

**PART VIII. INTELLECTUAL DISABILITY AND  
AUTISM MANUAL**

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**CHAPTER 6000. STATEMENTS OF POLICY**

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**Subchapter A. [Reserved]****Source**

The provisions of this Subchapter A adopted September 16, 1988, effective January 5, 1988, 18 Pa.B. 4254; reserved March 29, 2013, effective March 30, 2013, 43 Pa.B. 1732. Immediately preceding text appears at serial pages (361402), (213229) to (213232), (257661) to (257662), (213235) to (213236), (257663) to (257664), (213239) to (213240) and (344651) to (344652).

**§§ 6000.1—6000.3. [Reserved].**

**§§ 6000.21—6000.26. [Reserved].**

**§ 6000.31. [Reserved].**

**§ 6000.32. [Reserved].**

**§§ 6000.41—6000.44. [Reserved].**

**Subchapter B. [Reserved]****Source**

The provisions of this Subchapter B adopted July 1, 1988, effective May 31, 1988, 18 Pa.B. 2910; reserved June 26, 2009, effective July 1, 2009, 39 Pa.B. 3174. Immediately preceding text appears at serial pages (213242) to (213244).

**§§ 6000.201—6000.203. [Reserved].**

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- 6000.371. Dual licensure.

**Source**

The provisions of this Subchapter C adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3703, unless otherwise noted.

**TYPE OF CERTIFICATE OF COMPLIANCE****§ 6000.301. Certificate of compliance determination.**

The type of certificate of compliance indicated is determined by the type of noncompliance areas, the total weighted score for vocational and community residential mental retardation facilities, the percentage of compliance with the licensing regulations for adult day care centers and the number of repeated areas of noncompliance.

**COMMUNITY RESIDENTIAL MENTAL  
RETARDATION FACILITIES AND AGENCIES****§ 6000.302. Computation of weighted score.**

(a) The total weighted score for each facility shall be computed according to the instructions in the licensing inspection instrument. The individual weights for each licensing inspection instrument item are listed in Appendix A.

(b) The distribution of the weighted scores used to determine the type of license to be issued is as follows:

- (1) Score of 100 through 65 = Regular license.
- (2) Score of 64 through 43 = Provisional license.
- (3) Score of 42 and below = No license.

**§ 6000.303. No license factors.**

If there is noncompliance with either of the following two sections at the time the license is to be issued, no license will be issued:

- (1) Section 6400.13 (relating to maximum capacity)—first sentence. This is a no license regulation for new facilities and for facilities with no occupancy permit.
- (2) Section 6400.18 (relating to reporting of unusual incidents). Each incidence of abuse will be investigated and evaluated individually by the Office of Mental Retardation before any negative licensing action is taken.

**§ 6000.304. Provisional license factors.**

If there is noncompliance with any one of the following sections at the time the license is issued, a provisional license is indicated:

- (1) Section 6400.13 (relating to maximum capacity)—first sentence. This is a provisional regulation for existing facilities that have an occupancy permit, but the occupancy classification is not correct.
- (2) Section 6400.45 (relating to staff).

- (3) Section 6400.46(a) and (b) (relating to staff training).
- (4) Section 6400.103 (relating to evacuation procedures).
- (5) Section 6400.105 (relating to flammable and combustible materials).
- (6) Section 6400.133 (Reserved).
- (7) Section 6400.136 (Reserved).
- (8) Section 6400.156 (Reserved).

### VOCATIONAL FACILITIES

#### § 6000.311. Computation of weighted score.

(a) The total weighted score shall be computed according to the instructions in the licensing inspection instrument. The individual weights for each item are listed in Appendix B:

(b) The distribution of weighted scores used to determine the type of license to be issued is as follows:

- (1) Score of 100 through 70 = Regular license.
- (2) Score of 69 through 52 = Provisional license.
- (3) Score of 51 and below = no license.

#### § 6000.312. No license factors.

(a) Compliance with certain sections with a weight of 8 or above is so critical that if there is noncompliance with that section or subsection a regular license cannot be issued.

(b) If there is noncompliance with either of the following sections at the time the license is to be issued, no license will be issued:

- (1) Section 2390.14(a) (relating to fire safety occupancy permit)—weight 8.33. This is a no license regulation for new facilities and facilities with no occupancy permit.
- (2) Section 2390.19(a) (relating to abuse)—weight 8.81. Each incidence of abuse will be investigated and evaluated individually by the Office of Mental Retardation before negative licensing action is taken.

#### § 6000.313. Provisional license factors.

If there is noncompliance with any of the following sections at the time the license is issued, a provisional license is indicated:

- (1) Section 2390.14(a) (relating to fire safety occupancy permit)—weight 8.33. This is a provisional regulation for existing facilities that have an occupancy permit, but the occupancy classification is not correct.
- (2) Section 2390.19 (relating to abuse).
  - (i) Subsection (b)—weight 8.64.
  - (ii) Subsection (c)—weight 8.60.
  - (iii) Subsection (d)—weight 8.76.
- (3) Section 2390.53 (relating to outside walkways)—weight 8.17.

