policy of the Facility to use and disclose PHI for treatment, payment, and health care operations without a resident’s authorization unless required by law.

**PROCEDURE**

1. Acknowledgement
   1. The Facility will provide every resident with its Notice of Privacy Practices on or before the time of first service delivery and obtain an Acknowledgement Form signed and dated by the individual. The Facility may delay such actions in an emergency situation. The signed acknowledgement shall be filed with the resident’s records.
2. Uses and Disclosures for Treatment, Payment and Health Care Operations
   1. The following routine and recurring uses and disclosures shall be generally permitted:
   2. Disclosures to other health care providers upon the request of a health care provider of the Facility for treatment purposes;
   3. Disclosures for payment purposes; or
   4. Disclosures for health care operations purposes performed by the Facility.
   5. Psychotherapy notes, if an, shall be maintained separately from the resident’s medical record and shall not be disclosed without specific authorization signed by the resident for each disclosure, unless otherwise permitted by State or Federal law.

**{Facility}**

**Right to Access Protected Health Information   
Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws that grant residents, former residents, or a resident’s legal representative (collectively referred to herein as the (“resident”) the right to request access to their Protected Health Information (“PHI”) in the form of a Designated Record Set.

**POLICY**

It is the policy of the Facility that residents have the right to request access to inspect and/or obtain a copy of their PHI in a Designated Record Set, for as long as the PHI is maintained by the Facility. See the Facility’s Designated Record Set Policy and Procedure.

**PROCEDURE**

1. Right to Access PHI
   1. All residents have a right of access to inspect and obtain a copy of their PHI, except for psychotherapy notes and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, for as long as the PHI is maintained by the Facility.
2. Request for Access
   1. All requests for access to PHI must be made in writing. The Compliance and Ethics Officer will determine whether the written request is adequate based on the information provided. The Compliance and Ethics Officer may assist the resident in requesting access, if necessary. The Compliance and Ethics Officer will review the request in consultation with other the Facility staff to determine the feasibility of the request. If the resident’s request for access is incomplete, the Facility will send the resident a written form requesting necessary outstanding information so that the request can be processed.
3. Determining Right of Access
   1. The Compliance and Ethics Officer shall determine whether a request for access should be granted or denied, in whole or in part, for reasons acceptable under State and Federal law. Such determination should be made within thirty (30) days of the receipt of the request for the PHI. The Facility may have a onetime extension of thirty (30) days to the time frames noted above in 3.a., provided that:
      1. A written statement of the reasons for the delay are provided, and
      2. The date by which the Facility will complete its action on the request is stated.
4. Access Granted

If the Compliance and Ethics Officer determines that the Facility will grant the request for access, in whole or in part, the Facility will send the requesting resident a written notification and provide the access requested within the applicable timeframe as specified in section 3 above.

* 1. Form of Access. If the Compliance and Ethics Officer determines that the Facility will grant the request for access, the Facility will evaluate the form or format requested by the resident, and determine if such format is readily producible. If the requested format is not available, the Facility will contact the resident and agree upon another format. Upon the request of the resident, the Facility will provide a copy of the resident’s PHI that is maintained in the Facility’s electronic health record in an electronic format.

The Facility shall provide access to the resident in a timely manner as stated below in this policy. The Facility shall furthermore, arrange with the resident for a convenient time and place to inspect or obtain a copy of the PHI, or mailing the copy of the PHI at the resident’s request. The Facility may discuss the scope, format, and other aspects of the request for access with the resident as necessary to facilitate the timely provision of access.

* 1. Summary or Explanation. If the Compliance and Ethics Officer grants the request for access, and the resident has agreed in advance to a summary or explanation of their PHI, and any applicable fee for the summary, the Facility will create a summary or explanation of the resident’s PHI in lieu of providing access. Such summary or explanation will be provided within the applicable timeframe.
  2. Transmission of Electronic Copy to a Person or Entity Designated by the Resident. Upon the written request of the resident, the Facility will transmit an electronic copy of the resident’s PHI maintained in the Facility’s electronic health record directly to an entity or person clearly designated by such resident.
  3. Fees for Copies. The Compliance and Ethics Officer shall determine the fee to be imposed, if any, for copies within the limitations of the law. The Facility may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:
     1. Labor for copying the PHI requested by the individual, whether in paper or electronic form;
     2. Supplies for creating the paper copy or electronic media if the resident requests that the electronic copy be provided on portable media;
     3. Postage, when the resident has requested the copy, or the summary or explanation, be mailed; and
     4. Preparing an explanation or summary of the PHI, if agreed to by the resident as required.
     5. A charge of up to $20 may be collected for search, retrieval, and other direct administrative costs related to providing copies of medical records. A fee for certifying the medical records may also be charged not to exceed $7.50 for each record certified. The actual cost of postage incurred in mailing the requested records may also be charged. In addition, copying costs for a record which is in paper form shall not exceed $0.75 per page for the first 20 pages; $0.65 per page for pages 21 through 100; and $0.50 for each page copied in excess of 100 pages. Facilities may also recover the full reasonable cost of reproductions of records in non-paper form, such as radiology films. Payment may be required by the facility prior to the records being furnished. These fees and restrictions shall not apply to records requested in order to make or complete an application for a disability benefits program.

1. Access Denied

If the Compliance and Ethics Officer determines that the Facility will deny the resident’s request for access, in whole or in part, the Compliance and Ethics Officer must determine whether the resident must be given an opportunity for review of the denial of access.

1. Unreviewable Denial: The Facility may deny a resident access without providing the resident an opportunity for review in circumstances where the PHI requested is psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; the PHI is subject to the Privacy Act, 5 U.S.C. 552a; or the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.
2. Reviewable Access Denial: The Facility may deny a resident access, provided that the resident is given a right to have such denials reviewed, in the following circumstances:
   1. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the resident or another person
   2. The PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
   3. The request for access is made by the resident’s personal representative and a licensed health care 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.
3. Access Denied: If the Facility denies access, the Facility shall provide a timely, written denial to the resident. The denial shall be in plain language and contain:
   1. The basis for the denial;
      1. A statement of the resident’s review rights, including a description of how the resident may exercise such review rights (see d below); and
      2. A statement that the resident may complain to the Facility pursuant to the Facility’s Complaint Policy and Procedure, or to the Secretary of the Department of Health and Human Services. The description shall include the name, or title, and telephone number of the Compliance and Ethics Officer.
4. Review of a denial of access: If access is denied, the resident has the right to have the denial promptly reviewed by a licensed health care professional who is designated by the Facility to act as a reviewing official and who did not participate in the original decision to deny
5. Review Determination.
   1. The determination of the reviewing official is binding on the Facility. Once the review determination has been made, the Facility will promptly notify the resident of the reviewing official’s decision in writing.
6. Alternative Access.

If access is denied because the Facility does not maintain the information that is the subject of the request, and the Facility knows where the requested information is maintained, the Facility will inform the resident where to direct the request for access to the PHI. Additionally, the Facility shall, to the extent possible, give the resident access to any other PHI requested, after excluding the PHI as to which the Facility has a ground to deny access.

1. Documentation.

The Facility document the following and retain the following documentation as required by law

* 1. The designated record sets that are subject to access by residents; and
  2. The titles of the persons or offices responsible for receiving and processing requests for access by residents.

**{Facility}**

**Amendment of Protected Health Information   
Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with applicable laws that grant residents or a resident’s legal representative (collectively referred to herein as the “resident”) the right to request an amendment of their protected health information (“PHI”).

**POLICY**

It is the policy of the Facility that residents have the right to request an amendment of their PHI, for as long as the PHI is maintained by the Facility in a designated record set for as long as the PHI is maintained in the designated record set.

**PROCEDURE**

1. Request for Amendment
   1. All requests for amendments must be submitted to the Facility in writing.
   2. The resident must provide a reason to support a requested amendment.
      1. The Compliance and Ethics Officer will determine whether the request is adequate based on the information provided.
   3. Incomplete Requests
      1. If the resident’s request for amendment is incomplete, the Facility will request the necessary outstanding information from the resident so that the request can be processed.
2. Responding to Request for Amendment in a Timely Manner
   1. The Facility shall act on the resident’s request for an amendment no later than 60 after receipt of such a request, as follows:
      1. If the Facility grants the requested amendment, in whole or in part, it must take the actions required by this policy as stated below.
      2. If the Facility denies the requested amendment, in whole or in part, it must provide the resident with a written denial, in accordance with this policy.
   2. If the Facility is unable to act on the amendment within days, then the Facility may extend the time for such action by no more than 30 days, provided that:
      1. The Facility within days provides the resident with a written statement of the reasons for the delay and the date by which the Facility will complete its action on the request; and
      2. The Facility may have only one such extension of time for action on a request for an amendment.
   3. The Compliance and Ethics Officer shall determine in conjunction with the health care provider who created the information subject to the proposed amendment, whether a request for amendment should be accepted or denied for reasons acceptable under state and federal law. Such determination will be made within the applicable timeframes.
3. Amendment Accepted
   1. If the Facility accepts the requested amendment, in whole or in part, the Facility shall comply with the following requirements:
      1. Making the amendment. The Facility shall make the appropriate amendment to the PHI or record that is the subject of the request for amendment by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment.
      2. Informing the individual. In accordance with this policy, the Facility will timely inform the resident that the amendment is accepted and obtain the resident’s identification of an agreement to have the Facility notify the relevant persons with which the amendment needs to be shared in accordance with this section.
      3. Informing others. The Facility shall make reasonable efforts to inform and provide the amendment within a reasonable time to:
         1. Persons identified by the resident as having received PHI about the resident and needing the amendment; and
         2. Persons, including business associates, that the Facility knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to the detriment of the resident.
4. Amendment Denied
   1. Reasons for Denial. The Facility can deny a resident’s request for amendment, if it determines that the PHI that is the subject of the request:
      1. Was not created by the Facility, 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;
      2. Is not part of the designated record set;
      3. Would not be available for inspection pursuant to the Facility’s Right to Access Protected Health Information Policy and Procedure; or
      4. Is accurate and complete.
   2. Denial statement. If the Facility denies the resident’s request for an amendment, in whole or in part, the Facility will provide a written denial statement containing the following information to the requesting resident within the applicable timeframes:
      1. The resident’s right to submit a written statement disagreeing with the denial and how the resident may file such a statement;
      2. A statement that, if the resident does not submit a statement of disagreement, the resident may request that the Facility 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
      3. A description of how the resident may complain to the Facility pursuant to the Facility’s Complaints to the Facility Regarding the Facility Privacy Practices Policy and Procedure or to the Secretary of HHS. The description shall include the name and telephone number of the Facility’s Compliance and Ethics Officer.
   3. Statement of Disagreement
      1. The Facility shall permit the resident to submit to the Facility a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The Facility may reasonably limit the length of a statement of disagreement.
   4. Rebuttal Statement. In the event that the requesting resident submits a written statement of disagreement, the Compliance and Ethics Officer will determine whether or not the Facility will prepare a written “rebuttal statement” in response to the resident’s statement of disagreement.
      1. If the Facility prepares a written rebuttal statement in response to the resident’s statement of disagreement, the Facility will send a copy of the rebuttal statement to the resident.
   5. Recordkeeping. The Facility shall, 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 Facility’s denial of the request, the resident’s statement of disagreement, if any, and the Facility’s rebuttal, if any, to the designated record set.
   6. Future Disclosures
      1. If a statement of disagreement has been submitted by the resident, the Facility will append the resident’s request for an amendment, the Facility’s denial of the request, the resident’s statement of disagreement and the Facility’s rebuttal statement, if any, or at the election of the Facility, an accurate summary of any such information, with any subsequent disclosures of the PHI to which the disagreement relates.
      2. If the resident has not submitted a written statement of disagreement, the Facility 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 in accordance with this section.
5. Actions on Notices of Amendment
   1. If the Facility is informed by another entity of an amendment to a resident’s PHI, the Facility will identify all records that are affected by the amendment and will make the appropriate amendment to the PHI currently maintained by the Facility by appending a copy of the request for amendment.

**{Facility}**

**Request for Correction/Amendment of Protected Health Information Form**

|  |  |  |
| --- | --- | --- |
| RESIDENT NAME | DATE OF BIRTH | RESIDENT RECORD NUMBER |
| RESIDENT ADDRESS | DATE OF ENTRY TO BE CORRECTED/AMENDED |  |

1. Information to be corrected/amended

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Use additional sheets if needed and attach to this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you agree, the Facility will make a reasonable effort to provide the amendment to other persons who the Facility knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.

* I agree to allow the Facility to release any amended information to individuals or entities as described above.

1. Would you like this amendment sent to anyone else who received the information in the past?

* Yes
* No

If yes, please specify the name and address of the organization(s) or individual(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of resident or personal representative Date

(If Personal Representative, state relationship to resident)

**{Facility}**

**Accounting of Disclosures of Protected Health Information Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with applicable laws relating to granting a resident’s or a resident’s legal representative’s (collectively referred to herein as the “resident”) request to an accounting of certain disclosures of protected health information (PHI).

**POLICY**

It is the policy of the Facility to grant residents’ request to an accounting of certain disclosures of their PHI for the six (6) years preceding the request for an accounting, unless excluded or otherwise prohibited by law.

**PROCEDURE**

1. Maintaining an Accounting. The Facility shall maintain a written accounting of certain non-routine disclosures of PHI as required by federal law.
   1. Disclosures Not Subject to Accounting*:* Residents have a right to receive an accounting of disclosures of PHI made by the Facility in the six (6) years prior to the date on which the accounting is requested, except for disclosures:
      1. To carry out treatment, payment, or health care operations;
      2. To the resident about himself/herself;
      3. That are “incidental” disclosures pursuant to an otherwise permitted or required use or disclosure, i.e. an unintended disclosure to a third party during the course of a permitted use or disclosure;
      4. Pursuant to an authorization;
      5. For the Facility’s directory or that are made to persons involved in the patient’s care or for other notification purposes;
      6. For national security or intelligence purposes as permitted under law;
      7. To correctional institutions or law enforcement officials as permitted under law;
      8. Made as part of a limited data set in accordance with a “limited data use agreement,” used solely to disclose a subset of information for research, public health, or health care operations.
2. Disclosures Made by Business Associates of the Facility. In the event that a Business Associate of the Facility acting on behalf of the Facility (i) made disclosures of PHI other than for treatment, payment, or health care operations, or (ii) made disclosures through the Facility’s electronic health record for treatment, payment, or healthcare operations, upon request of a resident for an accounting of disclosures, the Facility shall either:
   1. provide an accounting of disclosures made by the Facility to or by a Business Associate in accordance with this policy, or
   2. refer the resident directly to the business associate to request an accounting of disclosures made by the business associate, in which event the Facility shall provide the resident with a list of business associate(s) acting on behalf of the Facility and contact information for each business associate, to include mailing address, phone number, and email address.
3. Period of Accounting.
   1. A resident may request an accounting of disclosures for a period of time less than six years from the date of the request.
4. Provision of the Accounting.
   1. The Facility shall act on the resident’s request for an accounting, no later than 60 days after receipt of such a request, as follows.
      1. The Facility shall provide the resident with the accounting requested; or
      2. If the Facility is unable to provide the accounting within the time required above, the Facility may extend the time to provide the accounting by no more than 30 days, provided that:
         1. The Facility, within the time limit set above, provides the resident with a written statement of the reasons for the delay and the date by which the Facility will provide the accounting; and
         2. The Facility may have only one such extension of time for action on a request for an accounting.
   2. The Facility shall provide the first accounting to a resident in any 12-month period without charge. The Facility may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same resident within the 12 month period, provided that the Facility informs the resident in advance of the fee and provides the resident with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.
5. Provision of the Accounting; Content Requirements.
   1. The Facility shall provide the resident with a written accounting that meets the following requirements:
      1. Except as otherwise provided by this policy, the accounting must include disclosures of PHI that occurred during the six years (or such shorter time period as requested by the resident) prior to the date of the request for an accounting, including disclosures to or by business associates of the Facility.
      2. Except as otherwise provided by the following paragraphs of this section, the accounting must include for each disclosure:
         1. The date of the disclosure;
         2. The name of the entity or person who received the PHI and, if known, the address of such entity or person;
         3. A brief description of the PHI disclosed; and
         4. A brief statement of the purpose of the disclosure that reasonably informs the resident of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure as provided by law, if any.
      3. If, during the period covered by the accounting, the Facility has made multiple disclosures of PHI to the same person or entity for a single purpose under as provided by law, the accounting may, with respect to such multiple disclosures, provide:
         1. The information as required above by this section for the first disclosure during the accounting period;
         2. The frequency, periodicity, or number of the disclosures made during the accounting period; and
         3. The date of the last such disclosure during the accounting period.
      4. If, during the period covered by the accounting, the Facility has made disclosures of PHI for a particular research purpose in accordance with the law for 50 or more residents, the accounting may, with respect to such disclosures for which the PHI about the resident may have been included, provide:
         1. The name of the research protocol or other research activity;
         2. A description, in plain language, of the research protocol or other research activity, including the purpose of the research and the criteria for selecting particular records;
         3. A brief description of the type of PHI that was disclosed;
         4. The date or time period during which disclosures occurred, or may have occurred, including date of last such disclosure during the accounting period;
         5. The name, address, and telephone number of the entity that sponsored the research and about the researcher to whom the information was disclosed; and
         6. A statement that the PHI of the resident may or may not have been disclosed for a particular protocol or other research activity.
      5. If the Facility provides an accounting for research disclosures, and if it is reasonably likely that the PHI of the resident was disclosed for such research protocol or activity, the Facility shall, at the request of the resident, assist in contacting the entity that sponsored the research and the researcher.
6. Suspension of Accounting of Certain Disclosures Pursuant to Health Oversight Agency or Law Enforcement Official Request.
   1. The Facility shall temporarily suspend a resident’s right to receive an accounting of disclosures to a health oversight agency or law enforcement official, for the time specified by such agency or official, if such agency or official provides the Facility with a written statement that providing such an accounting to the resident would be reasonably likely to impede the agency’s or official’s activities and specifying the time for which such suspension is required.
   2. If the agency or official makes such a request orally, the Facility must:
      1. Document the statement including the identity of the agency and official making the statement;
      2. Must temporarily suspend the patient’s right to an accounting of any disclosures made to such agency in accordance with the statement;
      3. Limit the temporary suspension to no longer thirty (30) days from the date of an oral request, unless the agency or official submits a written request during that time.
7. Documentation.
   1. The Facility shall document the following and retain the documentation as required by law
   2. The information required to be included in an accounting for disclosures of PHI;
   3. The written accounting that is provided to the resident under this section; and
   4. The titles of the persons or offices responsible for receiving and processing requests for an accounting by residents.
8. Accounting Request Denied. If the Compliance and Ethics Officer denies the resident's request for an accounting, the Facility shall send the resident a Notice of Accounting Denial notice.

**{Facility}**

**Accounting of Disclosures of Protected Health   
Information Form**

Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Accounting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Disclosure | If Multiple  Disclosures  to single  entity:  Frequency? | Name of  Recipient of  Disclosed  PHI | Address of  Recipient of  Disclosed  PHI | Brief  Description  of PHI  Disclosed | Purpose of  Disclosure |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

In lieu of this, you may attach copy of an individual authorization, copy of individual’s request for disclosure, or copy of request for disclosure not requiring authorization.

**{Facility}**

**Right to Request Restrictions on Use or Disclosure of Protected Health Information Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) to comply with applicable laws that grant residents or a resident’s legal representative (collectively referred to herein as the “resident”) the right to request restrictions on the use or disclosure of their protected health information (PHI).

**POLICY**

1. It is the policy of the Facility that residents have the right to request that otherwise permitted uses and disclosures of PHI be restricted. Specifically, residents may request restrictions on:
   1. The use and disclosure of PHI for treatment, payment, or health care operations, or
   2. The disclosures to family, friends, or others for involvement in care and notification purposes.
2. The Facility is not required to comply with such requests for restriction, but will consider and may agree to a restriction. The Facility will consider the need for access to PHI for treatment purposes when considering a request for a restriction.
3. Where the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law or the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full, the Facility must agree to the restriction.

**PROCEDURE**

1. Request for Restriction on Use or Disclosure:
   1. All requests for the restriction of PHI must be made in writing. If a resident submits a written request for restrictions, the Compliance and Ethics Officer will determine whether the request is adequate based on the information provided.
   2. A request for restriction will not be reviewed until the Request to Restrict form is completed and signed by the resident. The Compliance and Ethics Officer may assist the resident in completing the form, if necessary.
   3. The Compliance and Ethics Officer will review the request in consultation with the other Facility staff to determine the feasibility of the request. The Facility shall give primary consideration to the need for access to the PHI for treatment and payment purposes in making its determination.
2. Responding to Request for Restriction on Use or Disclosure: The Compliance and Ethics Officer shall determine whether a request for restriction on use or disclosure should be accepted or denied for reasons acceptable under State and Federal law and inform the resident in writing of the determination.
3. Restriction on Use or Disclosure Not Accepted:
   1. If the Facility declines the request for restriction, the Compliance and Ethics Officer will provide the resident with a copy of the signed response.
4. Restriction on Use or Disclosure Accepted:
   1. If the Facility agrees to the requested restriction, the Facility must abide by the restriction, except:
      1. The Facility may use the restricted PHI, or may disclose such information to a health care provider if:
         1. The resident is in need of emergency treatment, and
         2. The restricted PHI is needed to provide emergency treatment. In this case, the Facility will release the information, but ask the emergency treatment provider not to further use or disclose the resident’s PHI.
      2. The Facility may disclose the information to the individual who requested the restriction.
      3. The Facility may use and disclose the restricted PHI when statutorily required to use and disclose the information under the HIPAA Privacy Rule.
   2. The Compliance and Ethics Officer will notify appropriate the Facility staff of the restriction.
   3. Written Notice. If the Compliance and Ethics Officer determines that the Facility will grant the request for a restriction on use or disclosure, in whole or in part, the Facility will complete and send the resident a written notice of agreed upon restriction.
   4. Informing Others of Request for Restriction on Use or Disclosure. In the event restricted PHI is used or disclosed to a health care provider for emergency treatment, the Facility must request that such health care provider not further use or disclosure the PHI.
   5. Certain Circumstances in Which Requests Will Be Granted*.* Among other circumstances that may form the basis for a request to be granted, the Facility will grant the request for a restriction on use or disclosure if:
      1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and
      2. The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.
5. Restriction on Use or Disclosure Denied:
   1. Written Notice. If the Compliance and Ethics Officer denies the resident’s request for a restriction on use or disclosure, in whole or in part, the Facility will provide the resident with a written notice of restriction denial.
6. Termination of an Agreed to Restriction:
   1. The Facility may terminate its agreement to a restriction or the resident may seek to have the restriction terminated if:
      1. The resident agrees to or requests the termination in writing; or
      2. The resident agrees to the termination verbally and the verbal agreement is documented.
      3. The covered entity informs the individual that it is terminating its agreement to a restriction, except that such termination is:
   2. Not effective for protected health information that the Facility must agree to requested restrict by law
   3. Only effective with respect to protected health information created or received after it has so informed the individual.
7. Documentation of Restriction: As required by law the Facility will document a restriction, a copy of which will be placed in the resident’s file.

***REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION***

Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Directory Information Restriction**: I request that the disclosure of my information maintained in the Facility directory be restricted in the following manner:

\_\_\_\_\_Do not include my name, location, general condition or religious affiliation in the Facility directory.

\_\_\_\_\_Do not disclose my name or religious affiliation to members of the clergy.