- (4) Section 2390.54 (relating to combustible materials)—weight 8.59.
- (5) Section 2390.63 (relating to lighting)—weight 8.06.
- (6) Section 2390.64 (relating to handrails)—weight 8.06.
- (7) Section 2390.68 (relating to hazardous equipment)—weight 8.64.
- (8) Section 2390.69 (relating to personal protective equipment)—weight 8.65.
- (9) Section 2390.70 (relating to special signals on equipment)—weight 8.13.
- (10) Section 2390.71(b) (relating to ventilation)—weight 8.49.
- (11) Section 2390.75 (relating to nutrition).
  - (i) Subsection (a)(1)—weight 8.37.
  - (ii) Subsection (a)(2)—weight 8.17.
- (12) Section 2390.81 (relating to exits)—weight 8.42.
- (13) Section 2390.83 (relating to fire alarms)—weight 8.56.
- (14) Section 2390.84 (relating to fire extinguishers).
  - (i) Subsection (a)—weight 8.14.
  - (ii) Subsection (c)—weight 8.24.
  - (iii) Subsection (f)—weight 8.14.
  - (iv) Subsection (g)—weight 8.04.
- (15) Section 2390.101 (relating to communicable disease)—weight 8.37.
- (16) Section 2390.102 (relating to first aid staff)—weight 8.15.
- (17) Section 2390.104 (relating to emergency medical information)—weight 8.32.

#### ADULT DAY CARE CENTERS

##### § 6000.321. Computation of percentage of compliance.

- (a) If there is 95% compliance or above, a regular certificate is indicated.
- (b) If there is greater than or equal to 85% but less than 95% compliance, a provisional certificate is indicated.
- (c) If compliance is below 85%, no certificate is indicated.

##### § 6000.322. No license factors.

If there is noncompliance with § 2380.13 (relating to maximum capacity) at the time the license is to be issued, no license can be issued.

##### § 6000.323. Provisional license factors.

If there is noncompliance with any of the following sections at the time the license is issued, a provisional license is indicated:

- (1) Section 2380.25 (Reserved).
- (2) Section 2380.41 (Reserved).

**REQUIREMENTS FOR ALL TYPES  
OF FACILITIES AND AGENCIES**

**§ 6000.331. Repeated noncompliance areas.**

(1) Repeated noncompliance areas are determined based on the previous annual, provisional or interim—announced and unannounced—inspections.

(2) Repeated noncompliance areas are determined based on areas of non-compliance observed during the previous initial licensing inspection, and not at the time the previous license was issued.

(3) If there are one, two or three repeated noncompliance areas—regardless of weight—from the previous licensing inspection to the present licensing inspection, a provisional certificate is indicated.

(4) If there are four or more repeated noncompliance areas—regardless of weight—from the previous licensing inspection to the present licensing inspection, no certificate is indicated.

(5) If there are one or more repeated noncompliance areas—regardless of weight—in three or more consecutive annual, provisional or interim licensing inspections, no certificate is indicated.

(6) For community residential agencies, if the same noncompliance area at one facility is repeated at a different facility operated by the same community residential agency during the next inspection, this is considered a repeated noncompliance area.

(7) Physical site noncompliance areas under §§ 2380.61 and 6400.76 (relating to telephone; and furniture and equipment) are not considered repeated noncompliance areas if the specific object or condition cited for repair differs from the previous inspection. For example, if a doorknob is missing 1 year and the next year the paint is cracked and peeling, this is not repeated noncompliance. If there is cracked, peeling paint cited in two consecutive inspections—even in different community residential agency facilities—this is repeated noncompliance.

**§ 6000.332. Recommendation variance.**

(a) The weighting and percentage of compliance systems are guidelines used to determine the type of licensing to be issued. It is recognized that in special circumstances these standardized scoring systems may not be in the best interests of the clients and that professional discretion must be exercised.

(b) The policies and procedures for the type of certificate of compliance should be the basis for the licensure recommendation. If the Regional Mental Retardation Program Manager disagrees with the type of certificate to be issued based on this chapter, the Regional Mental Retardation Program Manager may make a recommendation that differs from these policies and procedures. If the Regional Mental Retardation Program Manager makes a recommendation for licensure that is inconsistent with the manual instructions, detailed written justi-

fication for the variance from the Regional Mental Retardation Program Manager will accompany the licensure packet.

### LICENSED/APPROVED CAPACITY

#### § 6000.341. Capacity.

(a) Licensed/approved capacity is defined as the maximum number of clients or residents who may be served at a facility at any one time. The licensed/approved capacity appears on a certificate of compliance. Capacity is based on the amount of available indoor floor space at the facility. Compliance with all other licensing regulations is measured by onsite observation, record review and interviews. Compliance with staffing ratios is measured by actual attendance on any given day.