\_\_\_\_\_Do not disclose my location in the building to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_Do not disclose my general condition to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Resident or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s Title (e.g., Guardian, Executor of Estate,

Health Care Power of Attorney)

**Other Restrictions:** I request the following restriction(s) on the use or disclosure of my Protected Health Information:

\_\_\_\_\_Do not release information to the following person(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other restriction (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Resident or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative

Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

**The Facility Response:**

\_\_\_\_\_Your request for restriction has been declined.

**Note: The Facility may not deny a request for restriction of Directory Information.**

\_\_\_\_\_Your request for restriction has been accepted. In the case of an emergency or if necessary to comply with the law, we may use and disclose your health information in violation of the restriction. Other than in those circumstances, we will abide by your request unless and until the restriction is terminated (with or without your agreement) and you are notified.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature of the Facility Privacy Official Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

**TERMINATION OF RESTRICTION**

\_\_\_\_\_The above-named resident agreed to terminate this restriction on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_The above-named resident was notified on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) that this restriction was terminated.

* + Resident was notified: (check appropriate box)

\_\_\_\_\_In person

\_\_\_\_\_By telephone (attach documentation of notification)

\_\_\_\_\_By mail (attach documentation of notification)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature of the Facility Privacy Official Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

**Distribution of copies: Original to resident's Medical Record; copy to resident.**

**{Facility}**

**Right to Request Confidential Communication of Protected Health Information Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws that grant residents or a resident’s legal representative (collectively referred to herein as the “resident”) the right to request confidential communication of their protected health information (“PHI”).

**POLICY**

It is the policy of the Facility that residents have the right to request confidential communication of their PHI.

**PROCEDURE**

1. Request for Confidential Communication
   1. All requests for the confidential communication of PHI must be made in writing. If a resident submits a written request for confidential communication, the Compliance and Ethics Officer will determine whether the request is adequate based on the information provided.
   2. If the resident’s request for confidential communication is incomplete, the Facility will request from the resident the necessary outstanding information so that the request can be processed.
2. Responding to Request for Confidential Communication
   1. The Compliance and Ethics Officer shall determine whether a request for confidential communication should be accepted or denied for reasons acceptable under State and Federal law. The Facility shall not require an explanation from the resident as to the basis for the request as a condition of providing communications on a confidential basis.
3. Confidential Communication Accepted
   1. Written Notice
      1. If the Compliance and Ethics Officer determines that the Facility will grant the request for confidential communication, in whole or in part, the Facility will inform the resident of the determination in writing.
   2. Implementing the Confidential Communication
      1. The Facility shall append the request for confidential communication in the resident’s record and make all necessary system changes to comply with the confidential communication request, such as changing contact information in the computer system.
4. Confidential Communication Denied
   1. If the Compliance and Ethics Officer denies the resident’s request for confidential communication, in whole or in part, the Facility will provide the requesting resident with a written notice of denial.

**{Facility}**

**Right to Request Alternative Communication of Protected Health Information Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with a resident’s right to request that communications of Protected Health Information (“PHI”) be delivered by alternative means or at alternate locations.

**POLICY**

A resident will be allowed to request that the Facility communicate PHI to him/her by alternative means or at alternative locations. The Facility shall accommodate reasonable requests.

**PROCEDURE**

1. The Compliance and Ethics Officer will manage requests to receive communications by alternative means.
2. All resident or resident representative requests for alternative communication must be submitted to the Facility in writing.
3. The Facility may not require an explanation for the request.
4. The Facility’s decision will not be based on the perceived merits of the request.
5. The Facility may condition the provision of a reasonable accommodation on:
   1. when appropriate, information as to how payment, if any, will be handled; and
   2. specification of an alternative address or other method of contact.
6. The Facility will accommodate a request determined to be reasonable.
7. The Compliance and Ethics Officer shall maintain all requests and responses in the appropriate location in the resident’s Medical Record.

**{Facility}**

**Use and Disclosure of Protected Health Information Subject to Resident Authorization Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws regarding use and disclosure of protected health information subject to an authorization.

**POLICY**

It is the policy of the Facility to obtain a written authorization from the resident to use and disclose protected health information (PHI) for purposes other than treatment, payment, and health care operations and in other special situations where required by law.

**PROCEDURE**

1. Protected Health Information Subject to Authorization. The Facility shall obtain a valid, written authorization from every resident before the resident’s PHI will be used or disclosed for purposes other than treatment, payment, or health care operations and in special situations. If the resident orally requests disclosure of PHI or if a written authorization provided by the resident is inadequate, the Facility shall request the appropriate authorization form from the resident (see “HIPAA Authorization for Use and Disclosure of Protected Health Information Form”). The signed authorization shall be retained and filed with the resident’s medical records.
2. Elements of a Valid Authorization.
3. A valid authorization under this section shall contain the following elements:
4. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
5. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
6. The name or other specific identification of the person(s), or class of persons, to whom the Facility may make the requested use or disclosure.
7. A description of each purpose of the requested use or disclosure.
   1. The statement “at the request of the resident” is a sufficient description of the purpose when a resident initiates the authorization and does not, or elects not to, provide a statement of the purpose.
8. An expiration date or an expiration event that relates to the resident or the purpose of the use or disclosure.
   1. The statement “end of the research study,” “none,” or similar language is sufficient if the authorization is for a use or disclosure of PHI for research, including for the creation and maintenance of a research database or research repository.
9. Signature of the resident and date.
   1. If the authorization is signed by a personal representative of the resident, a description of such representative's authority to act for the resident must also be provided.
10. The authorization shall also contain statements that notify the resident of the following:
    1. The resident’s right to revoke the authorization in writing, except for the situations enumerated below (see below Section 6 a and b “Revocation”),
    2. A description of how the resident may revoke the authorization,
    3. That the Facility will not condition treatment, payment, enrollment or eligibility for benefits on whether the resident signs the authorization, unless certain circumstances are present (see below Section 4 – “Conditioned Authorization”),
    4. The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer be protected.
11. Defective Authorizations*.*
    1. An authorization shall not be valid if it has any of the following defects:
       1. The expiration date has passed or the expiration event is known by the Facility to have occurred;
       2. The authorization has not been filled out completely,
       3. The authorization is known by the Facility to have been revoked,
       4. The authorization violates Sections 5, 6 below, if applicable,
       5. Any material information in the authorization is known by the Facility to be false.
12. Special Authorization Situations
13. Psychotherapy Notes. The Facility shall obtain authorization for any use or disclosure of psychotherapy notes. The Compliance and Ethics Officer must approve each use or disclosure of psychotherapy notes made without an authorization to ensure that such use or disclosure of psychotherapy notes is permitted by State and Federal law without an authorization.
14. HIV/AIDS Related Information. The Facility shall obtain an authorization for the use and disclosure of HIV/AIDS related information. The Compliance and Ethics Officer must approve each use or disclosure of HIV/AIDS related information made without an authorization to ensure that such use or disclosure of HIV/AIDS related information is permitted by State and Federal law without an authorization.
15. Substance Abuse Treatment Information. The Facility shall obtain an authorization for the use and disclosure of substance abuse treatment information. The Compliance and Ethics Officer must approve each use or disclosure of substance abuse treatment information made without an authorization to ensure that such use or disclosure of substance abuse treatment information is permitted by State and Federal law without an authorization.
16. Marketing. The Facility shall obtain an authorization for use or disclosure of PHI for marketing, unless marketing is in the form of a face-to-face communication or a promotional gift of nominal value. If the marketing is expected to result in direct or indirect remuneration to the Facility from a third party, the resident shall be notified that such remuneration is expected.

Certain categories of communications are not deemed to be “marketing” under HIPAA, as described in Section e) below. The requirements of Section e) below apply to any such communications.

1. Certain Other Communications.
2. Unless the communication meets the criteria set forth in Section (ii) below, the Facility shall obtain an authorization for use or disclosure of PHI if it receives any direct or indirect payment for the following:
3. to describe a health-related product or service (or payment for such product or service) that is provided by the Facility making the communication, including communications about the entities participating in a health care provider network;
4. for treatment of the resident; or
5. for case management or care coordination for the resident, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the resident.
6. The use or disclosure of PHI for any communication described in Section e)(i) above, for which the Facility receives direct or indirect payment, shall not require authorization if the communication:
7. describes only a drug or biologic that is currently being prescribed for the recipient of the communication, and any payment received by the Facility in exchange for making the communication is reasonable in amount; or
8. is made by a business associate on behalf of the Facility, and the communication is consistent with the Business Associate Agreement between the business associate and the Facility.
9. Sale of Protected Health Information.
10. The Facility shall obtain a resident’s authorization for any use or disclosure of the resident’s PHI in exchange for any direct or indirect remuneration received by the Facility, except as specified in Section (ii) below. The authorization shall specify whether the PHI can be further exchanged for remuneration by the entity receiving the PHI of that resident.
11. The resident’s authorization shall not be required when the purpose of the exchange is for:
12. public health activities;
13. research (in which case the price charged must reflect the costs of preparation and transmittal of the data for such purpose);
14. treatment of the resident;
15. the sale, transfer, merger, or consolidation of all or part of the Facility with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity;
16. remuneration provided by the Facility to a business associate for activities involving the exchange of PHI pursuant to a business associate agreement; or
17. providing a resident with a copy of the resident’s PHI.
18. The Compliance and Ethics Officer should be consulted in the event that guidance is required to determine the applicability of any of the exceptions specified above.
19. Compound Authorization. An authorization for use or disclosure of PHI may not be combined with any other document to create a compound authorization, except as follows:
    1. An authorization for the use or disclosure of PHI for a research study may be combined with any other type of written permission for the same research study, including another authorization for the use or disclosure of PHI for such research or a consent to participate in such research;
    2. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes;
    3. An authorization, other than an authorization for a use or disclosure of psychotherapy notes, may be combined with any other such authorization, except when the Facility has conditioned the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of one of the authorizations.
20. Conditioned Authorization. The Facility shall not condition treatment on the receipt of an authorization, except in certain limited circumstances such as:
21. research-related treatment;
22. prior to a resident’s enrollment in a health plan or eligibility for benefits; or
23. for the purpose of creating PHI solely for disclosure to a third party.
24. Use and Disclosure Pursuant to an Authorization. The Compliance and Ethics Officer shall review the written authorization provided by the resident to ensure that it is compliant with State and Federal law and shall approve each use and disclosure of PHI pursuant to authorization on a case-by-case basis.
25. Revocation. The Facility shall comply with a written request of a resident to revoke an authorization, except for circumstances when
26. The Facility has relied on the authorization and has taken action pursuant to the authorization, or
27. If the authorization was obtained as a condition of obtaining insurance coverage, then the insurer has the right to contest the claim under the policy or contest the policy itself.

**HIPAA Authorization**

**For Use and Disclosure of Protected Health Information (PHI) Form**

|  |  |  |
| --- | --- | --- |
| Resident Name: | | |
| Address: | | |
| DOB: | SSN: | MRN: |

1. I hereby authorize the Facility to use and/or disclose the above-named individual’s health information as described below.
2. The PHI that may be used and/or disclosed is (check all that apply):

\_\_ Entire Medical Record

\_\_ Entire Medical Record for specific dates: \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_

\_\_ Specific sections of the medical record (e.g. medications, x-rays, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Photographs or other audio-visual images for use on the facility’s social media or other marketing materials

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The PHI specified above may be used or disclosed to Entity(s)/Individual(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The PHI may be used and/or disclosed for the following purpose(s):

\_\_ At the request of the resident

\_\_ Other purpose: (e.g. life insurance request, social media, legal request) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. This authorization shall remain in effect until either:

\_\_ Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Expiration Event\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form, unless circumstances are present.
2. I understand that, as set forth in the Notice of Privacy Practices and the Facility’s Policies and Procedures, I have the right to revoke this authorization, in writing, at any time, except to the extent that the Facility has acted in reliance upon it, by sending written notification to the Facility at the following address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that I have the right to refuse to sign this authorization.
2. I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident’s Personal Representative Description of the representative’s authority to act on behalf of the resident

**{Facility}**

**Use and Disclosure Subject to the Minimum Necessary Standard Policy and Procedure**

**PURPOSE**

To provide guidance with the identification of the persons or class of persons that need access to protected health information (PHI) to perform their jobs, and to ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws that require the Facility to make reasonable efforts to limit PHI used, disclosed, or requested to the minimum necessary for the intended purpose.

**POLICY**

When using or disclosing PHI or when requesting protected health information from another covered entity or business associate, the Facility shall make reasonable efforts to limit protected health information to the “minimum necessary” to accomplish the intended purpose of the use, disclosure, or request. The Facility 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.

**PROCEDURE**

1. The Facility will not request, use, or disclose an entire medical record unless it is specifically justified as the amount that is reasonably necessary to meet the purpose of the request. Subject to the exceptions to the minimum necessary requirement set forth below, when disclosing PHI, the Facility, or the business associate disclosing such information on behalf of the Facility, shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.
2. The minimum necessary standard applies to all uses or disclosures except:
   1. disclosures to a or a request by a health care provider for treatment purposes;
   2. uses or disclosures made to a resident who is the subject of the PHI;
   3. disclosures made with an authorization;
   4. disclosures made to the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated;
   5. uses or disclosures that are required by law as confirmed with the Compliance and Ethics Officer.
3. The Facility shall 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. The Facility shall make reasonable efforts to limit the access of such persons or classes of persons to PHI.
4. Classes of workers who need access to PHI to carry out their duties include:
   1. Administrator
   2. Physicians
   3. Nurses
   4. Therapists
5. Disclosures:
   1. Routine disclosures:
      1. For requests or disclosures that occur on a routine basis, the Facility will follow standard protocols that limit PHI to the minimum necessary standard, as set forth above.
   2. Non-routing disclosures:
      1. For all non-routine requests or disclosures, the Administrator, Director of Nursing, or relevant medical records personnel will make a case-by-case minimum necessary determination based on, but not limited to, the following factors:
         1. the amount of information,
         2. the number of individuals or entities to whom the information is being disclosed,
         3. the importance of the use or disclosure,
         4. the likelihood of further disclosure, and
         5. whether the same result could be achieved with de-identified information.
   3. No determination needed:
      1. The Facility may rely, if such reliance is reasonable under the circumstances as determined by the Compliance and Ethics Officer, on a request or disclosure as the minimum necessary for the stated purpose when:
         1. Making disclosures to public officials if the public official represents that the information requested is the minimum necessary for the stated purpose;
         2. The information is requested by another entity that must be HIPAA compliant;
         3. The information is requested by a workforce member of the Facility or a business associate of the Facility for the purposes of providing services to the Facility using PHI, if the workforce member of the Facility or the business associate of the Facility represents that the requested information is the minimum necessary for the stated purposes; and
         4. Documentation from a Privacy Board or Institutional Review Board has been provided by a person requesting the information for research purposes.

**{Facility}**

**Use and Disclosure of Protected Health Information for Fundraising Purposes Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with rules enabling the Facility to use or disclose protected health information (“PHI”) for the Facility’s fundraising.

**POLICY**

To limit use and disclosure of a resident’s PHI for fundraising purposes as set forth below.

**PROCEDURE**

1. Fundraising Without Authorization. The Facility may use and disclose PHI for its fundraising purposes in accordance with the Facility’s Notice of Privacy Practices as long as the Facility has obtained an acknowledgement of receipt of the Notice of Privacy Practices signed and dated by the resident. The Facility will limit PHI used by the Facility or disclosed to a business associate or institutionally related foundation without an authorization for fundraising purposes to the resident’s demographic information, including name, address, other contact information, age, gender, and date of birth; dates of health care provided to the resident; department of service information; treating physician; outcome information; and health insurance status.
2. Fundraising with an Authorization. Unless otherwise permitted to use or disclose PHI without an authorization, the Facility will obtain written permission from a resident before using or disclosing PHI for fundraising purposes.
3. Fundraising Materials. With each fundraising communication made to a resident, the Facility will provide the resident with a clear and conspicuous opportunity to elect to opt out and not receive any further fundraising communications. The method for a resident to opt out may not cause the resident to incur an undue burden or more than a nominal cost.
4. Following Resident Opt Out. The Facility will ensure that residents who opt out of future fundraising communications are not sent such communications by removing the resident’s name from all fundraising contact information and maintaining the resident’s name on a “no contact” list. The Facility will not condition treatment or payment on the resident’s choice with respect to the receipt of fundraising communications.

**{Facility}**

**Use and Disclosure of Protected Health Information in the Facility Directory Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with rules enabling the Facility to use or disclose protected health information (“PHI”) for use in a facility directory.

**POLICY**

It is the policy of the Facility to use or disclose PHI in a facility directory as permitted by state and federal law and provided the resident is given an informed opportunity to object.

**PROCEDURE**

1. **Generally**
   1. The Facility may use the following PHI to maintain a directory of residents in the Facility’s facility, provided such PHI is disclosed only to members of the clergy or other persons who ask for the resident by name:
      1. Resident’s name;
      2. Resident’s location in the Facility’s facility;
      3. Resident’s condition described in general terms that do not communicate specific medical information about the resident (e.g. critical, stable, etc.); and
      4. Resident’s religious affiliation (disclosed only to clergy).
2. **Opportunity to Object**
   1. The Facility shall inform the resident that the facility directory may include PHI of the resident and the persons to whom PHI may be disclosed (including disclosures to clergy of information regarding religious affiliation) by including a separate statement in its Notice of Privacy Practices.
3. **Emergency Circumstances**
   1. If the opportunity to object to uses or disclosures required above cannot practicably be provided because of the resident’s incapacity or an emergency treatment circumstance, the Facility may use or disclose some or all of the PHI permitted for the facility's directory, if such disclosure is:
      1. Consistent with a prior expressed preference of the resident, if any, that is known to the Facility; and
      2. In the resident’s best interest as determined by the Facility in the exercise of professional judgment.
   2. The Facility provider shall inform the resident and provide an opportunity to object to uses or disclosures for directory purposes as required by this policy when it becomes practicable to do so.

**{Facility}**

**Personal Representation of Residents   
Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws that enable personal representatives to act on behalf of a resident regarding the use or disclosure of protected health information (“PHI”).

**PROCEDURE**

The Compliance and Ethics Officer will verify that the personal representative has the authority to act on behalf of a resident in making decisions related to health care. Once verified, the Facility will treat the personal representative as the resident with respect to PHI.

1. Verification
   1. Verification may consist of documentation, statements, or representations that are reasonable under the circumstances. Once verified, the Facility will treat such person as a personal representative with respect to PHI.
2. Deceased Residents
   1. The Compliance and Ethics Officer will verify that an executor, administrator, or other person has the authority to act on behalf of a deceased resident’s estate as a personal representative of the resident. Once verified, the Facility will treat such person as the resident’s personal representative.
3. Abuse, Neglect, and Endangerment Situations
   1. If there is evidence that access to PHI by a personal representative has or will subject the resident to domestic violence, abuse, neglect, or endangerment, the Compliance and Ethics Officer will be immediately notified. The Compliance and Ethics Officer will determine whether the evidence is reasonably believable and whether it is in the best interest of the resident to deny access to the personal representative. If the Compliance and Ethics Officer makes such a determination, the Compliance and Ethics Officer will refuse to treat the person as the personal representative of the resident.

**{Facility}**

**Use and Disclosure of Protected Health Information Not Subject to Permission of Resident Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with applicable laws that set forth rules enabling the use and disclosure of protected health information (“PHI”) without a resident’s written authorization or opportunity to agree or object.

**POLICY**

It is the policy of the Facility to use or disclose PHI without the written authorization of the resident or the opportunity to agree or object for certain limited public use purposes subject to applicable requirements.

**PROCEDURE**

1. The Compliance and Ethics Officer will approve each use and disclosure without a resident’s permission on a case by case basis as permitted by state and federal law for the following purposes:
   1. Uses and disclosures required by law
   2. Uses and disclosures for public health activities
   3. Disclosures about victims of abuse, neglect or domestic violence
   4. Uses and disclosures for health oversight activities
   5. Disclosures for judicial and administrative proceedings
   6. Disclosures for law enforcement purposes
   7. Uses and disclosures about decedents
   8. Uses and disclosures for cadaveric organ, eye, or tissue donation purposes
   9. Uses and disclosures to avert a serious threat to health or safety
   10. Uses and disclosures for specialized government functions
   11. Disclosures for workers' compensation
2. The exceptions described above are summaries of complicated laws. Questions regarding any use or disclosure of PHI without permission of the resident must be referred to the Compliance and Ethics Officer.

**{Facility}**

**Use and Disclosure of Protected Health Information for Research Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with applicable law that enables the use and disclosure of protected health information (“PHI”) for research.

**POLICY**

To use or disclose PHI for research, regardless of the source of funding for the research, provided the Facility obtains all documentation and representations from the resident, researcher, Privacy Board, or Institutional Review Board as necessary to permit the use and disclosure of PHI for research.

**PROCEDURE**

1. Permitted Use and Disclosures for Research Purposes
   1. The Facility shall obtain written authorization from the resident prior to using or disclosing PHI for research.
   2. The Facility may use PHI for research without the authorization of the resident provided that
      1. The Facility obtains written approval of a waiver of authorization from either:
         1. An Institutional Review Board (“IRB”) established in accordance with federal law, or
         2. A Privacy Board established in accordance with HIPAA that the authorization requirement is waived.
         3. The Privacy Board shall:
            1. Have members with varying backgrounds and appropriate professional competency as necessary to review the effect of the research protocol on the resident’s privacy rights and related interests;
            2. Include at least one member who is not affiliated with the Facility, not affiliated with any entity conducting or sponsoring the research, and not related to any person who is affiliated with any of such entities; and
            3. Not have any member participating in a review of any project in which the member has a conflict of interest.
         4. The Compliance and Ethics Officer shall ensure that the waiver criteria set forth in HIPAA are satisfied by the IRB or Privacy Board and documented.
      2. The Facility obtains from the researcher representations that:
         1. Use or disclosure is sought solely to review PHI as necessary to prepare a research protocol or for similar purposes preparatory to research;
         2. No PHI is to be removed from the Facility by the researcher in the course of the review; and
         3. The PHI for which use or access is sought is necessary for the research purposes.
      3. The Facility obtains from the researcher:
         1. Representation that the use or disclosure sought is solely for research on the PHI of decedents;
         2. Documentation, at the request of the Facility, of the death of such residents; and
         3. Representation that the PHI for which use or disclosure is sought is necessary for the research purposes.
2. Documentation of waiver approval
   1. For a use or disclosure to be permitted based on documentation of approval of an alteration or waiver pursuant to this policy as stated above, the documentation must include all of the following:
   2. Identification and date of action. A statement identifying the IRB or Privacy Board and the date on which the alteration or waiver of authorization was approved;
   3. Waiver criteria. A statement that the IRB or Privacy Board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:
      1. The use or disclosure of PHI involves no more than a minimal risk to the privacy of residents, based on, at least, the presence of the following elements;
         1. An adequate plan to protect the identifiers from improper use and disclosure;
         2. An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and
         3. Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of PHI would be permitted;
         4. The research could not practicably be conducted without the waiver or alteration; and
         5. The research could not practicably be conducted without access to and use of the protected health information.
   4. A brief description of the PHI for which use or access has been determined to be necessary by the IRB or Privacy Board, pursuant to this policy;
   5. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, as follows:
      1. An IRB must follow the requirements of the Common Rule, including the normal review procedures
      2. A Privacy Board must review the proposed research at convened meetings at which a majority of the Privacy Board members are present, including at least one member who is not affiliated with the Facility, not affiliated with any entity conducting or sponsoring the research, and not related to any person who is affiliated with any of such entities, and the alteration or waiver of authorization must be approved by the majority of the Privacy Board members present at the meeting, unless the Privacy Board elects to use an “expedited review procedure”
         1. A Privacy Board may use an “expedited review procedure” if the research involves no more than minimal risk to the privacy of the residents who are the subject of the PHI for which use or disclosure is being sought.
         2. If the Privacy Board elects to use an expedited review procedure, the review and approval of the alteration or waiver of authorization may be carried out by the chair of the Privacy Board, or by one or more members of the Privacy Board as designated by the chair
            1. The documentation of the alteration or waiver of authorization must be signed by the chair or other member, as designated by the chair, of the IRB or the Privacy Board, as applicable.

**{Facility}**

**Use and Disclosure of Protected Health Information to Persons Involved in the Resident’s Care and Notification Purposes Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable laws enabling the use and disclosure of protected health information (“PHI”) to persons involved in a resident’s care and notification to such persons.

**POLICY**

To use or disclose PHI to certain persons involved in the resident’s care or for notification purposes with the resident’s consent or pursuant to State and Federal law.

**PROCEDURE**

1. Permitted Uses and Disclosures
   1. Pursuant to the following, the Facility may disclose to a family member, other relative, or a close personal friend of the resident, or any other person identified by the resident, the PHI directly relevant to such person’s involvement with the resident’s health care or payment related to the resident’s health care.
   2. The Facility may use or disclose PHI to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the resident, or another person responsible for the care of the resident of the resident’s location, general condition, or death.
2. Uses and Disclosures with the Resident Present
   1. If the Compliance and Ethics Officer determines that the resident who is the subject of the PHI is present or can be contacted prior to the use or disclosure and is competent to make health care decisions, the Facility may use or disclose the PHI only if it either:
      1. obtains the resident’s agreement,
      2. the resident does not object when given the opportunity, or
      3. The Facility reasonably infers, based on the exercise of professional judgment, from the circumstances that the resident does not object.
3. Uses and Disclosures Without the Resident Present
   1. If the resident is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the resident’s incapacity or an emergency circumstance, the Facility may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the resident and, if so, disclose only the PHI that is directly relevant to the person’s involvement with the resident’s care or payment related to the resident’s health care or needed for notification purposes. The Facility may use professional judgment and its experience with common practice to make reasonable inferences of the resident’s best interest in allowing a person to act on behalf of the resident to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of PHI.
   2. The Facility shall make reasonable efforts to verify the identity of any person requesting information about, or acting on behalf of the resident, prior to discussing the resident’s PHI with them.
4. Uses and Disclosures for Disaster Relief Purposes
   1. The Facility may use or disclose PHI to a public or private entity authorized by law to assist in disaster relief efforts, or may coordinate with such entities to notify a family member or personal representative of the resident’s location, general condition, or death. Provided it does not interfere with the ability to respond to an emergency, the Facility must satisfy the use and disclosure requirements for use and disclosure of PHI that apply when a resident is or is not present (see above).
5. Deceased Residents
   1. If the resident is deceased, the Facility may disclose to a family member, or other persons identified in paragraph A above who were involved in the resident’s care or payment for health care prior to the resident’s death, PHI of the resident that is relevant to such person’s involvement, unless doing so is inconsistent with any prior expressed preference of the resident that is known to the Facility.

**{Facility}**

**Use and Disclosure of De-identified Health Information Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable rules regarding use and disclosure of de-identified protected health information (“PHI”).

**POLICY**

It is the policy of the Facility to use and disclose PHI that has been de-identified whenever possible.

**PROCEDURE**

1. Uses and Disclosures of De-identified Health Information
   1. With the approval of the Compliance and Ethics Officer, the Facility may use PHI to create de-identified health information and may disclose de-identified health information without the permission of the residents who are the subject of the de-identified health information.
2. De-identification of PHI
   1. The Compliance and Ethics Officer must confirm that information to be disclosed pursuant to this policy is de-identified. Health information is de-identified only if:
   2. A person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles and methods for rendering information not individually identifiable applies such principles and methods and determines that the risk of the information being used by an anticipated recipient to identify a resident is very small and provides documentation to the Facility supporting such determination; or
   3. Direct identifiers of the resident or of relatives, employers, or household members of the resident are removed as required by law, including: names; geographic subdivisions smaller than a State; all elements of dates (except year); telephone numbers; fax numbers; e-mail addresses; social security numbers; medical record numbers; health plan beneficiary numbers; account numbers; certificate/license numbers; Vehicle identifiers and serial numbers, including license plate numbers; device identifiers and serial numbers; URLs; IP address numbers; biometric identifiers; full face photographic images; and any other unique identifying number, characteristic, or code.
3. Re-Identification of De-identified Health Information
   1. The Facility may assign a code or other means of record identification to allow de-identified information to be re-identified provided that:
   2. The code or other means of record identification is not derived from or related to information about the resident and is not otherwise capable of being translated so as to identify the resident; and
   3. The Facility 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.

**{Facility}**

**Use and Disclosure of Protected Health Information Located Within a Limited Data Set Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with rules regarding use and disclosure of protected health information (“PHI”) located within a limited data set.

**POLICY**

It is the policy of the Facility to use or disclose PHI by utilizing a limited data set only under the limited circumstances permitted by law.

**PROCEDURE**

1. Limited Data Set Defined
   1. A limited data set is PHI that excludes the following direct identifiers of the residents or of relatives, employers, or household members of the resident:
      1. Names;
      2. Postal address information, other than town or city, State, and zip code;
      3. Telephone numbers;
      4. Fax numbers;
      5. Electronic mail addresses;
      6. Social security numbers;
      7. Medical record numbers;
      8. Health plan beneficiary numbers;
      9. Account numbers;
      10. Certificate/license numbers;
      11. Vehicle identifiers and serial numbers, including license plate numbers;
      12. Device identifiers and serial numbers;
      13. Web Universal Resource Locators (URLs);
      14. Internet Protocol (IP) address numbers;
      15. Biometric identifiers, including finger and voice prints; and
      16. Full face photographic images and any comparable images.
2. Permitted Uses and Disclosures
   1. The Facility may use or disclose a limited data set by utilizing a limited data set only for purposes of research, public health, or health care operations and only if the Facility enters into a Data Use Agreement with the recipient of the limited data set.
      1. All requests for use or disclosure of a limited data set must be approved by the Compliance and Ethics Officer.
      2. The Compliance and Ethics Officer shall ensure that the health information contained within the limited data set is limited by excluding direct identifiers as required by law.
      3. The Compliance and Ethics Officer shall ensure that the recipient of the limited data set has entered into a Data Use Agreement with the Facility.
      4. The Facility may use PHI to create a limited data set that meets the requirements of this section, or disclose PHI only to a business associate for such purpose, whether or not the limited data set is to be used by the Facility.
3. Data Use Agreement
   1. The Facility may use or disclose a limited data set only if the Facility obtains satisfactory assurance, in the form of a Data Use Agreement (See Appendix A), that the limited data set recipient will only use or disclose the PHI for limited purposes.
   2. A Data Use Agreement between the Facility and the limited data set recipient shall:
      1. Establish the permitted uses and disclosures of such information by the limited data set recipient, consistent with the purposes of research, public health, or health care operations.
         1. The data use agreement shall not authorize the limited data set recipient to use or further disclose the information in a manner that would violate the requirements of this policy
      2. Establish who is permitted to use or receive the limited data set; and
      3. Provide that the limited data set recipient will:
         1. Not use or further disclose the information other than as permitted by the data use agreement or as otherwise required by law;
         2. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the data use agreement;
         3. Report to the Facility any use or disclosure of the information not provided for by its data use agreement of which it becomes aware;
         4. Ensure that any agents to whom it provides the limited data set agree to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and
         5. Not identify the information or contact the residents.
4. Unauthorized Use or Disclosure by Recipient of Limited Data Set
   1. Any pattern of activity or practice of a recipient of a limited data set that constitutes a material breach or violation of the Data Use Agreement shall immediately be reported to the Compliance and Ethics Officer. The Compliance and Ethics Officer shall investigate the alleged activity or practice, and if necessary take reasonable steps to cure the breach or end the violation. If such steps are unsuccessful, the Facility shall discontinue disclosure of information to the recipient and report the wrongful pattern of activity or practice to the Secretary of the Department of Health and Human Services.
5. The Facility as the Recipient of a Limited Data Set
   1. In the event that the Facility is the recipient of a limited data set, the Facility will use or disclose information contained within the limited data set only as permitted by the applicable Data Use Agreement or as required by law.

**SAMPLE**

**DATA USE AGREEMENT BETWEEN THE FACILITY AND [Insert Name of Data Set Recipient/Researcher]**

This Data Use Agreement is made and entered into on [Insert Date] by and between [insert Holder name], hereafter “Holder” and [insert Recipient name], hereafter “Recipient.”

This agreement sets forth the terms and conditions pursuant to which Holder will disclose certain protected health information, (PHI) in the form of a Limited Data Set to the Recipient.

Terms used, but not otherwise defined, in this Agreement shall have the meaning given the terms in the HIPAA Regulations at 45 CFR Part 160-164.

# Permitted Uses and Disclosures

* 1. Except as otherwise specified herein, Recipient may make all uses and disclosures of the Limited Data Set necessary for (choose one):
* Research \_\_\_\_\_
* Public Health \_\_\_\_\_
* Health Care Operations \_\_\_\_\_
  1. In addition to the Recipient, the following individuals, or classes or individuals, are permitted to use or receive the Limited Data Set for purposes stated above: [insert names or classes of persons who may use or receive the limited data set, e.g. the researcher’s staff, any collaborators, other clinical sites involved in the research, sponsors if applicable, outside laboratories].
  2. To the extent that the classes of persons are not part of the Recipient’s workforce who are directly involved in using the Limited Data Set, the Recipient shall enter into a Data Use Agreement with the other classes of persons before such release of the Limited Data Sets.

# Recipient Responsibilities

* 1. Recipient will not use or further disclose the Limited Data Set for any purpose other than permitted by this Agreement pertaining to the use stated above, or as required by law;
  2. Recipient will use appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the Limited Data Set other than as provided for by this Agreement;
  3. Recipient will report to the Holder any use or disclosure of the Limited Data Set not provided for by this Agreement of which the Recipient becomes aware as soon as Recipient becomes aware of such use or disclosure;
  4. Recipient will ensure that any agent, including a subcontractor, to whom it provides the Limited Data Set, agrees to the same restrictions and conditions that apply through this Agreement to the Recipient with respect to the Limited Data Set;
  5. Recipient will not identify the information contained in the Limited Data Set; and
  6. Recipient will not contact the individuals who are the subject of the PHI contained in the Limited Data Set.

1. Term and Termination
   1. The terms of this Agreement shall be effective as of [insert effective date] and shall remain in effect until all PHI in the Limited Data Set provided to the Recipient is destroyed or returned to the Holder.
   2. Upon the Holder’s knowledge of a material breach of this Agreement by the Recipient, the Holder shall provide an opportunity for Recipient to cure the breach or end the violation. If efforts to cure the breach or end the violation are not successful within the reasonable time period specified by the Holder, the Holder shall discontinue disclosure of PHI to the Recipient and report the problem to the Secretary of the Department of Health and Human Services or its designee. The Holder shall immediately discontinue disclosure of the Limited Data Set to the Recipient if the Holder determines cure of the breach is not possible.

# General Provisions

* 1. Recipient and Holder understand and agree that individuals who are the subject of Protected Health Information are not intended to be third party beneficiaries of this Agreement.
  2. This Agreement shall not be assigned by Recipient without the prior written consent of the Holder.
  3. Each party agrees that it will be responsible for its own acts and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other party or the results thereof.

IN WITNESS WHEREOF, the parties hereto execute this agreement as follows:

|  |  |
| --- | --- |
| Date: | The Facility  By: |
| Date: | (Title person with authority to sign agreement for the holder of the data)  RECIPIENT  By:  (Title of recipient or person with authority to sign agreement for the recipient) |

**{Facility}**

**Safeguarding Against Wrongful Uses and Disclosures of Protected Health Information Policy and Procedure**

**PURPOSE**

The purpose of this policy is to ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable rules regarding safeguarding against wrongful uses and disclosures of protected health information (“PHI”).

**POLICY**

It is the policy of the Facility to apply reasonable safeguards to limit intentional or unintentional wrongful uses or disclosures of PHI.

**PROCEDURE**

1. Safeguarding Against Wrongful Uses and Disclosures of PHI
   1. The Compliance and Ethics Officer shall be responsible for ensuring that the Facility takes reasonable steps to ensure:
   2. That an assessment of the Facility’s use and disclosure of PHI is performed annually and based on the results of such assessments, appropriate administrative, technical, and physical safeguards are implemented to protect PHI; and
   3. That reasonable efforts are made to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure in accordance with the Facility’s Minimum Necessary Standard Policy and procedure.
2. Reporting  
   1. Workforce members of the Facility shall report to the Compliance and Ethics Officer any potentially wrongful uses and disclosures such workforce members believe to be unlawful. The Compliance and Ethics Officer shall investigate and resolve any wrongful uses and disclosures to ensure that such uses and disclosures are permissible.

**{Facility}**

**Employee Sanctions for HIPAA Violations   
Policy and Procedure**

**PURPOSE**

To ensure there are appropriate sanctions that will be applied to employees who violate the requirements of the HIPAA Privacy Rule and/or the {Facility}’s (the “Facility”) HIPAA privacy policies and procedures.

**POLICY**

It is the policy of the Facility to discipline employees who fail to comply with the Facility’s policies and procedures regarding HIPAA.

**PROCEDURE**

1. When a concern arises regarding a possible violation of HIPAA or the Facility’s policies or procedures related to HIPAA, the Compliance and Ethics Officer shall begin an investigation promptly.
2. If, at the conclusion of the investigation, it is found that a violation of the Facility’s policy or procedure has occurred, the employee involved shall be disciplined in accordance with the severity of the violation and the Facility’s disciplinary policy. Violations can be classified according to intent such as:
   1. Level I Violations are those made accidentally or due to a lack of education.
   2. Level II Violations are serious violations that are found to show purposeful disregard of the Facility’s policy.
3. The Compliance and Ethics Officer shall review the circumstances surrounding any substantiated violation and take appropriate action to mitigate, to the extent possible, any harmful effects of the violation.
4. Documentation from the investigation shall be given to Compliance and Ethics Officer to be maintained as a part of the Facility’s HIPAA documentation and retained for six years.

The disciplinary action report documenting the employee’s violation shall be placed in the employee’s personnel file.

**{Facility}**

**Complaints to {Facility} Regarding {Facility}'s Privacy Practices Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with applicable rules requiring the Facility to effectively receive, investigate, and resolve complaints regarding the Facility's privacy practices.

**POLICY**

It is the policy of the Facility to accept, investigate, and resolve complaints regarding alleged violations of the Facility’s privacy practices.

**PROCEDURE**

1. Complaints to the Facility
   1. The Facility shall provide individuals with an opportunity to lodge a complaint with the Facility regarding the Facility's privacy practices. All complaints shall be immediately given to the Compliance and Ethics Officer. The Compliance and Ethics Officer shall be responsible for investigating and resolving the complaint. All documentation regarding the complaint, the investigation and resolution of the complaint shall be maintained by the Facility in a “Complaint Log.”
2. Complaint Investigation
   1. The Facility shall cooperate with an investigation of the Facility's privacy practices undertaken by the United States Department of Health and Human Services. The Compliance and Ethics Officer shall immediately be notified of such an investigation and the Compliance and Ethics Officer shall coordinate the Facility's response to such an investigation.
3. Mitigation
   1. The Facility shall mitigate, to the extent practicable, any harmful effect that is known to the Facility of a use or disclosure of protected health information in violation of the Facility's information privacy policies and procedures or applicable law.

**{Facility}**

**HIPAA Recordkeeping Policy and Procedure**

**PURPOSE**

The purpose of this policy is to ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable rules regarding the maintenance of records, policies and procedures as required by HIPAA.

**POLICY**

It is the policy of the Facility to maintain records required for Compliance and Ethics with HIPAA for the period required by law.

**PROCEDURE**

1. Documentation
   1. The Facility must maintain:
      1. HIPAA policies and procedures in written or electronic format;
      2. Written communications required by HIPAA in electronic or paper format; and
      3. A written or electronic record of all actions, activities, or designations required by HIPAA.
2. Retention
   1. The Facility must maintain residents’ medical records for a period 10 years
   2. Every state needs to be checked.
3. <http://www.healthinfolaw.org/comparative-analysis/medical-record-retention-required-health-care-providers-50-state-comparison>
4. <https://www.healthit.gov/sites/default/files/appa7-1.pdf>

from the date of its creation or the date such record was last in effect, whichever is later. Upon request, the Facility must submit Compliance and Ethics reports to the Secretary of the United States Department of Health and Human Services that contain necessary and adequate information to enable the Secretary to ascertain whether the Facility has complied with HIPAA.

1. Availability
   1. The Facility shall make documentation available to those persons responsible for implementing the procedures to which the documentation pertains.
2. Updates
   1. The Facility shall review documentation periodically, and update as needed, in response to environmental or operational changes affecting the security of the electronic PHI.

**{Facility}**

**Verification of Entities or Persons to Whom Protected Health Information May Be Disclosed Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable rules regarding verification of the identity and authority of third parties to receive protected health information (“PHI”).

**POLICY**

It is the policy of the Facility to verify the identity and authority of a person or entity before disclosing PHI to such person or entity.

**PROCEDURE**

1. Verification
   1. The Facility must verify the identity and authority of an entity or person requesting PHI if the identity or authority is unknown to the Facility. If any member of the Facility's workforce is uncertain whether the identity or the authority of an entity or person is legitimate, such workforce member shall immediately notify the Compliance and Ethics Officer. The Compliance and Ethics Officer shall investigate and resolve whether the person or entity has the authority to receive the PHI requested.
2. Professional Judgment
   1. The Facility shall exercise professional judgment when verifying the identity or authority of:
   2. A person involved in the resident's care;
   3. A person responsible for the care of the resident; and
   4. A public or private entity authorized by law to assist the resident.
3. Documentation
   1. The Facility may rely on documentation, statements, or representations to verify the identity and authority of an entity or person, provided the Facility's reliance on such information is reasonable under the circumstances.
4. Identity of Public Officials
   1. The Facility may rely, if reasonable under the circumstances, on any of the following to verify the identity of a public official:
   2. If the request is made in person, presentation of an agency identification badge, other official credentials, or proof of government status;
   3. If the request is in writing, the request is on the appropriate government letterhead; or
   4. If the disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation that establishes that the person is acting on behalf of the public official.
5. Authority of Public Officials
   1. The Facility may rely, if reasonable under the circumstances, on any of the following to verify the authority of a public official:
   2. A written statement attesting to such legal authority or an oral statement when provision of a written statement is impracticable; or
   3. A request made pursuant to legal process, warrant, order, or other legal process issued by a judicial or administrative tribunal.

**{Facility}**

**Use and Disclosure of Protected Health Information To Business Associates Policy and Procedure**

**PURPOSE**

The purpose of this policy is to ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”) comply with applicable rules regarding when a business associate may use or receive protected health information (“PHI”) from the Facility.

**POLICY**

To disclose PHI to a business associate after it obtains satisfactory assurances that the business associate will appropriately safeguard the PHI.

**PROCEDURE**

1. Disclosures of PHI to Business Associates
   1. The Facility may disclose PHI to a business associate and may allow a business associate to create or receive PHI on its behalf if the Facility obtains satisfactory assurances that the business associate will appropriately safeguard the information, unless the disclosure is to a health care provider concerning treatment of a resident.
2. Documentation of Satisfactory Assurances
   1. The Facility must document the satisfactory assurances through a written Business Associate Agreement (see CCG 00214).
3. Compliance and Ethics with Business Associate Agreement

If the Facility knows of a pattern of activity or practice of the business associate that constitutes a material breach or violation of the business associate's obligation under the contract, the Compliance and Ethics Officer shall be immediately notified. The Compliance and Ethics Officer shall take reasonable steps to cure the breach or end the violation. If such steps are unsuccessful, upon recommendation by the Compliance and Ethics Officer, the Facility shall terminate the contract or arrangement, if feasible. If such termination is not feasible, the Facility shall report the problem to the Secretary of the United States Department of Health and Human Services.

**{Facility}**

**Destruction Of Protected Health Information  
Policy And Procedure**

**PURPOSE**

To ensure that any medium containing Protected Health Information (“PHI”) is properly destroyed.

**POLICY**

PHI stored in paper, electronic, or other format will be destroyed utilizing an acceptable method of destruction after the appropriate retention period has been met. Access to PHI stored on computer equipment and media will be limited by taking the appropriate measures to destroy electronically stored PHI.

**PROCEDURE**

1. Paper Documents
   1. PHI maintained in paper format will be destroyed at the end of the required document retention period.
   2. All paper documents that contain PHI will be destroyed using an acceptable method of destruction.
      1. Acceptable methods of destruction include:
         1. shredding,
         2. incineration,
         3. pulverization,
         4. and use of a bonded recycling company.
   3. {Facility} (the “Facility”) will maintain a record of the destroyed documents. The record will include the:
      1. date of destruction,
      2. the name of the individual responsible for destroying the records,
      3. the name of any person witnessing the destruction,
      4. the method used to destroy records, and
      5. resident information (full name, Medical Record number, date of admission, date of discharge).
   4. Prior to destruction of boxed items, the Facility will verify the retention period has expired.
   5. If the records are destroyed off-site through a destruction company, the Facility should obtain written verification attesting to destruction of the documents.
2. Computer Data Storage Media
   1. Personal Computers: Workstations, laptops, and servers use hard drives to store a wide variety of information. Residents’ health information may be stored in a number of areas on a computer hard drive. For example, health information may be stored in “folders” specifically designated for storage of this type of information, in temporary storage areas and in cache. Simply deleting the files or folders containing this information does not necessarily erase the data.
      1. To ensure that any residents’ health information has been removed, a utility that overwrites the entire disk drive with “1”s and “0”s must be used.
      2. If the computer is being re-deployed internally or disposed of due to obsolescence, the aforementioned utility must be run against the computer’s hard drive, after which the hard drive may be reformatted and a standard software image loaded on the reformatted drive.
      3. If the computer is being disposed of due to damage and it is not possible to run the utility to overwrite the data, then the hard drive must be removed from the computer and physically destroyed. Alternatively, the drive can be erased by use of magnetic bulk eraser. This applies to PC workstations, laptops, and servers.
3. Backup or Data Tapes
   1. Tapes are typically re-used many times but generally only by the data processing groups within the Facility, which routinely must handle resident health information. However, there may be situations where tapes are sent to external recipients for specific processing. Tapes used for this purpose should be segregated from the general pool used for backups. These tapes should be degaussed prior to use in creating the files being sent to ensure that no prior resident health information remains on that portion of the tape beyond the end of the current file.
   2. Tapes or diskettes that are being decommissioned must be degaussed before disposal. This can be accomplished using a bulk tape eraser. Alternatively, the media may be pulverized or shredded.
   3. Compact Disks (CDs) and Diskettes: CDs containing resident health information must be cut into pieces or pulverized before disposal.
   4. If a service is used for disposal, the vendor shall be required to certify the following:
      1. Computers and media that were decommissioned have been disposed of in accordance with environmental regulations as computers and media may contain hazardous materials.
   5. Data stored on the decommissioned computer and/or media was erased or destroyed per the previously stated method(s) prior to disposal.

**{Facility}**

**Device and Media Controls Policy and Procedure**

**PURPOSE**

This purpose of this policy is to ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for {Facility} (the “Facility” or “Associates”) who are responsible for, or otherwise administer, the Facility’s computing systems have appropriate control over the Facility’s healthcare computing systems and their associated electronic media containing electronic Protected Health Information (ePHI) moving into, out of, and within the Facility’s facility. The Facility strives to protect the confidentiality, integrity, and availability of ePHI by taking reasonable and appropriate steps to control its hardware and electronic media through the entire lifecycle, from initial receipt to final removal.

**POLICY**

The Facility shall ensure that ePHI located on the Facility’s healthcare computing systems and their associated electronic media are to be protected against damage, theft, and unauthorized access. EPHI shall be consistently protected and managed through its entire life cycle, from origination to destruction.

The Facility shall regularly conduct a formal, documented process that ensures consistent control of all healthcare computing systems and their associated electronic media containing ePHI that is created, sent, received, or destroyed. The destruction of any ePHI shall be governed by the Facility’s Destruction of Protected Health Information Policy and Procedure (see CCG 00444) or the Facility’s HIPAA Recordkeeping Policy and Procedure (see CCG 00441). Questions concerning the destruction of ePHI should be directed to the Facility’s Compliance and Ethics and Security Officer.

**PROCEDURE**

1. The Facility shall take reasonable steps to periodically identify all hardware and electronic media that contain or provide access to ePHI.
2. The Facility shall, at least annually, conduct an organization-wide inventory to identify all of its information systems and electronic media that contain ePHI and their locations within the facility.
   1. The Facility shall store the inventory results in a secure manner, e.g. on a computer with appropriate file access permissions or in a locked drawer.
3. All the Facility healthcare computing systems and their associated electronic media containing ePHI shall be located and stored in secure environments that are protected by appropriate security barriers and entry controls such as a “sign out” requirement. See CCG 00407, CCG 00408, and CCG 00408a.
4. All healthcare computing systems and their associated electronic media containing ePHI shall be disposed of securely and safely when no longer required. The destruction of any ePHI shall be governed by the Facility’s HIPAA Recordkeeping Policy and Procedure.
5. All ePHI on the Facility’s healthcare computing systems and their associated electronic media shall be carefully removed before the media or healthcare computing systems are made available for re-use.
6. All healthcare computing systems and their associated electronic media containing ePHI that is received by, or removed from, a sensitive area shall be appropriately tracked and logged.

**{Facility}**

**Photographing, Video/Audio Recording, and Other Imaging of Residents, Visitors and Associates Policy and Procedure**

**PURPOSE**

To ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for {Facility} (the “Facility” or “Associates”) comply with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), and any and all other applicable federal or state regulations and interpretive guidelines promulgated thereunder, to establish guidelines for situations where residents and/or Associates may or may not be photographed, video or audio recorded, or otherwise imaged within the facility.

**POLICY**

The Facility shall take reasonable steps to protect residents, visitors, and Associates from unauthorized photography, video or audio recordings, or other images. Due to the sensitive nature of protected health information (PHI) and to protect resident privacy, the Facility shall follow the procedures outlined below before allowing, or prior to, photographing, video or audio recording, or otherwise imaging residents, visitors, or Associates.

**PROCEDURE**

1. Photography/Audio Recording of Residents or Resident’s Visitors within the Facility by Associates for Personal Use
   1. Associates are strictly prohibited from photographing or audio recording residents or the resident’s visitors within the facility for personal use. This includes, but is not limited to, taking pictures to share with friends and/or co-workers, to post on the internet using social media (e.g., Facebook, MySpace, Twitter), etc.
2. Photographing/Audio Recording Residents and Associates by Residents, family members, and/or by a resident’s visitors
   1. The Facility is not required to obtain consent from the resident when the resident is the subject of photography/audio recording and such recording is performed by the resident or the resident’s family members or the resident’s authorized visitors.
   2. Residents, family members, and/or visitors are not permitted to take photographs of or audio record other residents or Associates without consent. To the extent an Associate is aware of any inappropriate attempt to photograph a resident and/or Associates, then the Associate must take reasonable steps to ensure that residents and/or Associates are not photographed within the facility by a resident or the resident’s family members or visitors.
3. Photographing Residents by the Facility for Security or Health Care Operations Purposes
   1. The Facility reserves the right to photograph or video residents for security or health care operations purposes (e.g. resident is an elopement risk).
4. Photographing/Audio Recording Residents by Associates for Publicity Purposes
   1. The Facility shall obtain written authorization from the resident prior to photographing/audio recording the resident for publicity purposes.

**ATTENTION**

**RESIDENTS, STAFF, VISITORS, FAMILY MEMBERS AND FRIENDS**

TO PROTECT RESIDENT AND PATIENT CONFIDENTIALITY, IT IS PROHIBITED TO PHOTOGRAPH, VIDEO, OR RECORD, USING ANY TYPE OF RECORDING DEVICE, ANY RESIDENT OR PATIENT IN OUR FACILITY.

PLEASE CONTACT OUR COMPLIANCE AND ETHICS OFFICER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IF YOU HAVE ANY QUESTIONS.

THANK YOU FOR YOUR COOPERATION.

**{Facility}**

**Protecting Resident Privacy And Prohibiting Mental Abuse Related To Photographs And Audio/Video Recordings By Staff Policy And Procedure**

**PURPOSE**

To ensure the privacy of all residents is protected and to ensure that all residents are free from all types of abuse, including mental abuse, which includes but is not limited to abuse that is facilitated or caused by Associates (as defined below) taking or using photographs or recordings in any manner that would demean or humiliate a resident.

**POLICY**

It is the policy of {Facility} (the “Facility”) to ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) are aware that all residents have the right to personal privacy of not only their own physical body, but also of their personal space, including accommodations and personal care. Taking photographs or recordings of either a resident and/or his/her private space without the resident’s, or designated representative’s, written consent, is a violation of the resident’s right to privacy and confidentiality. Examples include, but are not limited to, Associates taking unauthorized photographs of a resident’s room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area. Likewise, Associates are prohibited from taking, keeping and/or distributing photographs and recordings that demean or humiliate a resident.

The Facility strives to establish an environment that is as homelike as possible and includes a culture and environment that treats each resident with respect and dignity. Treating a resident in any manner that does not uphold the resident’s sense of self-worth and individuality dehumanizes the resident and creates an environment that perpetuates a disrespectful and/or potentially abusive attitude towards the resident. Federal and applicable state regulations require the Facility to provide care and services in a person-centered environment in which all individuals are treated as human beings.

**PROCEDURE**

1. Residents Right to Privacy and Confidentiality.
2. The Facility’s residents have varying degrees of physical/psychosocial needs, intellectual disabilities, and/or cognitive impairments and may be dependent on Associates for some or all aspects of care, such as assistance to eat, ambulating, bathing, grooming/dressing and toileting.
3. Each resident has the right to privacy and confidentiality and to be free from physical or mental abuse for all aspects of care and services.
   1. Only authorized Associates directly involved in providing care and services for the resident may be present when care is provided, unless the resident consents to other individuals being present during the delivery of care. For example, if a resident requires assistance during toileting and/or other activities of personal hygiene, authorized Associates should assure the resident’s privacy, dignity and confidentiality.
   2. Each resident must be provided individualized care with dignity and respect. During the delivery of personal care and services, staff must remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts.
   3. For further guidance relating to privacy and HIPAA, see CCG 00446 – the Facility’s Photographing, Video/Audio Recording, and Other Imaging of Residents, Visitors and Associates Policy and Procedure.
4. Residents Right to be free from Abuse/No Unauthorized Photographs or Recordings of Residents.
5. All residents have the right to privacy and confidentiality and to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion for all aspects of care and services.
6. The Facility therefore strictly prohibits all Associates from taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (e.g., cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media networks.
7. A photograph or recording of a resident, or the manner that it is used, may not be used to demean or humiliate a resident, regardless of whether the resident provided consent and regardless of the resident’s cognitive status. This would include, but is not limited to, photographs and recordings of residents 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 the 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, and showing the resident in a compromised position.
   1. A lack of response by the resident does not mean that mental abuse did not occur. It is critical to note that there may be some situations in which a resident is unable to express him/herself due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), cannot relate what has occurred, or may not express outward signs of physical harm, pain, or mental anguish.
8. Even if a resident may give consent for taking of photographs or videos, the use of those photographs must be consistent with the consent and cannot be demeaning or humiliating. Using photographs or video recordings in ways not covered by the consent may be inappropriate.
9. Training on Abuse Prevention
10. The Facility will provide training on abuse prohibition policies for all Associates who provide care and services to residents and who come into routine contact with residents, including prohibiting staff from using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings of residents that are demeaning or humiliating.
11. The Facility will provide ongoing oversight and supervision of Associates in order to assure that these policies are implemented as written.
12. The Facility will provide nurse aides with initial and annual abuse prevention training, in accordance applicable federal and state statutes, rules, and regulations.
13. Reporting
14. Associates that witness any conduct that violates this policy, must report such conduct to their department head or any other department head as soon as possible. Associates may also directly report such conduct to the Compliance and Ethics Officer or via the toll-free Compliance and Ethics hotline number.
15. The Facility will directly and thoroughly investigate all reports and will take prompt corrective action, including termination, if appropriate. The Facility reserves the right to contact law enforcement and the state survey agency, if appropriate. See CCG 00304 for the Facility’s Elder Justice Act Policy and Procedure.
16. Response to Allegations of Abuse
17. The Facility shall report all allegations of abuse to the proper authorities, provide protections for any resident involved in the allegations, conduct a thorough investigation, implement corrective actions to prohibit further abuse, and to report the findings to appropriate bodies as required.
18. Upon receipt of an allegation of abuse, including those involving the posting of an unauthorized photograph or recording of a resident on social media, the Facility shall initiate an immediate investigation and prevent further potential abuse.
    1. Examples of steps that the Facility may put in place immediately to prevent further potential abuse include, but are not limited to, staffing changes, increased supervision, protection from retaliation, and follow-up counseling for the resident.
19. Based on the investigation findings, the Facility shall implement corrective actions to prevent recurrence.
20. Non-intimidation and Non-retaliation
21. The Facility shall ensure that there is an environment in the facility that encourages individuals to report allegations of abuse without fear of recrimination or intimidation.
22. No one will be subject to, and the Facility prohibits, any form of discipline, reprisal, intimidation, or retaliation for all good faith reporting pursuant to this policy and procedure, and for cooperating in related investigations.

**{Facility}**

**ACKNOWLEDGEMENT OF RECEIPT OF POLICY AND PROCEDURE REGARDING PROTECTING RESIDENT PRIVACY AND PROHIBITING MENTAL ABUSE RELATED TO PHOTOGRAPHS AND AUDIO/VIDEO RECORDINGS BY STAFF**

I hereby acknowledge by my signature that I have received a copy of the above-referenced {Facility} policy and procedure. I hereby agree to abide by the requirements of this policy as well the Compliance and Ethics program in general. I further understand that adherence to this policy is a condition of employment or continued business dealings with {Facility}, and that I have a duty to report any Compliance and Ethics concerns to either my manager, the Administrator, the Compliance and Ethics Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or as a last resort by openly or anonymously calling our Compliance and Ethics Hotline at (800) 610-2544.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name (If Contractor) Date

**AUTHORIZATION TO RECORD**

|  |  |  |
| --- | --- | --- |
| Resident Name: | | |
| Address: | | |
| DOB: | MRN: |  |

**(AUDIO/VISUAL) RESIDENT ON PERSONAL DEVISE AND STATEMENT OF RESIDENT RIGHTS**

All residents have the right to privacy and confidentiality and to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion for all aspects of care and services.

Unless specifically authorized by the resident, the Facility strictly prohibits all staff, independent contractors, and volunteers from taking unauthorized photographs or recordings of residents using any type of equipment (e.g., cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media networks.

A photograph or recording of a resident, or the manner that it is used, may not be used to demean or humiliate a resident, regardless of whether the resident provided consent and regardless of the resident’s cognitive status. This includes, but is not limited to, photographs and recordings of residents 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 the 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, and showing the resident in a compromised position.

1. I hereby authorize the Facility or any of its staff to take photographs or other audio-visual images or materials at my request or the request of my visitor or family member. The photograph or audio-visual image may be taken on my personal device or a device belonging to my visitor or family member.
2. Please check off if applicable:

\_\_ I hereby authorize the Facility or any of its staff to take photographs or other audio-visual images for use on the facility’s social media or other marketing materials

1. This authorization shall remain in effect until either:

Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that the Facility’s staff have acted in reliance upon it, by sending written notification to the applicable Facility staff.
2. I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident’s Personal Representative Description of the representative’s authority

to act on behalf of the resident

**{Facility}**

**Quality of Care Policy and Procedure**

PURPOSE

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) provide all residents with the best possible quality of care in Compliance with applicable federal and state laws and regulations.

# POLICY

It is the policy of the Facilitythat 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.

# PROCEDURE

To achieve the goal of providing quality of care, the Facility shall:

1. Conduct both initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity. The assessment shall be based on a uniform data set specified by the state and approved by HHS;
2. Develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident’s medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment;
3. Ensure that each resident receives 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;
4. Ensure that each resident is given the appropriate treatment and services to maintain or improve his or her ability to bathe, dress, groom, transfer, ambulate;
5. Ensure that a resident who enters the facility without pressure sores does not develop them unless the resident’s clinical condition demonstrates that they were unavoidable;
6. Ensure that a resident with pressure sores will receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing;
7. Ensure that a resident who enters the facility without an indwelling catheter may not be catheterized unless the resident’s clinical condition demonstrates that catheterization is necessary;
8. Ensure that 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
9. Ensure that a resident who displays mental or psychosocial adjustment difficulty will receive a psychological evaluation with appropriate treatment and services to correct the assessed problem;
10. 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;
11. 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;
12. 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;
13. Ensure that each resident’s drug regimen will be free from unnecessary drugs, and that residents are free of significant medication errors;
14. Ensure that the Facility has 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;
15. Ensure that food menus 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;
16. Ensure that each resident receives at least three meals daily, at regular times comparable to normal mealtimes in the community;
17. Ensure that the medical care of each resident is supervised by a physician;
18. Ensure that residents are seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter;
19. Provide or arrange for the provision of physician services 24 hours a day, in case of an emergency;
20. If required by the written order of a physician, provide or obtain specialized rehabilitative services, including, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental rehabilitative services;
21. Assist residents in obtaining routine and 24-hour emergency dental care, including assistance in making appointments and arranging for transportation;
22. 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;
23. Ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist;
24. Establish an infection control program under which it investigates, controls, and prevents the spread of infections in the facility.

**{Facility}**

**Quality Assurance and Performance Improvement (QAPI)**

**Policy and Procedure**

**PURPOSE**

To provide continuous evaluation of {Facility}’s (the “Facility”) systems with the objectives of keeping systems functioning satisfactorily; preventing deviation from care processes; discerning issues and concerns; providing points of accountability for ensuring quality of care and quality of life; allowing the Facility to deal with quality deficiencies in a confidential manner; and correcting inappropriate care processes.

Quality Assurance and Performance Improvement (QAPI) is a management process that must be ongoing, multi-level, and facility-wide. QAPI encompasses all the Facility’s managerial, administrative, clinical, and environmental services, as well as the performance of outside (contracted) providers and suppliers of care and services.

**POLICY**

It is the policy of the Facility to maintain a Quality Assurance and Performance Improvement (QAPI) program. The program will be ongoing and comprehensive and will address the full range of care and services provided by the facility. The program will

1. Address all systems of care and management practices;
2. Include clinical care, quality of life and resident choice;
3. Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes
4. Reflect the complexities, unique care, and services provided.

**PROCEDURE**

1. The facility will develop a QAPI program with the following components
   1. Program Feedback, data systems and monitoring, including
      1. Facility maintenance of effective systems to obtain and use of feedback and input from staff, residents and representatives,
      2. Facility maintenance of effective systems to identify, collect and use data and information from all departments.
      3. Facility development, monitoring and evaluation of performance indicators, including the methodology and frequency for such development, monitoring and evaluation.
      4. Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility and how the facility will use the data to develop activities to prevent adverse events.
         1. An adverse event is defined as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.
   2. Program systematic analysis and system action
      1. The facility will take actions aimed at performance improvement. It will measure the success of these actions and track performance to ensure that improvements are realized and sustained.
      2. The QAPI program will include policies addressing
         1. The use of a systematic approach to determine underlying causes of problems impacting larger systems
         2. The development of corrective actions
         3. Monitoring the effectiveness of its performance improvement activities.
   3. Program activities
      1. The facility will set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas.
      2. The activities will track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.
      3. The facility will conduct distinct performance improvement activities.
2. Governance and leadership
   1. The governing body and/or executive leadership is responsible and accountable to ensure that the QAPI program is
      1. Defined, implemented and maintained
      2. Addresses identified priorities
      3. Sustained during transitions in leadership and staffing
      4. Adequately resourced
      5. Identifies and prioritizes problems and opportunities
      6. Implementing effective corrective action plans
      7. Maintaining clear expectations regarding safety, quality, rights, choice and respect.
3. Committee
   1. The QAPI program must maintain a quality assessment and assurance committee consisting of a minimum

(Federal Guidelines)

* + 1. The director of nursing services,
    2. The Medical Director or his/her designee,
    3. At least three other members of the facility’s staff, at least one of which must be the administrator, owner, a board member or other individual in a leadership role, and
    4. The infection control and prevention officer.
  1. The committee will report to the facility’s governing body or designated person functioning as a governing body regarding its activities.
  2. The committee must meet at least quarterly
  3. appropriate plans of action to correct identified quality deficiencies.
  4. The committee must regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews. It must act on available data to make improvements.

**{Facility}**

**Resident Nondiscrimination Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”), do not exclude, deny benefits to, or otherwise discriminate against any resident on the basis of race, color, national origin, sex, disability, or age in relation to admission, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by the Facility directly or through a contractor or any other entity with which the Facility arranges to carry out its programs and activities.

**POLICY**

The Facility and its Associates serve a diverse population and respect the rights of all residents to culturally competent care. The Facility and its Associates recognize that each resident is an individual with personal dignity and unique healthcare needs, and strives to provide care focused upon the resident’s needs.

It is the policy of the Facility to not exclude, deny benefits to, or otherwise discriminate against persons who are clients or desiring to be admitted to the Facility, 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, 91 and 92 No resident shall be denied admission or appropriate care and placement following admission because of race, creed, color, national origin, ancestry, age, sex, handicap, disability, or any other category prohibited by applicable federal, state, or local laws and regulations.

**PROCEDURE**

1. Under no circumstances will the Facility or its Associates exclude, deny benefits to, or otherwise discriminate against residents based upon race, creed, color, national origin, ancestry, age, sex, handicap, disability, or any other category prohibited by applicable federal, state, or local laws and regulations.
2. Non-Retaliation

The Facility will not retaliate against any Associate who reports concerns about discrimination, files a discrimination complaint, or cooperates in an investigation of discrimination on behalf of a resident or applicant.

1. The Facility staff will determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment on the basis of race, creed, color, national origin, ancestry, age, sex, handicap, disability, or any other category prohibited by applicable federal, state, or local laws and regulations.
2. The Facility will take appropriate steps to provide public notice of its nondiscriminatory and related policies.
   1. A full nondiscriminatory notice will be included in significant publications, in conspicuous physical locations, and on the web site. The full notice will include taglines identifying specific policies as well as the following information:
      1. the Facility does not discriminate on the basis of race, color, national origin, sex, age, or disability;
      2. the availability of appropriate auxiliary aids and services and how to obtain these aids or services (see Policy CCG 00504);
      3. the provision of language assistance services and how to request them (see Policy CCG 00509);
      4. identification or contact information for the individual responsible for coordinating or facilitating the nondiscrimination policies;
      5. the availability of a grievance process and how to initiate it (see Policy CCG 00505); and
      6. how to file a complaint with the United States Office of Civil Rights.
   2. A brief nondiscrimination notice may be substituted for the full notice in certain small publications such as postcards or tri-fold brochures. This brief notice must include taglines in two languages and information on the availability of auxiliary aids and services for individuals with disabilities.
3. The Facility’s Compliance and Ethics Officer shall be responsible for coordinating Compliance and Ethics with this Policy, including giving notice to and training all Associates on this Policy, and, when applicable, conducting investigations, keeping records and submitting Compliance and Ethics reports to the Office of Civil Rights.

**NONDISCRIMINATION NOTICE**

The Facility and its Associates serve a diverse population and respect the rights of all residents to culturally competent care. The Facility and its Associates recognize that each resident is an individual with personal dignity and unique healthcare needs and strives to provide care focused upon the resident’s needs.

* The Facility will not exclude, deny benefits to, or otherwise discriminate against persons who are residents or desiring to be admitted to the Facility, in accordance with federal and state statutes and regulations. The Facility does not discriminate on the basis of race, color, national origin, sex, age, or disability, and no resident shall be denied admission or appropriate care and placement following admission because of race, creed, color, national origin, ancestry, age, sex, handicap, disability, or any other category prohibited by applicable federal, state, or local laws and regulations.
* Appropriate auxiliary aids and services are available pursuant to the Facility’s Auxiliary Aids and Services Policy and Procedure;
* Language assistance services are available pursuant to the Facility’s Residents and Families with Limited English Proficiency Policy and Procedure
* Residents and their families are entitled to the prompt resolution of medical and non-medical grievances pursuant to the Facility’s Grievance Policy and Procedure
* The Facility shall provide information to individuals on how to file a complaint with the United States Office of Civil Rights.

The Compliance and Ethics Officer, \_\_\_\_\_\_\_\_\_\_\_\_\_\_, is responsible for coordinating or facilitating the items listed above as well as any additional Facility nondiscrimination policies. The Compliance and Ethics officer can be reached at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**{Facility}**

**Auxiliary Aids and Services Policy and Procedure**

# PURPOSE

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”), accommodate individuals with special needs as defined in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990, which prohibit discrimination on the basis of disability in the delivery of healthcare services. The regulation implementing these Acts requires that individuals with a disability be provided with appropriate auxiliary aids at no cost to allow them an equal opportunity to participate in, and benefit from, the healthcare services provided by the Facility.

**POLICY**

The Facility is committed to full Compliance and Ethics with federal and state laws barring discrimination on the basis of disability. The Facility recognizes its legal obligations and is committed to proactively assessing the communication needs of its disabled applicants and residents to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals as a result of the absence of auxiliary aids and services. Auxiliary aids and services may include qualified readers or interpreters, written materials, Brailed materials and displays, audio recordings, or assistive listening devices. Disabilities may be self-identified and the input of the applicant or resident should be considered when choosing an auxiliary aid or service. Auxiliary aids and services used to effectively communicate with disabled residents or applicants are to be provided in a timely manner and at no cost to the disabled individual. All requests for auxiliary aids or services should be documented in the medical record.

Appropriate auxiliary aids and services must also be provided to a disabled companion to an applicant or resident, if the companion is an appropriate person with whom the Facility should communicate. For purposes of this policy, a companion may include a family member, friend, or associate of the resident or applicant.

If providing these aids would fundamentally alter the nature of the services or accommodations being offered, or the steps would result in a significant difficulty or expense, the Facility will work with the applicant or resident to facilitate proper accommodations.

# PROCEDURE

1. The Facility will provide notice of the availability of, and procedure for requesting, qualified sign-language interpreters and/or other appropriate auxiliary aids and services where necessary to ensure effective communication with applicants or residents with disabilities.
2. The Facility will inform residents with disabilities of the availability, at no cost to them, of qualified interpreters and/or other auxiliary aids, and will provide each service promptly upon request.
3. If an individual with a disability specifically requests an accompanying adult to interpret or facilitate communication, the Facility may rely on this request, provided the accompanying adult agrees to provide the assistance and the Facility feels that the assistance is appropriate under the circumstances. This request should be documented in the individual’s medical record.
4. Residents or applicants with a grievance regarding the provision of auxiliary aids or services are referred to the Facility’s Grievance Policy.
5. Notice of the provision of auxiliary aids and services and related information should be posted in a public area of the facility, in accordance with the Facility’s Nondiscrimination Policy.
6. The Compliance and Ethics Officer is designated to coordinate and carry out this policy.

**Section 504 Notice of Program Accessibility**

In accordance with Section 504 of the Rehabilitation Act of 1973, this facility’s policy is to ensure that handicapped individuals are not be denied benefit, or excluded from participation in, or otherwise subjected to discrimination under any program or benefit that is offered, accessible or available to a non-handicapped individual. This facility has policies and procedures in place to ensure that handicapped individuals are not discriminated against and are not denied benefit, excluded, or discriminated against in any program or benefit to which they should be entitled.

{Facility} 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. Auxiliary aids and services will be made available, and may include qualified readers or interpreters, written materials, Brailed materials and displays, audio recordings, or assistive listening devices.

Accommodations and auxiliary aids will be provided

* in a timely manner
* at no cost to the disabled individual
* to a disabled companion to an applicant or resident, if the companion is an appropriate person with whom the facility should communicate
* in a manner in which will enable effective communication between the facility and the resident or applicant.

Inquiries regarding auxiliary aids and services, or related accommodations in Compliance and Ethics with Section 504 of the Rehabilitation Act of 1973 should contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_ at extension \_\_\_\_\_\_.

**{Facility}**

**Resident and Family Concerns and Grievances Policy and Procedure**

**PURPOSE**

To provide for the prompt resolution of medical and non-medical grievances while maintaining confidentiality, in accordance with applicable federal and state statutes and regulations.

**POLICY**

{Facility} (the “Facility”) is committed to providing its residents with exceptional care and services. To ensure the continued provision of such exceptional care and services, the Facility and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”), have an established grievance process to address resident and family member concerns or dissatisfaction about the Facility’s provision of care and services.

**PROCEDURE**

1. Filing of Grievances.
   1. Residents or their family members, guardian, or representative may voice a grievance to the Facility staff in person, by telephone, or via written communication.
   2. Should a resident require assistance in voicing a grievance, the Facility Associates shall provide any needed assistance to the resident.
   3. The Facility shall provide the attached “Grievance Report Form” to facilitate the voicing of a grievance if requested by a resident or family member.
2. Documentation of Grievances
   1. The Facility’s Compliance and Ethics Officer or a designated Associate will document and keep a log of all grievances expressed either orally and/or in writing on the day that it is received or as soon as possible after the event or events that precipitated the grievance.
3. Investigation of Grievances
   1. The Facility’s Compliance and Ethics Officer shall notify the management or supervisory staff responsible for the services or operations which are the subject of the grievance. The management or supervisory staff will commence a formal investigation of the grievance as soon as is practicable.
4. Responses to and Resolution of Grievances
   1. The Facility will follow up with resident or their family members, guardian, or representative within 72 hours of the filing of the grievance.
   2. The Facility will make reasonable efforts to ensure that all grievances areadequatelyresolved within thirty (30) calendar days from the day the grievance is received.
   3. The Facility will advise the resident of the outcome of the grievance investigation and shall make reasonable efforts to contact the resident’s family members to advise them of the outcome of the grievance investigation.
   4. The Facility will provide the resident with a written Grievance Decision, which shall include:
      1. the date the grievance was received;
      2. a summary statement of the resident’s grievance;
      3. the steps taken to investigate the grievance;
      4. a summary of the pertinent findings or conclusions regarding the resident’s concern(s);
      5. a statement as to whether the grievance was confirmed or not confirmed;
      6. any corrective action taken or to be taken by the facility as a result of the grievance; and
      7. the date the written decision was issued.
   5. In the event that the Facility cannot resolve the grievance within thirty (30) calendar days, the Facility will notify the resident their family members, guardian, or representative of the status and estimated completion date of the grievance resolution.
   6. The Facility will document all steps of the grievance resolution in the Facility’s records, including whether or not the resident/family was satisfied with the resolution. The documentation will be kept for a minimum of 3 years.
   7. If the person filing the grievance is not satisfied by the action taken by the Compliance and Ethics Officer or a designated Associate, the complainant shall submit an oral or written complaint to the state or community ombudsman, pursuant to applicable state regulations.
   8. If the ombudsman does not resolve the grievance to the complainant’s satisfaction within ten days, the complainant may submit the grievance to an impartial referee, jointly chosen by the Compliance and Ethics Officer or a designated Associate and the complainant, who will conduct a hearing.
   9. The referee’s hearing shall be held at the facility within 14 days after submission of the grievance to him, at a time convenient to the referee, the complainant, and the Compliance and Ethics Officer or designated Associate. The complainant and the Compliance and Ethics Officer or a designated Associate may review relevant records and documents, present evidence, call witnesses, cross-examine witnesses, make oral arguments, and be represented by any person of their choice. The referee may ask questions of any person, review relevant records and documents, call witnesses, and receive other evidence as appropriate. The referee shall keep a record of the proceedings, which record may be a sound recording. Within 72 hours after the grievance review, the referee shall render a decision and shall give to the complainant and to the administrator of the Facility a written statement of the decision and reasons therefor, which statement shall also describe the appeal rights set forth in Georgia Code Section 31-8-125. Such decision shall be binding on the parties unless reversed upon appeal.
5. Notification of Grievance Policy
   1. The Facility will notify residents, individually or through postings in prominent locations throughout the facility, of the right to file a grievance. The notification (CCG 00505b) must include the following information:
      1. Grievances may be filed orally or in writing, and may be anonymous;
      2. Contact information of the grievance official;
      3. A reasonable expected time frame for completing the review of the grievance;
      4. Filers have the right to obtain a written decision regarding a grievance;
      5. Contact information for the relevant state agency or Ombudsman program for filing a complaint.
6. (GA only) If the person filing the grievance is not satisfied by the action taken by the Compliance and Ethics Officer or a designated Associate, the complainant shall submit an oral or written complaint to the state or community ombudsman, pursuant to applicable state regulations.
7. If the ombudsman does not resolve the grievance to the complainant’s satisfaction within ten days, the complainant may submit the grievance to an impartial referee, jointly chosen by the Compliance and Ethics Officer or a designated Associate and the complainant, who will conduct a hearing.
8. The referee’s hearing shall be held at the facility within 14 days after submission of the grievance to him, at a time convenient to the referee, the complainant, and the Compliance and Ethics Officer or designated Associate. The complainant and the Compliance and Ethics Officer or a designated Associate may review relevant records and documents, present evidence, call witnesses, cross-examine witnesses, make oral arguments, and be represented by any person of their choice. The referee may ask questions of any person, review relevant records and documents, call witnesses, and receive other evidence as appropriate. The referee shall keep a record of the proceedings, which record may be a sound recording. Within 72 hours after the grievance review, the referee shall render a decision and shall give to the complainant and to the administrator of the Facility a written statement of the decision and reasons therefor, which statement shall also describe the appeal rights set forth in Georgia Code Section 31-8-125. Such decision shall be binding on the parties unless reversed upon appeal.

**Resident/Family**

**Concern/Grievance Form**

* Resident’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Room Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Time of Concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Staff Member Receiving Concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1: Please Describe the Nature of the Concern:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concern Received From: \_\_ Resident \_\_\_\_\_ Family \_\_ Other

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: All Concerns Referred to the Department Head for Review**

Department Head: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review and Action Taken:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department Head Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Administrator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Section 3 Follow Up With Resident/Family Member:**

Name of Individual Contacted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Staff Member Completing Follow up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: For Administrator or Compliance and Ethics Officer to Complete:**

* Further Action Required and/or New Grievance Generated
* Concern and/or Grievance Resolved

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**GRIEVANCE POLICY**

The Facility is committed to providing its residents with exceptional care and services. To ensure the continued provision of care and services, and to facilitate the prompt resolution of medical and non-medical grievances, the facility has established a grievance process to address resident and family member concerns or dissatisfaction with the provision of care and/or services.

Residents, family members, visitors, employees and all others with a grievance may voice their grievances in person, by telephone or via written communication.

Grievances may be followed anonymously.

The Compliance and Ethics Officer is responsible for investigating grievances. The Compliance and Ethics Officer can be reached by phone at [phone] and by email at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The Compliance and Ethics Officer works at the facility located at [address], [city], [state] [zip] .

The Facility’s policy is to follow up with the individual reporting the grievance within 72 hours of the filing.

Individuals filing grievances have a right to obtain a written decision regarding the grievance.

If a filer is not satisfied with the grievance process, a complaint can be filed with the State Department of Health Nursing Home Complaint hotline at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Questions regarding the Grievance Policy and Procedure can be

addressed to the Compliance and Ethics Officer or the Compliance and Ethics Hotline.

**Grievance Decision**

* Resident’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Room Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date grievance was received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Staff Member Providing Decision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date issued to Resident/Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide a summary statement of the resident’s grievance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List the steps taken by staff to investigate the grievance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide a summary of the pertinent findings or conclusions regarding the resident’s concern(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide a statement as to whether the grievance was confirmed or not confirmed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide the corrective action taken or to be taken by the facility as a result of the grievance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident/Family Member Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**{Facility}**

**Resident Funds Policy and Procedure**

**PURPOSE**

To ensure that {Facility}’s (the “Facility”) residents have access to, and are able to manage, their personal funds.

**POLICY**

Each one of the Facility’s residents has the has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges the Facility may impose against a resident’s personal funds.

The Facility does not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility shall act as a fiduciary of the resident’s funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this policy.

**PROCEDURE**

1. **Managing Resident Funds – Generally**
2. If a resident or resident representative chooses to have the Facility manage the resident’s funds, facility staff may not refuse to handle these funds. Facility staff, however, are not expected to be familiar with resident assets not on deposit with the facility.
   1. Managing the resident’s financial affairs includes money that individuals give to the Facility for the sake of providing a resident with a non-covered service. In these instances, the Facility will provide a receipt to the gift giver and retain a copy in its files.
3. Banks may charge the resident a fee for handling their funds and pass this fee on to residents. The Facility, however, will not charge residents for managing residents’ funds because the services are covered by Medicare or Medicaid or by the Facility’s per diem rate. The Facility will credit monies due to residents to their respective bank accounts within a few business days.
4. Residents may make requests that the Facility temporarily place their funds in a safe place, without authorizing the Facility to manage those funds. The Facility shall keep track of such funds, through an established system, in order to document the date, time, amount, and who the funds were received from or dispersed to.
5. The Facility will ensure, through established systems in place, safeguarding against any misappropriation of a resident’s funds.
6. **Deposit of funds.**
7. In general. Except as set out in Section B. herein, the facility shall deposit any residents’ personal funds in excess of $100 in an interest-bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there shall be a separate accounting for each resident’s share.) The facility shall maintain a resident’s personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
8. Residents whose care is funded by Medicaid. The facility shall deposit the residents’ personal funds in excess of in an interest-bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there shall be a separate accounting for each resident’s share.) The facility shall maintain personal funds that do not in a non-interest bearing account, interest-bearing account, or petty cash fund.
9. The Facility staff will provide each resident that deposited funds with a receipt for these funds and the Facility will retain a copy of the receipt in its records.
10. **Access to Funds**
11. Residents shall have access to petty cash on an ongoing basis and be able to arrange for access to larger funds. Although the Facility need not maintain $100.00 per resident on its premises, it is expected to maintain petty cash on hand to honor resident requests.
12. Resident requests for access to their funds will be honored by Facility staff as soon as possible but no later than:
    1. The same day for amounts less than $100.00 or amounts less than $50.00 for Medicaid residents;
    2. Three banking days for amounts of $100.00 or $50.00 for Medicaid residents or more.
13. **Accounting and records.**
14. The Facility acts as a fiduciary of its residents’ funds and has established and maintains a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the Facility on the resident’s behalf in a clear and understandable manner.
    1. Facility staff shall employ proper bookkeeping techniques, by which staff can determine, upon request, the amount of individual resident funds and, in the case of an interest-bearing account, how much interest these funds have earned for each resident, as last reported by the banking institution to the Facility.
    2. Proper bookkeeping techniques include an individual record established for each resident on which only those transactions involving his or her personal funds are recorded and maintained. The record shall have information on when transactions occurred, what they were, and maintain the ongoing balance for every resident. For each transaction, the resident shall be given a receipt and the Facility shall retain a copy.
15. The system precludes any commingling of resident funds with Facility funds or with the funds of any person other than another resident.
16. The Facility makes available to its residents individual financial records through quarterly statements and upon request. The quarterly statements shall be provided in writing to the resident or the resident’s representative within 30 days after the end of the quarter, and upon request.
17. **Notice of certain balances.**
18. The facility shall notify each resident that receives Medicaid benefits:
    1. When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Social Security Act; and
    2. That, if the amount in the account, in addition to the value of the resident’s other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
19. **Conveyance upon discharge, eviction, or death.**
20. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the Facility, the Facility shall convey within 30 days the resident’s funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident’s estate, in accordance with State law.
21. **Assurance of financial security.**
22. The facility shall purchase a surety bond to assure the security of all personal funds of residents deposited with the facility.
23. The surety bond shall not be limited to personal needs allowance funds. Any resident funds thatare entrusted to the Facility for a resident shall be covered by the surety bond, includingrefundable deposit fees.
24. The facility shall be named as a beneficiary of the surety bond.
25. Self-insurance is not an acceptable alternative to a surety bond. Likewise, fundsdeposited in bank accounts protected by the Federal Deposit Insurance Corporation, orsimilar entity, also are not acceptable alternatives.
26. **Facility Charges**
27. The Facility may not (and will not) impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The Facility also may not (and will not) require a resident to request any item or services as a condition of admission or continued stay.
    1. The Following are services which are included in Medicare or Medicaid payments:
       1. Nursing services as required by law.
       2. Food and Nutrition services as required by law.
       3. An activities program as required by law.
       4. Room/bed maintenance services.
       5. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.
       6. Medically-related social services as required by law.
       7. Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.
28. The Facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with the federal and state laws.
    1. The following are general categories and examples of items and services that the Facility may charge to residents’ funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident’s care plan, if the Facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
       1. Telephone, including a cellular phone.
       2. Television/radio, personal computer or other electronic device for personal use.
       3. Personal comfort items, including smoking materials, notions and novelties, and confections.
       4. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.
       5. Personal clothing.
       6. Personal reading matter.
       7. Gifts purchased on behalf of a resident.
       8. Flowers and plants.
       9. Cost to participate in social events and entertainment outside the scope of the activities program.
       10. Non-covered special care services such as privately hired nurses or aides.
       11. Private room, except when therapeutically required (for example, isolation for infection control).
       12. Specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, except as provided below in VI. B. a. xii. 1 and 2.
           1. The Facility may **not**, however, charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident’s physician, physician assistant, nurse practitioner, or clinical nurse specialist.
           2. Additionally, when preparing foods and meals, the Facility shall take into consideration residents’ needs and preferences and the overall cultural and religious make-up of the facility’s population.
    2. Prior to the Facility providing a non-covered service for which there is an additional charge to a resident pursuant to a resident’s request, the Facility will provide the resident with written confirmation of the request and the fee to be charged to the resident.
29. Requests for items and services.
    1. The Facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.
    2. The Facility shall not require a resident to request any item or service as a condition of admission or continued stay.
    3. The Facility shall inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
30. Residents, however, will not be charged for universal items such as computers, telephones, television services or other electronic devices, books, magazines or newspaper subscriptions intended for use by all residents.

**{Facility}**

**Active Shooter Policy and Procedure**

**“CODE SILVER”**

**PURPOSE**

To assist {Facility}’s (the “Facility”) employees and staff in responding to an active shooter event and to ensure the safety and wellbeing of all staff, residents, and others in the facility.

**POLICY**

In order to preserve life and address the reality of an active shooter event, these guidelines have been established to guide the Facility’s response to this event to maximize survivability. It is very important to quickly determine the most reasonable way to protect one’s own life and to assist others as appropriate.

An active shooter is a person or persons who appear to be actively engaged in killing or attempting to kill people in the facility. In most cases, active shooters use a firearm(s) and display no pattern or method for selection of their victims. In some cases, active shooters use other weapons and/or improvised explosive devices to cause additional victimization and act as an impediment to law enforcement and emergency services responders. These improvised explosive devices may detonate immediately, have delayed detonation fuses, or detonate on contact.

**PROCEDURE**

1. The intent of most active shooters is to kill as many people as quickly as possible. Traditional law enforcement response will include the concept of “surround and contain” in order to minimize the number of victims. In order to save lives, the law enforcement agency having jurisdiction will initiate an immediate response.
2. Upon discovery of an active shooter situation, as soon as possible and when safe to do so, staff must notify law enforcement (911) and provide overhead announcement in the facility of a Code Silver or “Active Shooter” and the location of the shooter.
3. The phone call to 911 (from the area where they are safely concealed) should provide the following information:
   1. Description of suspect and possible location
   2. Number and types of weapons
   3. Suspect’s direction of travel
   4. Location and condition of any victims
4. The Administrator or person in charge of the facility will meet and guide law enforcement officers if possible and as appropriate. The goal of law enforcement is to locate, isolate, and neutralize the shooter as quickly as possible to prevent additional deaths or injuries.
5. Response
6. Evacuate
   1. If there is an accessible escape path, staff should make an attempt to evacuate the premises.
   2. Staff should be sure to:
      1. Have an escape route and plan in mind
      2. Evacuate regardless of whether others agree to follow
      3. Leave belongings behind
      4. Help others escape, if possible
      5. Prevent individuals from entering an area where the active shooter may be
      6. Keep hands visible
      7. Follow the instructions of any police officers
      8. Do not attempt to move wounded people
      9. Call 911 when safe
7. Hide out
   1. If evacuation is not possible, staff should find a place to hide where the active shooter is less likely to come
   2. Staff should direct personnel into resident rooms or other adjacent rooms, close the door and attempt to barricade the door.
   3. The hiding place should
      1. Be out of the active shooter’s view
      2. Provide protection if shots are fired in a staff member’s direction (i.e., locating into a resident bathroom and locking the door, stay as low to floor as possible and remain quiet and still)
      3. Not trap or restrict options for movement
   4. To prevent an active shooter from entering a hiding place
      1. Lock the door
      2. Blockade the door with heavy furniture
   5. If the active shooter is nearby
      1. Lock the door
      2. Silence cell phones and/or pagers
      3. Turn off any source of noise (i.e., radios, televisions)
      4. Hide behind large items (i.e., cabinets, desks)
      5. Remain quiet
   6. If evacuation and hiding out are not possible:
      1. Remain calm
      2. Dial 911, if possible, to alert police to the active shooter’s location
      3. If staff cannot speak, leave the line open and allow the dispatcher to listen
8. Take action against the active shooter
   1. As a last resort, and only when a staff member’s life is in imminent danger, the staff member should attempt to disrupt and/or incapacitate the active shooter by
      1. Acting as aggressively as possible against him/her
      2. Throwing items and improvising weapons
      3. Yelling
9. An “all clear” Code Silver will be announced overhead when the situation has been addressed and the scene is declared safe by law enforcement officials.
10. How to Respond when Law Enforcement Arrives
11. Law enforcement’s purpose is to stop the active shooter as soon as possible. Officers will proceed directly to the area in which the last shots were heard.
12. Officers usually arrive in teams of four (4)
13. Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment
14. Officers may be armed with rifles, shotguns, handguns
15. Officers may use pepper spray or tear gas to control the situation
16. Officers may shout commands, and may push individuals to the ground for their safety
17. How to react when law enforcement arrives:
18. Remain calm, and follow officers’ instructions
19. Put down any items in your hands (i.e., bags, jackets)
20. Immediately raise hands and spread fingers
21. Keep hands visible at all times
22. Avoid making quick movements toward officers such as holding on to them for safety
23. Avoid pointing, screaming and/or yelling
24. Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the premises
25. Recovery after the event
    1. Share Information with Employees and Residents
       1. The health and wellbeing of our residents and employees is critical. As soon as possible after law enforcement has relinquished command and control of the scene, the facility administrator and social worker will develop information strategies to address resident, employee, and family questions related to the event.
       2. Initially, the site of a violent incident will be secured as a crime scene. After the authorities have completed their investigation and have released the crime scene, management will need to have the facility appropriately cleaned and sanitized. Cleanup for the safe removal of bio-hazardous substances including blood borne pathogens must take place, yet must be sensitive compassionate, and caring for the deceased.
       3. Buffer those Affected from Post-Event Stresses
       4. Effective coordination with the media and timely dissemination of information can help reduce media pressure on those who are the most vulnerable. Assistance with employee benefits and other administrative issues can reduce the burden on victims and families. The administrator or a corporate representative will be designated as the Public Information Officer who is authorized to speak on behalf of the facility to the media.
26. Bring in Crisis Response Professionals
27. When an incident occurs, the Facility will retain emergency mental health consultants to provide as soon as possible any necessary physical, emotional, and psychological support to staff and residents.

**smoking**

**{Facility}**

**Resident Smoking Policy and Procedure**

**PURPOSE**

To accommodate the individual needs and preferences of residents while still protecting the safety and health of individuals residing in the facility. As per 42 CFR 483.25, this policy will maintain an environment that remains as free of accident hazards as is possible, and will ensure that each resident receives adequate supervision and assistance to prevent accidents. It will also provide accommodation of individual needs and preferences, without endangering the health or safety of any resident in the facility, as per 42 CFR 483.15.

**POLICY**

To ensure compliance with regulatory guidelines and safety protocols, {Facility} (the “Facility”) prohibits smoking in its facility except for specifically designated areas. To protect the safety of other residents and employees, the use of medical oxygen is prohibited in smoking areas. Residents deemed to need assistance to smoke should have this designation noted in the care plan. For purposes of this policy, electronic cigarettes (e-cigarettes), pipes, cigars and similar paraphernalia are to be treated as cigarettes.

**PROCEDURE**

1. Residents
   1. Each resident should be individually assessed to determine whether or not he/she can safely smoke without supervision. The Facility shall conduct an assessment to determine whether the resident requires a smoking apron and shall document this in the resident’s care plan. Re-assessments should be conducted, as necessary. The determination should be noted in the resident’s care plan and in a smoking log to be kept on each residential floor.
   2. Residents are not permitted to have any smoking paraphernalia in their room or on their person. All smoking paraphernalia should be given to the nursing staff for safekeeping. Nursing staff should maintain records of residents’ property and distribute it accordingly. Nursing staff are required to confirm the resident’s status in the smoking log before distributing smoking materials to the resident. Residents who have been determined to require supervision must be actively supervised by a staff member while in the designated smoking area.
   3. Residents with medical oxygen are not permitted to smoke or enter a designated smoking area.
   4. Residents may not provide other residents with cigarettes or other smoking paraphernalia and may not light a cigarette for another resident.
   5. Residents must sign a “Smoking Agreement” (see Attachment) as part of the admission process. Smoking Agreements should be amended and re-signed when the resident’s smoking status has changed.
   6. Designated areas
   7. Designated areas must be public spaces
   8. Medical oxygen is not allowed in designated areas.
   9. Designated areas will have
      1. signage to indicate that smoking is allowed;
      2. easy access to fire extinguishers;
      3. a design which limits second hand smoke exposure to other residents; and
      4. ash trays on noncombustible material in sufficient numbers;
      5. Adequate outside ventilation;
      6. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be available to all areas where smoking is permitted
      7. “No Smoking” signs or the international “No Smoking” symbol consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it may be clearly and conspicuously posted by the Facility where smoking is prohibited. Smoking is prohibited in any place in which these signs are posted.
      8. Ashtrays shall be removed from any area where smoking is prohibited, unless such ashtray is permanently affixed to an existing structure.
2. Responsible Party

The compliance and ethics officer is responsible for ensuring compliance with this policy.

**{Facility}**

**Resident Smoking Agreement**

Resident name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Resident has been designated as a (choose one) non-smoker, smoker not requiring supervision, smoker requiring supervision.

The following is a summary of the Facility’s Resident Smoking Policy

1. {Facility} prohibits smoking in its facility except for specifically designated areas. Designated areas include:
   1. SPACE ONE
   2. SPACE TWO
2. Residents are not permitted to have any smoking paraphernalia in their room or on their person. All smoking paraphernalia should be given to the nursing staff for safekeeping. Residents wishing to smoke should request the materials from the nursing staff.
3. Residents designated as requiring supervision while smoking must be accompanied by a staff member while smoking.
4. The use of medical oxygen is prohibited in smoking areas.
5. Residents may not provide other residents with cigarettes or other smoking paraphernalia and may not light a cigarette for another resident.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Resident’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Social worker, Psychologist, or RN Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Social worker, Psychologist, or RN Printed Name Date

**{Facility}**

**Residents And Families With Limited English Proficiency** **Policy And Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”), provide meaningful access to care for those residents and their families with limited English proficiency.

**POLICY**

The Facility and its Associates serve a diverse population and respect the rights of all residents to culturally competent care. In order to provide meaningful access to care, it is the policy of the Facility to ensure that residents and their families are provided with timely and accurate language assistance services, and to ensure that residents and their families are notified as to the availability of the service. This notification will be available in the Facility’s STATE’s 15 most frequently used languages spoken by individuals with limited English proficiency (LEP). Notifications will be provided via “taglines[[6]](#footnote-7)” in certain of the Facility’s publications and communications, in physical locations, and in a location accessible from the home page of the Facility’s web site.

**PROCEDURE**

1. Language services

The Facility will offer language services at no charge to individuals with limited English proficiency (LEP). The language services will be timely and accurate and may include oral interpretation and written translation when this is a reasonable step to provide meaningful access to an individual with LEP. Oral interpretation may be offered through qualified bilingual staff or through a translation service.

Individuals with LEP may choose to use a family member or friend as an interpreter. In these cases, documentation should be placed in the medical record indicating that the individual was informed as to the availability of free language services.

1. Taglines and notifications
   1. Taglines and notifications of translation services will be posted in the following locations:
      1. Significant publications and communications, as well as the Facility’s web site and physical location will post taglines in the state’s 15 most frequently used non-English languages, as provided by the OCR[[7]](#footnote-8).
      2. Significant but small publications and communications such as postcards and tri-fold brochures will receive taglines in the state’s 2 most frequently used non-English languages, as designated by the OCR.
2. Identification and Documentation of LEP

At admission or at any other time, staff must identify the language and communication needs of the LEP individual. Documentation of the LEP should be kept in the medical record.

1. The Facility’s Compliance and Ethics Officer shall be responsible for ensuring Compliance and Ethics with this policy and procedure.

**{Facility}**

**Resident Transfer and Discharge Policy and Procedure**

**PURPOSE**

To ensure that residents being transferred or discharged are subject to a standardized process which ensures regulatory compliance and ethics as well as maintenance of the resident’s quality of care.

**POLICY**

{Facility} will maintain a transfer and discharge process that complies with regulatory requirements and maintains the resident’s quality of care.

**PROCEDURE**

1. Residents may be transferred or discharged as a result of any of the following:
   1. The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;
   2. The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility;
   3. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
   4. The health of individuals in the facility would otherwise be endangered;
   5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to the Facility, the Facility shall charge a resident only allowable charges under Medicaid; or
   6. The facility ceases to operate.
2. The Facility shall not transfer or discharge a resident while an appeal is pending if the resident exercises his or her right to appeal a transfer or discharge notice from the Facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the Facility. The Facility shall document the danger that failure to transfer or discharge would pose.
3. All transfers or discharges must be documented in the medical record and appropriate information is communicated to the receiving health care institution or provider.
4. Documentation in the resident’s medical record must include:
   1. The basis for the transfer per section I of this policy.
   2. The specific resident need(s) that cannot be met under section I.A. of this policy, Facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
5. The documentation must be made by:
   1. The resident’s physician when transfer or discharge is necessary under section I.A or B. of this policy; and
   2. A physician when transfer or discharge is necessary under Section I.C or D of this policy.
6. Information provided to the receiving provider shall include a minimum of the following:
   1. Contact information of the practitioner responsible for the care of the resident;
   2. Resident representative information including contact information.
   3. Advance Directive information;
   4. All special instructions or precautions for ongoing care, as appropriate;
   5. Comprehensive care plan goals;
   6. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
7. Notice before transfer.
   1. Before the Facility transfers or discharges a resident, the Facility shall, in a written notice:
      * 1. Notify the resident and the resident’s representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The Facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
        2. Record the reasons for the transfer or discharge in the resident’s medical record in accordance with this policy and procedure.
   2. Contents of the notice.
      * 1. The written notice shall include the following:
8. The reason for transfer or discharge
9. The effective date of transfer or discharge;
10. The location to which the resident is transferred or discharged;
11. A statement of the resident’s appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
12. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
13. For Facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (402 Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
14. For Facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.
    1. Timing of the notice.
       * 1. Except as specified in section IV.C.b. below and except in cases of facility closure, the notice of transfer or discharge required shall be made by the Facility at least 30 days before the resident is transferred or discharged.
         2. Notice must be made as soon as practicable before transfer or discharge when:
15. The safety of individuals in the Facility would be endangered;
16. The health of individuals in the facility would be endangered;
17. The resident's health improves sufficiently to allow a more immediate transfer or discharge
18. An immediate transfer or discharge is required by the resident’s urgent medical needs; or
19. A resident has not resided in the facility for 30 days.
20. Changes to the notice. If the information in the notice under Section IV changes prior to effecting the transfer or discharge, the Facility shall update the recipients of the notice as soon as practicable once the updated information becomes available.
21. Orientation for transfer or discharge. The Facility shall provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the Facility. This orientation must be provided in a form and manner that the resident can understand.
22. Notice in advance of facility closure. In the case of the Facility’s closure, the individual who is the administrator of the Facility shall provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the Facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required by applicable regulations.
23. Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part are subject to the requirements of 42 § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part’s locations.

**{Facility}**

**Resident Admission Policy and Procedure**

**PURPOSE**

To ensure that applicants for admission are subject to a standardized process by which all laws are followed, and correct information is obtained.

**POLICY**

{Facility} (the “Facility”) will maintain an admissions process that is thorough, fair, consistent, complies with all applicable laws and treats prospective residents with respect.

**PROCEDURE**

1. All applicants for admission will be required to:
   1. complete an admission application;
   2. provide evidence of a valid payor source;
   3. provide any additional medical or financial information as requested by the Facility.
2. Determination of payment arrangement will be made prior to admission.
   1. The Facility will not require residents or potential residents to waive their rights to Medicare or Medicaid and will not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.
   2. The Facility will not request or require residents or potential residents to waive potential Facility liability for losses of personal property.
3. The Facility shall not request or require a third-party guarantee of payment to the Facility as a condition of admission or expedited admission or continued stay in the Facility. However, the Facility may request and require a resident representative who has legal access to a resident’s income or resources available to pay for Facility care to sign a contract, without incurring personal financial liability, to provide Facility payment from the resident’s income or resources.
4. In the case of a person eligible for Medicaid, the Facility shall not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the Facility. However:
   1. The Facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term “nursing facility services” so long as the Facility gives proper notice of the availability and cost of these services to residents and does not condition the resident’s admission or continued stay on the request for and receipt of such additional services; and
   2. The Facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the Facility for a Medicaid eligible resident.
5. The Facility shall disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the Facility.
6. All individuals admitted to the facility will be required to read and sign an admission contract agreement prior to admission or within 24 hours after admission
7. Payment for the first month’s rent and service needs will be made on admission and will be expected every 30 days in advance of the next month’s stay.
8. At the time of admission or within 48 hours of admission, the following information should be determined and entered into the resident’s medical record.
   1. A baseline interim care plan;
   2. The resident’s designated representative;
   3. The resident’s selected physician (if applicable);
   4. The resident’s selection of roommate (if applicable).
9. When conducting its admissions process, the Facility will abide by its Nondiscrimination and other related policies, as required by law.

**{Facility}**

**Volunteer Policy and Procedure**

**PURPOSE**

To ensure the safety of {Facility}’s (the “Facility”) residents while enhancing residents’ quality of life by enabling volunteers to properly assist its residents.

**POLICY**

It is the Facility’s policy to ensure safety and quality of life for its residents by ensuring, to the best of its ability, that volunteers are properly screened to enable them to provide services to residents.

**PROCEDURE**

1. The Facility’s Administrator, Human Resource Director, or Compliance and Ethics officer shall be responsible for directing the volunteer program.
2. Volunteers shall be required to complete an orientation program as provided by the Facility, in accordance with their facility responsibilities and with the facility's policies and procedures governing the volunteer program. The orientation shall include, but not be limited to:
3. Residents’ rights;
4. Confidentiality;
5. Disaster preparedness (i.e., fire, tornado);
6. Emergency response procedures;
7. Safety procedures/precautions;
8. Infection control; and
9. Body mechanics.
10. Volunteers shall be informed of and shall implement medical and physical precautions related to the residents with whom they work.
11. Volunteers shall not take the place of qualified staff (e.g., activity professionals, nursing assistants, or case workers).
12. Volunteer Opportunities (Examples):
13. Assist with games or other activities
    1. Morning coffee social
    2. Baking or cooking classes
    3. Arts and crafts
    4. Painting
    5. Gardening
    6. Assist with outings
    7. Play Music
    8. Singing
    9. Wii
    10. Movies
    11. Making popcorn
    12. Reading
    13. Visiting
    14. Parties
    15. Assist with dining
    16. Stroll and roll
14. Clerical and organizational
15. Set-up or clean-up
16. Decorate the facility (e.g. holiday parties, birthday parties)
17. Confidentiality
18. Prior to volunteering, the Facility’s Compliance and Ethics officer, or a designated employee, shall inform the volunteer(s) of the laws governing the confidentiality of resident information, both personal and health information, as they are protected by State and Federal laws. Additionally, the Compliance and Ethics Officer or a designated employee shall inform volunteers that there may be severe penalties for disclosing resident information to those who do not have a legitimate need for the information.
19. Courtesy Rules
    1. The Facility will direct volunteers to:
       1. smile and carry on pleasant conversation
       2. be reliable and punctual
       3. show respect for all persons, races, religions, and cultures
       4. to remember that the facility is the residents’ home
       5. always knock and wait for a response and permission before entering a resident room
       6. let staff know immediately if the resident has a need beyond what the volunteer can provide.
       7. not accept gifts or gratuities
       8. be a good listener and refrain from argumentative behavior or abusive or offensive language.
20. Wellness Commitment
    1. To protect the residents and volunteers, volunteers shall be instructed to:
       1. remember that some of the Facility’s residents have a weakened immune system and that if volunteers feel sick they should stay home until they are well.
    2. Handwashing: Studies have shown that the single most important factor for preventing the spread of infection is handwashing. Volunteers must always wash hands:
21. Before starting work
22. Before and after touching a food utensil
23. After smoking
24. After using the toilet
25. After handling trash, soiled linen, etc.
26. After touching your hair, nose, ears, or mouth.
27. Hand sanitizing gels can be used instead of washing hands.
28. Complaints/Problems
    1. Residents are encouraged to voice complaints. If they do, volunteers should notify the activity director, social service director, or unit manager, or nurse as soon as possible so steps can be taken to resolve the concern.
29. Criminal background checks
    1. All volunteers must agree to a voluntary criminal background check prior to commencing volunteer work at the facility. The Facility’s Compliance and Ethics Officer or Human Resource Director shall review the results of all background checks to determine the eligibility of the volunteer to volunteer in the Facility.
    2. Any volunteer that has a criminal background of any sort shall not be permitted to volunteer in the Facility.

**Volunteer Screening Authorization**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the release of criminal background screening reports to the Facility.

Name of Applicant: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GUIDELINES FOR VOLUNTEERS**

**of**

**{Facility}**

Dear Volunteer,

Welcome to the Volunteers Program for the residents of {Facility} (the “Facility”)! As a potential volunteer working with the residents of the Facility, you can be a very important part of our team. Our goal is to provide quality care in an atmosphere that allows both residents and their families to feel at ease during the resident’s stay in the facility. Through the efforts of all, the Facility has achieved a solid reputation in the community for providing consistent, quality care for those who reside here.

Listed below are a few qualities that are useful for us to find in our volunteers:

* A solid interest in the elderly
* Dependability
* Courtesy
* Punctuality

Becoming a volunteer will involve:

* Completing an application
* Taking a tour of the facility
* Reviewing the guidelines for volunteers
* Being introduced to staff and/or residents
* Asked to have a TB test (provided by the Facility and/or the Health Department at no cost to you).

Please make special note of Section 8 in the following pages. Thanks for your interest in helping the Facility!

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Volunteers Coordinator

**THE FOLLOWING IS A GUIDE FOR ALL THE FACILITY VOLUNTEERS**

1. Residents’ Right to Privacy
   1. Medical and personal care are private. Volunteers must respect the privacy of a resident at all times.
   2. Volunteers may not share information about a resident or his/her care to unauthorized persons without the resident’s or an authorized person’s permission. A resident has the right to have private visits at any reasonable hour. The only exception is if his/her doctor has ordered limited visits for medical reasons.
2. Volunteers are not allowed inside the rooms of any residents without express permission from the resident.
   1. A resident may ask a visitor to leave their personal living area.
   2. A resident has the right to make and receive phone calls in private.
   3. The facility must deliver a resident’s personal mail promptly, and promptly send mail out for the resident. The facility may not open a resident’s personal mail.
3. Confidentiality
   1. As a volunteer, you will have direct contact with many of the residents residing in the facility. Depending on your involvement, it is possible you will come to know a significant amount of confidential information about a few, or possibly several, of our residents. This can range from family relationships to their medical history. This information is strictly confidential and should not be discussed with others outside the facility.
4. Disaster Preparedness
   1. If you are present at a time of a disaster, move to a safe place and if possible locate and ask a staff member (preferably a department head or charge nurse) where your help may be needed.
5. Emergency Response Procedures
   1. Elopement:The facility has policies and procedures to monitor residents who are at risk for elopement (high risk of leaving the facility without authorization). **Contact a staff member immediately if you believe a resident is in danger of elopement**. There is a list of high risk residents at each nurse’s station and the front desk. Anyone taking a resident outside the facility, MUST have:
      1. Family authorization to do so.
      2. Nurse’s authorization to do so.
      3. Notified the nurse and the front desk that they are leaving the building (even to sit on the patio or walk around the building).
   2. Falls
      1. If a resident falls while in the building, **encourage the resident to remain in their current position and notify staff**. Verbally call (YELL) for a staff member. Stay with the resident and wait for a staff member. **Do not attempt to move the resident.**
      2. If a resident falls outside the nursing home, contact the nursing home immediately so it can be determined if there is a need for them to be taken to an emergency room.
6. Infection Control
   1. Use proper hand washing and sanitizing techniques at all time. This is as much a protection for you as it is for our residents.
   2. Hand sanitizer is available throughout the nursing home. Feel comfortable using it; use it often.
   3. Gloves are available on all residential units and the dining room for your use.
7. Resident Care
   1. At no time is a volunteer to remove a restraint from a resident.
   2. At no time is a volunteer to move, reposition, or take a resident to the bathroom.
   3. Nursing must be notified to assist the resident with any personal care. **A volunteer must call for assistance from nursing staff for any and all resident care.**
   4. Do not give a resident food or drink, whether or not they ask for something specific, without asking the resident’s nurse first.
8. Personal Expectations
   1. Volunteers will dress professionally while volunteering. Clothes can be casual, but tops will not have low necklines and/or advertising on them and need to have sleeves. Flip flops are not allowed.
   2. Volunteers will wear a nursing home provided name badge while volunteering.
   3. Volunteers will not eat food designated as “resident” food, under any circumstances.
   4. Volunteers may not request and/or eat food if it is not offered to them.
   5. Volunteers will not work past 7:30 p.m., Monday through Friday and 4 p.m. on Saturdays and Sundays.

**{Facility}**

**OSHA Record Keeping**

**PURPOSE**

To promote safe and healthful working conditions, the Occupational Safety and Health Administration (OSHA) requires employers to create and maintain accurate records of any work-related fatalities, injuries, and illnesses. OSHA believes that tracking and disclosure will improve workplace safety. OSHA has designated Forms 300, 300A and 301 for this purpose.

**POLICY**

{Facility} (the “Facility”) will create and maintain accurate records of work-related fatalities, injuries, and illnesses for purposes of OSHA reporting. Records will be maintained and reported as per OSHA requirements, regardless of responsible parties or liability. The Facility will not retaliate against any individual who reports an injury or illness and will inform employees of this policy by posting the OSHA *Job Safety and Health – It’s The Law* worker rights poster.

**PROCEDURE**

1. Recordable injuries and illnesses include
   1. Any work-related fatality;
   2. Any work-related injury or illness that results in loss of consciousness, days away from work, restricted work, or transfer to another job;
   3. Any work-related injury or illness requiring medical treatment beyond first aid;
   4. Any work-related diagnosed case of cancer, chronic irreversible diseases, fractured or cracked bones or teeth, and punctured eardrums;
   5. Any work-related needlestick injury or cut from sharp objects that are contaminated with another person’s blood or other potentially infections material;
   6. Certain work-related hearing loss;
   7. Certain cases of tuberculosis after a work-related exposure.
2. A tool for determining if injuries and illnesses are recordable is included as Attachment A.
3. OSHA forms can be found on the OSHA web site at https://www.osha.gov/recordkeeping/RKforms.html.
4. Employees will be notified of their rights under OSHA by the posting of OSHA’s *Job Safety and Health – It’s The Law* worker rights poster.
5. Reports of work-related injuries and illnesses should be reported to supervisors or directly to the Compliance and Ethics Officer. Supervisors should relay the information to the Compliance and Ethics Officer.
6. The Compliance and Ethics Officer is responsible for maintaining and reporting OSHA Forms 300, 300A and 301.
7. Form 300A must be submitted electronically by March 2 of each year with the previous year’s data.
8. OSHA Forms 300, 300A and 301 must be kept for five years.

ATTACHMENT A



**{Facility}**

**Effective Training for Associates and Facility Assessment Policy and Procedure**

**PURPOSE**

To ensure that any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for {Facility} (the “Facility” or “Associates”) receive proper training as required by law to ensure the health and safety of the Facility’s residents.

**POLICY**

It is the Facility’s policy to constantly develop, implement, and maintain an effective training program for all Associates consistent with their expected roles and to ensure that a proper facility assessment is conducted and documented to enable the Facility to care for its residents competently during both day-to-day operations and emergencies.

**PROCEDURE**

1. The Facility will train Associates on topics that include, but are not limited to:
2. Communication. Effective communications with residents, family members, and other Associates as mandatory training for direct care staff.
3. Resident’s rights and facility responsibilities. The Facility will ensure that Associates are educated on the rights of residents and the responsibilities of the Facility to properly care for its residents, respectively.
4. Abuse, neglect, and exploitation. In addition to educating staff on its residents’ right to be free from abuse, neglect, and exploitation per CCG 00515 Resident Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, the Facility will also provide training to 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.
5. Quality assurance and performance improvement. The Facility will include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the Facility’s QAPI program.
6. Infection control. The Facility will include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program.
7. Compliance and Ethics. The Facility will include as part of its compliance and ethics program
   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
8. Required in-service training for nurse aides. In-service training must
   1. Be sufficient to ensure the continuing competence of nurse aides, 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 nurse aides’ performance reviews and facility assessment and may address the special needs of residents as determined by facility staff.
   4. For nurse aides providing services to residents with cognitive impairments, also address the care of the cognitively impaired.
9. Required training of feeding assistants. The Facility will not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants.
10. Behavioral health. The Facility will provide behavioral health training consistent with the requirements as set forth by federal and state statutes and regulations and as determined by the facility assessment.
    1. The Facility shall make a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.
    2. The Facility shall review and update that assessment, as necessary, and at least annually. The Facility shall also review and update this assessment whenever there is, or the Facility plans for, any change that would require a substantial modification to any part of this assessment.
    3. The assessment must address or include:
       1. The facility’s resident population, including, but not limited to,
          1. Both the number of residents and the facility’s resident capacity;
          2. The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
          3. The staff competencies that are necessary to provide the level and types of care needed for the resident population;
          4. The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
          5. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.
       2. The facility’s resources, including but not limited to,
          1. All buildings and/or other physical structures and vehicles;
          2. Equipment (medical and non-medical);
          3. Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
          4. All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
          5. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
          6. Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.
       3. A facility-based and community-based risk assessment, utilizing an all-hazards approach.

**{Facility}**

**Residents Right To Freedom from Abuse, Neglect, and Exploitation Policy and Procedure**

**PURPOSE**

To ensure that all of {Facility}’s (the “Facility”) residents are free from abuse, neglect, misappropriation of their property, and exploitation.

**POLICY**

The Facility’s residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy. 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. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility (“Associates”).

**PROCEDURE**

1. Associates must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion against any resident;
2. The Facility will ensure that residents are 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.
3. The Facility will not employ or otherwise engage individuals who:
4. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
5. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
6. 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.
7. The Facility will 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.
8. The Facility explicitly and expressly prohibits, and will take steps to prevent, any Associates from engaging in any behavior or actions that may result in the abuse, neglect, and exploitation of residents and misappropriation of resident property.
9. The Facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property.
10. The Facility will ensure that all Associates are properly trained pursuant to the Facility’s Associate Training policies (see CCG 00111 Associate Training and Education Policy and Procedure and CCG 00514 Effective Training for Associates and Facility Assessment Policy and Procedure.)
11. The Facility will ensure that any suspicion of resident abuse, neglect, misappropriation of property, and exploitation is coordinated with the Facility’s QAPI program.
12. The Facility will ensure Compliance and Ethics with the Elder Justice Act pursuant to the Facility’s Elder Justice Act Policy and Procedure. (See CCG 00304.)
13. Response
14. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility shall:
    1. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to this policy.
    2. Have evidence that all alleged violations are thoroughly investigated.
    3. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
    4. 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.

**{Facility}**

**Resident Rights Policy and Procedure**

**PURPOSE**

To ensure the preservation of every resident’s right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

**POLICY**

It is {Facility}’s (the “Facility”) policy that any all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality. The Facility will protect and promote the rights of each resident and will provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. The Facility shall ensure that Associates are educated on the rights of residents and the responsibilities of the Facility to properly care for its residents as set forth in this policy.

**PROCEDURE**

1. Exercise of rights. Every resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
2. The Facility shall ensure that every resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.
3. Every resident has the right to be free of interference, coercion, discrimination, and reprisal from the Facility in exercising his or her rights and to be supported by the Facility in the exercise of his or her rights as required by applicable federal and state statutes and regulations.
4. In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident’s rights to the extent provided by state law. 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 celebrated.
   1. The resident representative has the right to exercise the resident’s rights to the extent those rights are delegated to the resident representative.
   2. The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.
5. The Facility will treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.
6. The Facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.
7. If the Facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the Facility shall report such concerns in the manner required under State law.
8. In the case of a resident adjudged incompetent under the laws of the State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident’s behalf. The court-appointed resident representative exercises the resident’s rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
   1. In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative’s authority.
   2. The resident’s wishes and preferences must be considered in the exercise of rights by the representative.
   3. To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.
9. Planning and implementing care. Each resident has the right to be informed of, and participate in, his or her treatment, including:
10. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
11. The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:
    1. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
    2. The right to participate in establishing the expected 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. The right to be informed, in advance, of changes to the plan of care.
    4. The right to receive the services and/or items included in the plan of care.
    5. The right to see the care plan, including the right to sign and authorize after significant changes to the plan of care.
12. The Facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must:
    1. Facilitate the inclusion of the resident and/or resident representative.
    2. Include an assessment of the resident’s strengths and needs.
    3. Incorporate the resident’s personal and cultural preferences in developing goals of care.
13. The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
14. The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.
15. The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research if such treatment or research is available at the Facility, and to formulate an advance directive.
16. The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.
17. Nothing in this Section II should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.
18. Choice of attending physician. The resident has the right to choose his or her attending physician.
19. The physician must be licensed to practice, and
20. If the physician chosen by the resident refuses to or does not meet requirements as specified below in Section III D-E, the Facility may seek alternate physician participation as specified in Section III D-E to assure provision of appropriate and adequate care and treatment.
21. The Facility shall ensure that each resident remains informed of the name, specialty, and contact information for the physician and other primary care professionals responsible for his or her care.
22. The Facility shall inform the resident if the Facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this policy and the Facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The Facility will discuss the alternative physician participation with the resident and honor the resident’s preferences, if any, among options
23. If the resident subsequently selects another attending physician who meets the requirements specified in this policy, the Facility will honor that choice
24. Respect and dignity. Every resident has a right to be treated with respect and dignity, including:
25. 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.
26. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
27. The 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.
28. The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
29. The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
30. The right to receive written notice, including the reason for the change, before the resident’s room or roommate in the facility is changed.
31. The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:
    1. To relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or
    2. to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
    3. solely for the convenience of staff.
32. A resident’s exercise of the right to refuse transfer does not affect the resident’s eligibility or entitlement to Medicare or Medicaid benefits.
33. Self-determination. Every resident has the right to, and the Facility must promote and facilitate, resident self-determination through support of resident choice, including but not limited to the rights specified in this Section.
34. Each resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care.
35. Each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.
36. Each resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.
37. Each resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.
    1. The Facility must provide immediate access to any resident by:
       1. Any representative of the Secretary of the Department of Health and Human Services,
       2. Any representative of the State,
       3. Any representative of the Office of the State long term care ombudsman,
       4. The resident’s individual physician,
       5. Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000,
       6. Any representative of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000), and
       7. The resident representative.
    2. The Facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident’s right to deny or withdraw consent at any time.
    3. The Facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident’s right to deny or withdraw consent at any time;
    4. The Facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident’s right to deny or withdraw consent at any time; and
    5. The Facility shall have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.
    6. The Facility shall meet the following requirements:
       1. Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this policy.
       2. Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.
       3. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
       4. Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.
38. Each resident has a right to organize and participate in resident or family groups in the facility.
    1. The Facility shall provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
    2. Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group’s invitation.
    3. The Facility shall provide a designated staff person who is approved by the resident or family group and the Facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
    4. The Facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
       1. The Facility must be able to demonstrate its response and rationale for such response.
       2. This should not be construed to mean that the Facility must implement as recommended every request of the resident or family group.
39. Each resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
40. Each resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
41. Each resident has a right to choose to or refuse to perform services for the Facility and the Facility must not require a resident to perform services for the Facility. A resident may perform services for the Facility, if he or she chooses, when:
    1. The Facility has documented the resident’s need or desire for work in the plan of care;
    2. The plan specifies the nature of the services performed and whether the services are voluntary or paid;
    3. Compensation for paid services is at or above prevailing rates; and
    4. The resident agrees to the work arrangement described in the plan of care.
42. Each resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges the Facility may impose against a resident’s personal funds.
    1. The Facility shall not require residents to deposit their personal funds with the Facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the Facility shall act as a fiduciary of the resident’s funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the Facility, as specified in this Section.
    2. Deposit of funds.
       1. In general: Except as set out in Section V. I. b. ii. below, the Facility shall deposit any resident’s personal funds in excess of $100 in an interest-bearing account (or accounts) that is separate from any of the Facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The Facility shall maintain a resident’s personal funds that do not exceed $100 in a non-interest-bearing account, interest-bearing account, or petty cash fund.
       2. For residents whose care is funded by Medicaid, Federal law requires the Facility to deposit the residents’ personal funds in excess of $50 in an interest-bearing account (or accounts) that is separate from any of the facility’s operating accounts, and that credits all interest earned on resident’s funds to that account. (In pooled accounts, there must be a separate accounting for each resident’s share.) The Facility shall maintain personal funds that do not exceed $50 in a non-interest-bearing account, interest-bearing account, or petty cash fund. State laws may have additional requirements.
    3. Accounting and records.
       1. The Facility shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf.
       2. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.
       3. The individual financial record must be available to the resident through quarterly statements and upon request.
    4. Notice of certain balances. The Facility shall notify each resident that receives Medicaid benefits
       1. When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and
       2. That, if the amount in the account, in addition to the value of the resident’s other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
    5. Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the Facility must convey within 30 days the resident’s funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident’s estate, in accordance with State law.
    6. Assurance of financial security. The Facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary of the Department of Health and Human Services, to assure the security of all personal funds of residents deposited with the facility.
43. The Facility shall not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The Facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with applicable federal and state statutes and regulations. 
    1. Items and Services that cannot be charged to a resident’s funds: Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, the Facility shall not charge a resident for the following categories of items and services as required by applicable federal and state statutes and regulations:
       1. Nursing services
       2. Food and Nutrition services
       3. Activities program
       4. Room/bed maintenance services
       5. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry
       6. Medically-related social services
       7. Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan
    2. Items and services that may be charged to resident’s funds. Section V. J. b. i-xii are general categories and examples of items and services that the facility may charge to resident’s funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident’s care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
       1. Telephone, including a cellular phone
       2. Television/radio, personal computer or other electronic device for personal use
       3. Personal comfort items, including smoking materials, notions and novelties, and confections
       4. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare
       5. Personal clothing
       6. Personal reading matter
       7. Gifts purchased on behalf of a resident
       8. Flowers and plants
       9. Cost to participate in social events and entertainment outside the scope of the activities program that is required by statute or regulation
       10. Non-covered special care services such as privately hired nurses or aides
       11. Private room, except when therapeutically required (for example, isolation for infection control)
       12. Except as provided below in 1-2, specially prepared or alternative food requested instead of the food and meals generally prepared by the Facility
           1. The Facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident’s physician, physician assistant, nurse practitioner, or clinical nurse specialist.
           2. When preparing foods and meals, the Facility shall take into consideration resident’s needs and preferences and the overall cultural and religious make-up of the Facility’s population.
    3. Requests for items and services
       1. The Facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.
       2. The Facility shall not require a resident to request any item or service as a condition of admission or continued stay.
       3. When a resident requests an item for which a charge will be made to the resident’s fund, the Facility will inform the resident of the charge, orally and in writing.
44. Information and communication.
45. Each resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.
46. Each resident has the right to access personal and medical records pertaining to him or herself.
    1. The Facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and
    2. Federal law requires the Facility to allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The Facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:
       1. Labor for copying the records requested by the individual, whether in paper or electronic form;
       2. Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and
       3. Postage, when the individual has requested the copy be mailed.

Additional State laws may apply.

1. With the exception of information described in Sections VI. B. and VI. K., the Facility shall ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in Section VI. B. may be made available to the resident at their request and expense in accordance with applicable law.
2. Each resident has the right to receive notices orally and in writing (including Braille) in a format and a language he or she understands, including;
   1. The Facility must furnish to each resident a written description of legal rights which includes:
      1. A description of the manner of protecting personal funds, under paragraph V. I. above.
      2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
      3. A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit.
      4. A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-Compliance and Ethics with the advance directives requirements and requests for information regarding returning to the community.
      5. Information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program, and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000).
      6. Information regarding Medicare and Medicaid eligibility and coverage.
      7. Contact information for the Aging and Disability Resource Center or other No Wrong Door Program.
      8. Contact information for the Medicaid Fraud Control Unit.
      9. Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-Compliance and Ethics with the advance directives requirements and requests for information regarding returning to the community.
3. The Facility shall post, in a form and manner accessible and understandable to residents, and resident representatives:
   1. A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and
   2. A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-Compliance and Ethics with the advance directives requirements and requests for information regarding returning to the community.
4. Each resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident’s own expense.
5. The Facility shall protect and facilitate the resident’s right to communicate with individuals and entities within and external to the facility, including reasonable access to:
   1. A telephone, including TTY and TDD services;
   2. The internet, to the extent available to the facility; and
   3. Stationery, postage, writing implements and the ability to send mail.
6. Each resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
   1. Privacy of such communications consistent with this section; and
   2. Access to stationery, postage, and writing implements at the resident’s own expense.
7. Each resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for Internet research.
   1. If the access is available to the facility
   2. At the resident’s expense, if any additional expense is incurred by the facility to provide such access to the resident.
   3. Such use must comply with state and federal law.
8. Each resident has the right to
   1. Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and
   2. Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.
9. The Facility shall
   1. Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.
   2. Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and
   3. Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
   4. The Facility shall not make available identifying information about complainants or residents.
10. The Facility shall comply with the requirements specified in 42 CFR part 489, subpart I with regard to Advance Directives.
    1. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident’s option, formulate an advance directive.
    2. This includes a written description of the Facility’s policies to implement advance directives and applicable State law.
    3. The Facility is permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
    4. If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the Facility may give advance directive information to the individual’s resident representative in accordance with State law.
    5. The Facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
11. The Facility must display in the facility 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.
12. Notification of changes.
    1. The Facility will immediately inform each resident; consult with the resident’s physician; and notify, consistent with his or her authority, the resident representative(s), when there is
       1. An accident involving the resident which results in injury and has the potential for requiring physician intervention;
       2. A significant change in the resident’s physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
       3. A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
       4. A decision to transfer or discharge the resident from the facility.
    2. When making notification pursuant to this Section VI. N., the Facility shall ensure that all pertinent information specified in the Facility’s Resident Transfer and Discharge Policy and Procedure (CCG 00510) is available and provided upon request to the physician.
    3. The Facility shall also promptly notify the resident and the resident representative, if any, when there is
       1. A change in room or roommate assignment; or
       2. A change in resident rights under Federal or State law or regulations.
    4. The Facility shall record and periodically update the address (mailing and email) and phone number of the resident representative(s).
13. Admission to a composite distinct part. If the Facility is a composite distinct part, it shall disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and it shall specify the policies that apply to room changes between its different locations.
14. The Facility shall provide a notice of rights and services to each resident prior to or upon admission and during the resident’s stay.
    1. The Facility shall inform each resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.
    2. The Facility will also provide each resident with the State-developed notice of Medicaid rights and obligations, if any.
    3. Receipt of such information by residents, and any amendments to it, shall be acknowledged in writing.
15. The Facility will
    1. Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of:
       1. The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
       2. Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
    2. Inform each Medicaid-eligible resident when changes are made to these items and services.
16. The Facility shall inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility’s per diem rate.
    1. Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the Facility shall provide notice to residents of the change as soon as is reasonably possible.
    2. Where changes are made to charges for other items and services that the facility offers, the Facility shall inform the resident in writing at least 60 days prior to implementation of the change.
    3. If a resident dies or is hospitalized or is transferred and does not return to the facility, the Facility shall refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility’s per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
    4. The Facility shall refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident’s date of discharge from the facility.
17. Privacy and confidentiality. Each resident has a right to personal privacy and confidentiality of his or her personal and medical records.
18. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
19. The Facility shall respect the residents’ right to personal privacy, including the right to privacy in his or her oral (that is, spoken), 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, including those delivered through a means other than a postal service.
20. Each resident has a right to secure and confidential personal and medical records.
    1. The resident has the right to refuse the release of personal and medical records except as provided for under applicable federal or state laws.
    2. The Facility shall allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident’s medical, social, and administrative records in accordance with State law.
21. Safe environment. Each resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The Facility shall provide:
22. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
    1. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
    2. The Facility shall exercise reasonable care for the protection of the resident’s property from loss or theft.
23. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
24. Clean bed and bath linens that are in good condition;
25. Private closet space in each resident room;
26. Adequate and comfortable lighting levels in all areas;
27. Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71 to 81 degrees Fahrenheit; and
28. For the maintenance of comfortable sound levels.
29. Grievances.
    * 1. Each resident has the right to voice grievances to the Facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include 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. Each resident has the right to and the Facility must make prompt efforts by the Facility to resolve grievances the resident may have, in accordance with this policy.
      3. The Facility shall make information on how to file a grievance or complaint available to each resident.
      4. The Facility shall establish a grievance policy (CCG 00505) to ensure the prompt resolution of all grievances regarding the residents’ rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
    1. Provisions to notify a resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
    2. Identification of a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
    3. As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
    4. Immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
    5. Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident’s grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident’s concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
    6. Taking appropriate corrective action in accordance with State law if the alleged violation of the residents’ rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation of any of these residents’ rights within its area of responsibility; and
    7. Maintaining evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
30. Contact with external entities. The Facility will not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including 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 disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.

**{Facility}**

**ACKNOWLEDGEMENT OF RECEIPT OF POLICY AND PROCEDURE REGARDING RESIDENT RIGHTS**

I hereby acknowledge by my signature that I have received a copy of the above referenced policies and procedures.

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Resident Name Signature

**{Facility}**

**Food, Nutrition and Dietary Services Policy and Procedure**

**PURPOSE AND POLICY**

To ensure that each resident of {Facility} (the “Facility”) is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

**PROCEDURE**

1. Staffing Requirements.
2. The facility shall employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the Facility’s resident population in accordance with the facility assessment as required.
3. The facility must have a qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis.
   1. A qualified dietitian
      1. A qualified dietitian or other clinically qualified nutrition professional is one who:
         1. Holds a bachelor’s or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
         2. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
         3. Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a “registered dietitian” by the Commission on Dietetic Registration or its successor organization, or meets the requirements of Section I.A.a.i-ii of this policy.
      2. Dieticians hired prior to November 28, 2016 must meet these requirements no later than 5 years after November 28, 2016 or as required by state law.
   2. If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the Facility shall designate a person to serve as the director of food and nutrition services.
      1. The director of food and nutrition services must
         1. be a certified dietary manager; or
         2. be a certified food service manager, or
         3. have similar national certification for food service management and safety from a national certifying body; or
         4. have an associate’s or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and

For designations prior to November 28, 2016, the director of food and nutrition services has five years after November 28, 2016 to meet these requirements.

* + 1. In States that have established standards for food service managers or dietary managers, the director of food and nutrition services must meet State requirements for food service managers or dietary managers, and
    2. The director of food and nutrition services must receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

1. Support staff. The Facility shall provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.
2. Interdisciplinary team
   1. A member of the Food and Nutrition Services staff must participate on the interdisciplinary team.
   2. The resident’s interdisciplinary team must prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.
3. Menus and nutritional adequacy
4. The Facility’s menus shall:
   1. Meet the nutritional needs of residents in accordance with established national guidelines;
   2. Be prepared in advance;
   3. Be followed;
   4. Reflect, based on the Facility’s reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups;
   5. Be updated periodically;
   6. Be reviewed by the Facility’s dietitian or other clinically qualified nutrition professional for nutritional adequacy.
5. Nothing in this policy should be construed to limit the resident’s right to make personal dietary choices.
6. Food and drink
7. Each resident shall receive and the Facility shall provide:
   1. Food prepared by methods that conserve nutritive value, flavor, and appearance;
   2. Food and drink that is palatable, attractive, and at a safe and appetizing temperature;
   3. Food prepared in a form designed to meet individual needs;
   4. Food that accommodates resident allergies, intolerances, and preferences;
   5. Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and
   6. Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.
   7. The facility must serve the food
      1. In appropriate quantity;
      2. At appropriate temperature;
      3. In a form consistent with the developmental level of the resident; and
      4. With appropriate utensils.
8. Therapeutic diets
9. Therapeutic diets must be prescribed by the attending physician.
10. The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident’s diet, including a therapeutic diet, to the extent allowed by State law.
11. Frequency of meals
12. Each resident must receive and the Facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.
13. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. There may not be less than 10 hours between breakfast and the evening meal of the same day, except as provided in this policy.
14. Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.
15. Dining area and service
    1. The facility shall
       1. Serve meals for all residents, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;
       2. Provide table service for all residents who can and will eat at a table, including residents in wheelchairs;
       3. Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident;
       4. Supervise and staff dining rooms adequately to direct self-help dining procedure, to assure that each resident receives enough food and to assure that each resident eats in a manner consistent with his or her developmental level; and
       5. Ensure that each resident eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.
16. Assistive devices
17. The Facility shall provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.
18. Paid feeding assistants
19. State-approved training course. The Facility may use a paid feeding assistant if:
    1. The feeding assistant has successfully completed a State-approved training course that meets the regulatory requirements before feeding residents; and
    2. The use of feeding assistants is consistent with State law.
20. Supervision.
    1. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).
    2. In an emergency, a feeding assistant must call a supervisory nurse for help.
21. Resident selection criteria.
    1. The Facility shall ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.
    2. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
    3. The Facility must base resident selection on the interdisciplinary team’s assessment and the resident’s latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.
22. Food safety requirements. The facility shall:
23. Procure food from sources approved or considered satisfactory by federal, state, or local authorities;
    1. This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
    2. This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to Compliance and Ethics with applicable safe growing and food-handling practices.
    3. This provision does not preclude residents from consuming foods not procured by the Facility.
24. Store, prepare, distribute, and serve food in accordance with professional standards for food service safety.
25. Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption (see section XI.b of this policy), and
26. Dispose of garbage and refuse properly.
27. Safe and sanitary storage, handling and consumption
    1. Food served to residents individually and uneaten must be discarded.
    2. Food brought to residents by family and other visitors must be stored in a manner which is safe and sanitary. The director of food and nutrition services is responsible for developing these protocols.

**{Facility}**

**Freedom from Abuse, Neglect, and Exploitation Policy and Procedure**

**PURPOSE**

To ensure the proper management of conduct between residents and the staff of {Facility} (the “Facility”) to facilitate the resident’s right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

**POLICY**

It is the Facility’s policy to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the residents’ 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.

**PROCEDURE**

1. Discipline and restraints
2. The facility will not use verbal, mental, sexual or physical abuse; corporal punishment; or involuntary seclusion;
3. The facility will 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.
   1. If the use of restraints is indicated, the facility will use the least restrictive alternative for the least amount of time. Documentation will be kept identifying ongoing re-evaluation of the need for restraints.
4. The facility will not employ or otherwise engage individuals who
   1. Have been found guilty of abuse, neglect, exploitation, misappropriate of property, or mistreatment by a court of law;
   2. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property;
   3. 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.
5. The facility will 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.
6. The facility shall develop and implement written policies and procedures that
7. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property
8. Establish policies and procedures to investigate any such allegations
9. Include training on preventing abuse, neglect, and exploitation to all staff, service providers and volunteers, consistent with their expected roles.
   1. Training must include education on those activities which constitute abuse, neglect, misappropriation of property and exploitation; procedures for reporting relevant incidents; and dementia management and resident abuse prevention.
10. Coordinates this policy with the QAPI program.
11. Complies with section 1150B of the Social Security Act (see CCG Policy 00304 and 00304a).
12. Responding to allegations of abuse, neglect, exploitation, or mistreatment
13. The facility must ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported in accordance with Policy 00304 and 00304a.
14. The facility must have evidence that all alleged violations are thoroughly investigated.
15. The facility must prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
16. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, within 5 working days of the incident.
17. If the alleged violation is verified, appropriate corrective action must be taken.

**{Facility}**

**Dental Services Policy and Procedure**

**PURPOSE**

To ensure that each resident of {Facility} (the “Facility”) is provided with routine and emergency dental care.

**POLICY**

The facility will assist residents in obtaining routine and 24-hour emergency dental care.

PROCEDURE

1. Skilled Nursing Facilities
   1. The facility will provide or obtain for an outside resource routine and emergency dental services to meet the needs of each resident.
   2. The facility may charge a Medicare resident an additional amount for routine and emergency dental services.
   3. If dental services are necessary or requested, the facility will assist the resident in making appointments for dental services and arranging transportation to and from the dental services location.
   4. Lost or damaged dentures
      1. The facility will identify circumstances when the loss or damage of dentures is the facility’s responsibility and will not charge a resident for the loss or damage of dentures determined to be the facility’s responsibility.
      2. The facility will promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility will provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services. The facility will also document the extenuating circumstances that led to the delay.
2. Nursing Facilities
   1. The facility will provide or obtain from an outside resource the following dental services to meet the needs of each resident
      1. Routine dental services, to the extent covered under the State plan
      2. Emergency dental services.
   2. If dental services are necessary or requested, the facility will assist the resident in making appointments for dental services and arranging transportation to and from the dental services location.
   3. The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
   4. Lost or damaged dentures
      1. The facility will identify circumstances when the loss or damage of dentures is the facility’s responsibility and will not charge a resident for the loss or damage of dentures determined to be the facility’s responsibility.
      2. The facility will promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility will provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services. The facility will also document the extenuating circumstances that led to the delay.

**{Facility}**

**Protection of Residents Policy and Procedure**

**PURPOSE AND POLICY**

To ensure the safety, wellbeing, and dignity of the residents of {Facility} (the “Facility”) during emergencies in cases where restraints or seclusion may be necessary for the protection of the resident.

**PROCEDURE**

1. Restraint and seclusion policy for the protection of residents.
2. Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.
3. An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
4. Restraint or seclusion must not result in harm or injury to the resident and must be used only:
   1. To ensure the safety of the resident or others during an emergency safety situation; and
   2. Until the emergency safety situation has ceased and the resident’s safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
5. Restraint and seclusion must not be used simultaneously.
6. Emergency safety intervention.
7. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident’s chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
8. Notification of facility policy.
9. At admission, the Facility shall:
   1. Inform both the incoming resident or the resident’s legal guardian(s) of the Facility’s policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;
   2. Communicate its restraint and seclusion policy in a language that the resident, or his or her legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the Facility must provide interpreters or translators;
   3. Obtain an acknowledgment, in writing, from the resident, or from the legal guardian(s) that he or she has been informed of the Facility’s policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident’s record; and
   4. Provide a copy of the Facility policy to the resident or to the resident’s legal guardian(s).
10. Contact information.
11. The Facility’s shall provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

**{Facility}**

**Advance Directives Policy and Procedure**

**PURPOSE**

To provide an atmosphere of respect and caring and to ensure that each resident’s ability and right to participate in medical and mental health decision making is maximized, and to ensure that residents have the means to establish an advance directive relating to the provision of health care in the event the resident is incapacitated.

**POLICY**

It is the policy of {Facility} (the “Facility”) to respect and encourage resident rights and self-determination in relation to the establishment and documentation of advance directives. Residents will be encouraged and assisted to be active participants in the decision-making process regarding their care through education, inquiry, and assistance as requested. Residents will be encouraged to communicate their desires in regard to advance directives to their personal representatives, to allow for guidance to health care providers following the resident’s wishes should the resident become incapacitated, rendering them unable to make decisions.

For purposes of this policy, an advance directive is defined as a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

**PROCEDURE**

1. Upon a resident’s admission, the Facility shall provide written information to all residents concerning:
   1. Residents’ rights under applicable state law (whether statutory or recognized by the courts of the state) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the resident’s option, advance directives. The Facility may, at its own discretion and expense, contract with other entities to furnish this information.
   2. The Facility shall update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to applicable state law(s).
2. Statement of Limitation
3. If the Facility cannot implement an advance directive on the basis of conscience, the Facility shall provide residents with a Statement of Limitation, which, at a minimum, will:
4. clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
5. Identify the state legal authority permitting such objection; and
6. Describe the range of medical conditions or procedures affected by the conscience objection.
7. The Facility shall document in a prominent part of the resident’s current medical record whether or not the resident has executed an advance directive. Any changes to or termination of the advance directive shall also be documented in the medical record. It is the responsibility of the resident or the resident’s representative to notify the Facility of the existence of the advance directive.)
8. The Facility will not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.
9. The Facility will ensure compliance and ethics with requirements of state law (whether statutory or recognized by the courts of the state) regarding advance directives. The Facility will inform residents that complaints concerning the advance directive requirements may be filed with the state survey and certification agency.
10. The Facility will provide for education of staff concerning its policies and procedures on advance directives.
11. The Facility shall provide for community education regarding issues concerning advance directives that may include material required in this policy, either directly or in concert with other providers and organizations. Separate community education materials may be developed and used, at the discretion of the Facility. The material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated resident’s control over medical treatment, and describe applicable state law concerning advance directives. The Facility must be able to document its community education efforts.
12. The Facility shall:
    1. Not be required to provide care that conflicts with an advance directive.
    2. Not be required to implement an advance directive if, as a matter of conscience, the Facility cannot implement an advance directive and state law allows any health care provider or any agent of such provider to conscientiously object.
13. If a resident is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the Facility may give advance directive information to the resident’s family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with state law. The Facility is not relieved of its obligation to provide this information to the resident once he or she is no longer incapacitated or unable to receive such information. The Facility shall implement and establish follow-up procedures to provide the information to the resident directly at the appropriate time.
14. GA only – A health care decision made by the resident’s representative in accordance with the terms of an advance directive shall be complied with by every health care provider to whom the decision is communicated, subject to the health care provider's right to administer treatment for the declarant's comfort or alleviation of pain; provided, however, that if the health care provider is unwilling to comply with the health care agent's decision, the health care provider shall promptly inform the health care agent who shall then be responsible for arranging for the declarant's transfer to another health care provider. A health care provider who is unwilling to comply with the health care agent's decision shall provide reasonably necessary consultation and care in connection with the pending transfer.

**{Facility}**

**Facility Bed-Hold And Return to Facility Policy and Procedure**

**PURPOSE**

To ensure that residents being transferred to a hospital or placed on therapeutic leave are informed as to the facility’s bed-hold and return policy.

**POLICY**

{Facility} (“the Facility”) will permit residents to return to the Facility after they are hospitalized or placed on therapeutic leave, provided certain conditions are met. The Facility will notify residents or their resident representatives of this policy in accordance with the provisions below.

**PROCEDURE**

1. Before a resident is transferred to a hospital or the resident goes on therapeutic leave, the Facility must provide written information to the resident or the resident representative regarding the Facility’s bed-hold and return policy. The information may be given in the resident’s admission packet and must include the following information:
   1. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the Facility;
   2. The reserve bed payment policy in the state plan, if applicable;
   3. The Facility’s policies regarding bed-hold periods, which must be consistent with regulations, Facility policy, and other notices provided to the resident; and
   4. The Facility’s policy regarding returning residents.
2. At the time of transfer of a resident for hospitalization or therapeutic leave, the facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed.
3. The facility will permit residents to return to the Facility after they are hospitalized or placed on therapeutic leave.
   1. A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the Facility to his/her previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident
      1. Requires the services provided by the facility; and
      2. Is eligible for Medicare skilled nursing facility services or Medicaid nursing Facility services.
   2. If the Facility determines that a resident who was transferred with an expectation of returning to the facility cannot return to the Facility, the Facility must comply with the requirements of its Resident Transfer and Discharge Policy and Procedure (CCG 00510).
4. When the Facility to which a resident returns is a composite distinct part, the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

**{Facility}**

**Resident Behavior And Facility Practices**

**Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) promotes the resident’s right to growth, development and independence; encourages resident choice; and delineates the facility’s management of inappropriate resident behavior, including the use of time-out rooms, physical restraints, and the use of drugs to manage inappropriate behavior.

**POLICY**

The Facility’s will promote the growth, development and independence of all residents; will encourage resident choice; and will develop protocols to manage inappropriate resident behavior.

**PROCEDURE**

1. The facility must develop and implement written policies and procedures for the management of conduct between staff and residents. These policies and procedures must
   1. Promote the growth, development and independence of the resident;
   2. Address the extent to which resident choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible;
   3. Specify resident conduct to be allowed or not allowed; and
   4. Be available to all staff, residents and legal guardians.

When practicable, residents must participate in the formulation of these policies and procedures.

1. Residents must not discipline other residents, except as part of an organized system of self-government which has been set forth in facility policy.
2. The facility must develop and implement written policies and procedures that govern the management of inappropriate resident behavior. Interventions to manage inappropriate resident behavior must be employed with sufficient safeguards and supervision to ensure the protection of the resident’s safety, welfare and civil and human rights. Techniques for managing inappropriate resident behavior must never be used for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program. These procedures must
   1. Specify all facility approved interventions to manage inappropriate resident behavior;
   2. Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;
   3. Insure, prior to the use of more restrictive techniques, that the resident’s record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.
   4. Address the following
      1. The use of time-out rooms
         1. A time-out room is a room from which egress is prevented.
         2. The placement must be part of an approved systematic time-out program (i.e. emergency placement of a resident into a time-out room is not allowed).
         3. The resident must be under the direct constant visual supervision of designated staff.
         4. The door to the room is held shut by staff or by a mechanism requiring consistent physical pressure from a staff member to keep the mechanism engaged.
         5. Placement in a time-out room may not exceed one hour.
         6. Residents in time-out rooms must be protected from hazardous conditions, including sharp objects, uncovered light fixtures, and unprotected electrical outlets.
         7. A record of time-out activities must be kept.
      2. The use of physical restraints
         1. The facility may employ physical restraint only
            1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;
            2. As an emergency measure, but only if absolutely necessary to protect the resident or others from injury; or
            3. As a health-related protection prescribed by a physician, but only if absolutely necessary

during the conduct of a specific medical or surgical procedure; or

for resident protection during the time that a medical condition exists.

* + - 1. Authorizations to use or extend restraints as an emergency must be
         1. In effect no longer than 12 consecutive hours;
         2. Obtained as soon as the resident is restrained or stable.
      2. The facility must not issue orders for restraint on a standing or “as needed” basis.
      3. A resident placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage must be documented.
      4. Restraints must be designed and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort.
      5. Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed. A record of such activity must be documented.
      6. Barred enclosures must not be more than three feet in height and must not have tops.
    1. The use of drugs to manage inappropriate behavior
       1. The facility must not use drugs in doses that interfere with the resident’s daily living activities
       2. Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team and be used only as an integral part of the resident’s individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.
       3. Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweighs the potentially harmful effects of the drugs.
       4. Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences. Monitoring should be done by facility staff, in conjunction with the physician and in Compliance with the drug regimen review requirements.
       5. Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.
    2. The application of painful or noxious stimuli
    3. The staff members who may authorize the use of specified interventions; and
    4. A mechanism for monitoring and controlling the use of such interventions.

**{Facility}**

**Facility Closure Policy and Procedure**

**PURPOSE AND POLICY**

To ensure the protection, safety, and wellbeing of {Facility}’s (hereinafter the “Facility”) residents in the event of the facility’s closure.

**PROCEDURE**

1. In the event of the Facility’s closure, the administrator will:
2. Submit to the State Survey Agency, the State LTC ombudsman, residents of the Facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:
   1. At least 60 days prior to the date of closure; or
   2. In the case where the Secretary or a State terminates the Facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate;
3. Ensure that the Facility does not admit any new residents on or after the date on which such written notification is submitted; and
4. Include in the notice the plan, that has been approved by the State, for the transfer and adequate relocation of the Facility’s residents by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

**{Facility}**

**Comprehensive Person-Centered Care Planning   
Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for the Facility (“Associates”) provide each and every resident with the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the Facility that is consistent with the resident’s comprehensive assessment and baseline plan of care.

**POLICY**

The Facility and its Associates shall provide the necessary care and services to its residents to ensure that residents’ abilities related to their activities of daily living do not diminish, unless the particular circumstances demonstrate that such diminution was unavoidable. Each resident shall be treated with respect, dignity, and care and in a manner and environment that promotes maintenance or enhancement of quality of life, recognizing each resident’s individuality. The Facility will protect and promote the rights of each resident and will provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.

**PROCEDURE**

1. Baseline care plans.
2. The facility shall 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 shall:
   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:
      1. Initial goals based on admission orders.
      2. Physician orders.
      3. Dietary orders.
      4. Therapy services.
      5. Social services.
      6. PASARR recommendation, if applicable.
   3. The facility shall provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
      1. The initial goals of the resident.
      2. A summary of the resident’s medications and dietary instructions.
      3. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
      4. Any updated information based on the details of the comprehensive care plan, as necessary.
3. Comprehensive Care Plans.
4. The facility shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth under the law (see CCG 00517 Section II) that includes measurable objectives and timeframes to meet each resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan shall describe the following:
   1. The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under law; and
   2. Any services that would otherwise be required under law or regulation but are not provided due to the resident’s exercise of rights, including the resident’s right to refuse treatment.
   3. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations.
      1. If the Facility disagrees with the findings of the PASARR, it shall indicate its rationale in the resident’s medical record.
   4. In consultation with the resident and the resident’s representative(s):
      1. The resident’s goals for admission and desired outcomes.
      2. The resident’s preference and potential for future discharge. The Facility shall document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
      3. Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth below in this policy.
5. The comprehensive care plan shall be:
   1. Developed within 7 days after completion of the comprehensive assessment.
   2. Prepared by an interdisciplinary team, that includes but is not limited to:
      1. The attending physician.
      2. A registered nurse with responsibility for the resident.
      3. A nurse aide with responsibility for the resident.
      4. A member of food and nutrition services staff.
      5. To the extent practicable, the participation of the resident and the resident’s representative(s).
         1. An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident’s care plan.
      6. Other appropriate staff or professionals in disciplines as determined by the resident’s needs or as requested by the resident.
   3. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
6. The services provided or arranged by the Facility, as outlined by the comprehensive care plan, shall:
   1. Meet professional standards of quality;
   2. Be provided by qualified persons in accordance with each resident’s written plan of care; and
   3. Be culturally-competent and trauma-informed.
7. Discharge planning
8. Discharge planning process. The Facility shall develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The Facility’s discharge planning process must be consistent with the discharge rights as required by law (see CCG 00510) as applicable and:
   1. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
   2. Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
   3. Involve the interdisciplinary team in the ongoing process of developing the discharge plan.
   4. Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
   5. Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
   6. Address the resident’s goals of care and treatment preferences.
   7. Document that a resident has been asked about their interest in receiving information regarding returning to the community.
      1. If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
      2. The Facility shall update a resident’s comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
      3. If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
   8. For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident’s goals of care and treatment preferences.
   9. Document, complete on a timely basis based on the resident’s needs, and include in the clinical record, the evaluation of the resident’s discharge needs and discharge plan. The results of the evaluation shall be discussed with the resident or resident’s representative. All relevant resident information shall be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident’s discharge or transfer.
9. Discharge summary. When the Facility anticipates a discharge, it shall create a discharge summary that includes, but is not limited to, the following:
   1. A recapitulation of the resident’s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
   2. A final summary of the resident’s status to include items included in the resident’s comprehensive assessment, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident’s representative.
   3. Reconciliation of all pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter).
   4. A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care shall indicate where the individual plans to reside, any arrangements that have been made for the resident’s follow up care and any post-discharge medical and non-medical services.

**{Facility}**

**Quality of Life Policy and Procedure**

**PURPOSE**

To ensure that each resident of {Facility} (the “Facility”) receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care.

**POLICY**

The Facility and any all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently working for the Facility shall provide the necessary care and services to ensure that a resident’s abilities in activities of daily living do not diminish unless circumstances of the resident’s clinical condition demonstrate that such diminution was unavoidable. Resident shall be treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality. The Facility will protect and promote the rights of each resident and will provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.

**PROCEDURE**

1. Provision of Necessary Care and Services. Based on the comprehensive assessment of its resident and consistent with the residents’ needs and choices, the Facility shall provide the necessary care and services to ensure that residents’ abilities in activities of daily living do not diminish unless circumstances of a resident’s clinical condition demonstrate that such diminution was unavoidable. This includes ensuring that:
2. A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out activities of daily living,
3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, and
4. Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident’s advance directives.
5. Activities of daily living. The Facility shall provide care and services in accordance with the following activities of daily living:
6. Hygiene--bathing, dressing, grooming, and oral care,
7. Mobility--transfer and ambulation, including walking,
8. Elimination--toileting,
9. Dining--eating, including meals and snacks,
10. Communication, including
11. Speech,
12. Language,
13. Other functional communication systems.
14. Activities
15. The Facility shall provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
16. The activities program shall be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State, and is
    * + - 1. Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
          2. Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or
          3. Is a qualified occupational therapist or occupational therapy assistant; or
          4. Has completed a training course approved by the State.

**{Facility}**

**Resident Assessment Policy and Procedure**

**PURPOSE AND POLICY**

To ensure that {Facility} (the “Facility”) upon a resident’s admission and periodically thereafter, conducts a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

**PROCEDURE**

1. Admission orders. At the time each resident is admitted, the Facility shall ensure that it has physician orders for the resident’s immediate care.
2. Comprehensive assessment/Resident assessment instrument.
3. The Facility shall make a comprehensive assessment of a resident’s needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment shall include at least the following:
   1. Identification and demographic information.
   2. Customary routine.
   3. Cognitive patterns.
   4. Communication.
   5. Vision.
   6. Mood and behavior patterns.
   7. Psychosocial well-being.
   8. Physical functioning and structural problems.
   9. Continence.
   10. Disease diagnoses and health conditions.
   11. Dental and nutritional status.
   12. Skin condition.
   13. Activity pursuit.
   14. Medications.
   15. Special treatments and procedures.
   16. Discharge planning.
   17. Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
   18. Documentation of participation in assessment.
       1. The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
4. Timeframe for conducting resident assessments. The Facility shall conduct comprehensive assessment of residents:
   1. Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)
   2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.)
   3. Not less often than once every 12 months.
5. Quarterly review assessment. The Facility shall assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.
6. Use. The Facility shall maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review, and revise the resident’s comprehensive plan of care.
7. Coordination. The Facility shall coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:
8. Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care.
9. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
10. Automated data processing requirement.
11. Encoding data. Within 7 days after the Facility completes a resident’s assessment, the Facility shall encode the following information for each resident in the Facility:
    1. Admission assessment.
    2. Annual assessment updates.
    3. Significant change in status assessments.
    4. Quarterly review assessments.
    5. A subset of items upon a resident’s transfer, reentry, discharge, and death.
    6. Background (face-sheet) information, if there is no admission assessment.
12. Transmitting data. Within 7 days after the Facility shall complete a resident’s assessment, the Facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.
13. Transmittal requirements. Within 14 days after the Facility completes a resident’s assessment, the Facility shall electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
    1. Admission assessment.
    2. Annual assessment.
    3. Significant change in status assessment.
    4. Significant correction of prior full assessment.
    5. Significant correction of prior quarterly assessment.
    6. Quarterly review.
    7. A subset of items upon a resident’s transfer, reentry, discharge, and death.
    8. Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.
14. Data format. The Facility shall transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
15. Resident-identifiable information.
    1. The Facility may not release information that is resident-identifiable to the public.
    2. The Facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.
16. Accuracy of assessments. The assessment must accurately reflect the resident’s status.
17. Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
18. Certification.
19. A registered nurse shall sign and certify that the assessment is completed.
20. Each individual who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.
21. Penalty for falsification.
22. Under Medicare and Medicaid, an individual who willfully and knowingly:
    1. Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $ 1,000 as adjusted annually under 45 CFR part 102 for each assessment; or
    2. Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $ 5,000 as adjusted annually under 45 CFR part 102 for each assessment.
23. It is critical to note that clinical disagreement does not constitute a material and false statement.
24. Preadmission screening for individuals with a mental disorder and individuals with intellectual disability.
25. The Facility shall not admit any new resident with:
    1. Mental disorder (an individual is considered to have a mental disorder if the individual has a serious mental disorder as defined in 42 CFR § 483.102(b)(1)), unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission:
       1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
       2. If the individual requires such level of services, whether the individual requires specialized services.
          1. Exceptions.
             1. This preadmission screening program need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
             2. The State may choose not to apply this preadmission screening program to an individual:

Who is admitted to the Facility directly from a hospital after receiving acute inpatient care at the hospital,

Who requires nursing facility services for the condition for which the individual received care in the hospital, and

Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

* 1. Intellectual disability, (an individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in 42 CFR § 483.102(b)(3) or is a person with a related condition as described in 42 CFR § 435.1010) unless the State intellectual disability or developmental disability authority has determined prior to admission:
     1. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
     2. If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

1. The Facility shall notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for resident review.

**{Facility}**

**Emergency Preparedness Policy and Procedure**

**PURPOSE**

To ensure that {Facility} (the “Facility”) complies with all applicable Federal, State and local emergency preparedness requirements.

**POLICY**

The Facility shall establish and maintain an emergency preparedness program that meets applicable regulatory requirements.

**PROCEDURE**

The emergency preparedness program shall include, but not be limited to, the following elements:

1. Emergency Plan. The Facility shall develop and maintain an emergency preparedness plan that shall be reviewed, and updated at least annually. The plan shall do all of the following:
2. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
3. Include strategies for addressing emergency events identified by the risk assessment.
4. Address resident population, including, but not limited to, persons at-risk; the type of services the Facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
5. Include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the Facility’s efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.
6. Policies and Procedures. The Facility shall develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth above, including the risk assessment, and the communication plan set forth below. The policies and procedures shall be reviewed and updated at least annually. At a minimum, the policies and procedures shall address the following:
7. The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following:
   1. Food, water, medical, and pharmaceutical supplies.
   2. Alternate sources of energy to maintain:
      1. Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;
      2. Emergency lighting;
      3. Fire detection, extinguishing, and alarm systems; and
      4. Sewage and waste disposal.
8. A system to track the location of on-duty staff and sheltered residents in the Facility’s care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the Facility must document the specific name and location of the receiving facility or other location.
9. Safe evacuation from the Facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.
10. A means to shelter in place for residents, staff, and volunteers who remain in the Facility.
11. A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records.
12. The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.
13. The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents.
14. The role of the Facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.
15. Communication plan. The Facility shall develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan shall include all of the following:
16. Names and contact information for the following:
    1. Staff.
    2. Entities providing services under arrangement.
    3. Residents’ physicians.
    4. Other LTC facilities.
    5. Volunteers.
17. Contact information for the following:
    1. Federal, State, tribal, regional, or local emergency preparedness staff.
    2. The State Licensing and Certification Agency.
    3. The Office of the State Long-Term Care Ombudsman.
    4. Other sources of assistance.
18. Primary and alternate means for communicating with the following:
    1. The Facility’s staff.
    2. Federal, State, tribal, regional, or local emergency management agencies.
19. A method for sharing information and medical documentation for residents under the Facility’s care, as necessary, with other health care providers to maintain the continuity of care.
20. A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii).
21. A means of providing information about the general condition and location of residents under the facility’s care as permitted under 45 CFR 164.510(b)(4).
22. A means of providing information about the Facility’s occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.
23. A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives.
24. Training and testing. The Facility shall develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth above, including the risk assessment, policies and procedures, and the communication plan. The training and testing program shall be reviewed and updated at least annually.
25. Training program. The Facility shall do all of the following:
    1. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
    2. Provide emergency preparedness training at least annually.
    3. Maintain documentation of the training.
    4. Demonstrate staff knowledge of emergency procedures.
26. Testing. The Facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The Facility shall do the following:
    1. Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the Facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the Facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
    2. Conduct an additional exercise that may include, but is not limited to the following:
       1. A second full-scale exercise that is community-based or individual, facility-based.
       2. A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
    3. Analyze the Facility’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the Facility’s emergency plan, as needed.
27. Emergency and standby power systems. The Facility shall implement emergency and standby power systems based on the emergency plan set forth above.
28. Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.
29. Emergency generator inspection and testing. The Facility must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.
30. Emergency generator fuel. LTC facilities that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.
31. Integrated healthcare systems. If the Facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the Facility may choose to participate in the healthcare system’s coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:
32. Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
33. Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.
34. Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in Compliance with the program.
35. Include a unified and integrated emergency plan that meets the requirements of Section I above. The unified and integrated emergency plan must also be based on and include:
    1. A documented community-based risk assessment, utilizing an all-hazards approach.
    2. A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
36. Include integrated policies and procedures that meet the requirements set forth above, a coordinated communication plan and training and testing programs that meet the requirements set forth above, respectively.
37. The standards incorporated by reference in this policy were approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. The Facility may obtain the material from the sources listed below. The Facility may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal]register/code]of]federal]regula tions/ibr]locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.
38. National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.
    1. NFPA 99, Health Care Facilities Code 2012 edition, issued August 11, 2011.
    2. Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.
    3. TIA 12-3 to NFPA 99, issued August 9, 2012.
    4. TIA 12-4 to NFPA 99, issued March 7, 2013.
    5. TIA 12-5 to NFPA 99, issued August 1, 2013.
    6. TIA 12-6 to NFPA 99, issued March 3, 2014.
    7. NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.
    8. TIA 12-1 to NFPA 101, issued August 11, 2011.
    9. TIA 12-2 to NFPA 101, issued October 30, 2012.
    10. TIA 12-3 to NFPA 101, issued October 22, 2013.
    11. TIA 12-4 to NFPA 101, issued October 22, 2013.
    12. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.

Northwind Database

The Northwind sample database (Northwind.mdb) is included with all versions of Access.

1. To be used with Individual Reporting of Compliance and Ethics Concerns Policy and Procedure (CCG 00113). [↑](#footnote-ref-2)
2. To be used with Internal Investigation of Violations Checklist Policy and Procedure (CCG 00115). [↑](#footnote-ref-3)
3. To be used with the Response to Detected Issues and Remediation Policy and Procedure (CCG00117) [↑](#footnote-ref-4)
4. OCR’s commentary characterizes a data storage company that has access to PHI in either hard copy or digital form as a business associate even if the storage company never views the PHI or does so only on a random or infrequent basis. [↑](#footnote-ref-5)
5. Defined as a person or entity to which a business associate delegates a function, activity or service in a capacity other than as a member of the workforce of such business associate. [↑](#footnote-ref-6)
6. A tagline is a short statement written in a non-English language indicating the availability of language assistance. [↑](#footnote-ref-7)
7. https://www.hhs.gov/sites/default/files/resources-for-covered-entities-top-15-languages-list.pdf?language=es [↑](#footnote-ref-8)