(b) Licensed/approved capacity does not mean that the facility currently meets all the staffing requirements necessary for that number of clients. Licensed/approved capacity means only that the facility may serve up to the specified number of clients as determined by the application of minimum floor space requirements. The actual number of clients served depends on the facility meeting staffing and other regulations.

(c) The capacity of a facility will be increased or decreased only in the following instances:

- (1) There is renovation or construction of the facility which changes the amount of indoor floor space.
- (2) There is reallocation of the indoor space.
- (3) There was an error in the previous calculation of the amount of indoor floor space.

(d) The licensed/approved capacity of a currently licensed/approved facility will be adjusted, if necessary, according to this statement of policy in either of the following instances:

- (1) When the facility's next renewal certificate of compliance is issued.
- (2) If a facility requests that its capacity be adjusted according to this statement of policy prior to their current certificate expiration, a new certificate adjusting the capacity will be issued at this time.

#### § 6000.342. Indoor floor space.

The minimum amount of indoor floor space required for facilities is specified in the appropriate chapter of licensing regulations and further clarified in the corresponding licensing inspection instrument.

- (1) Community Residential Mental Retardation Facilities—§§ 6400.85(b) and 6400.232 (relating to swimming pools; and awake staff persons) and corresponding sections of the Licensing Inspection Instrument. In addition to the amount of indoor floor space, the licensed/approved capacity for community residential facilities shall also be based upon the type of fire safety approval



that the facility has. The licensed/approved capacity shall be based upon the amount of indoor floor space not to exceed the occupancy limit of the facility's current fire safety approval. For example, if a facility has indoor floor space for 12 residents, but the facility has only a C-3 Certificate of Occupancy from the Department of Labor and Industry which limits occupancy to eight residents, the licensed/approved capacity will be eight.

(2) Adult Day Care Centers—§ 2380.61 (relating to minimum amount of space) and corresponding section of the licensing inspection instrument. For the adult day care centers, indoor floor space is measured wall to wall, including space occupied by furniture. Hallways and offices are not counted when measuring indoor floor space. Dining areas, kitchens, bathrooms and first aid rooms are counted when measuring indoor floor space if it is clearly documented that the area is used for program purposes for at least 50% of each program day or if it is clearly documented in the facility's training curriculum that the area is used as an integral part of their training program.

(3) Vocational Facilities—§ 2390.52 (relating to indoor floor space) and corresponding sections of the licensing inspection instrument.

#### **LICENSURE OF COMMUNITY RESIDENTIAL MENTAL RETARDATION FACILITIES**

#### **§ 6000.351. Licensing criteria.**

(a) The following criteria should be applied to determine if a facility should be licensed under Chapter 6400 (relating to community homes for individuals with mental retardation).

(1) If a facility meets either of the following criteria, the facility is considered a community residential facility and shall comply with Chapter 6400:

(i) The facility is leased or owned by the provider agency or County MH/MR Program. The resident does not sign his own lease or own his own home.

(ii) An average of more than 10 hours of direct staff contact per week is provided to the facility. Staff may or may not live within the same apartment building or complex.

(2) Direct staff contact includes person to person contact spent in training, programming and assisting the resident with daily living skills. It does not include telephone contact and time spent providing transportation to residents.

(3) Licensing staff should review written leases and staffing schedules to determine if the criteria in this section apply to a specific individual facility. Following is a matrix that may be helpful in determining applicability of the regulations for a specific facility.

	If more than 10 hours of direct staff contact per week per facility	If 10 hours or less direct staff per week per facility
If all residents sign their own lease without agency co-signature or own their own home	LICENSE	DO NOT LICENSE
If agency signs lease or owns building; or if agency co-signs lease with resident	LICENSE	LICENSE

### **LICENSURE OF ADULT DAY CARE CENTERS LOCATED IN NURSING HOMES**

#### **§ 6000.361. Adult day care centers located in a nursing home.**

(a) If an adult day care center located in a nursing home serves only nursing home clients, the Department should not license the adult day care center.

(b) If an adult day care center located in a nursing home serves one or more public clients (nursing home clients), with at least a total of four clients, the Department should license the adult day care center using the following procedures:

(1) The inspector asks the provider or inspects the facility to determine if the facility has a current License to Operate a Health Care Facility issued by the Department of Health. This license covers both skilled and intermediate nursing homes. This license should be posted in a conspicuous place in the facility.

(2) If the facility has a current Department of Health license, the provider shall acquire a letter from the Department of Health stating that specific space within the nursing home building may be utilized for adult day care.

(3) If the provider produces a letter from the Department of Health stating that specific space may be used for adult day care, standard procedures should be followed.

(4) If the provider cannot produce a letter from the Department of Health stating that space may be used for adult day care, the Department of Human Services cannot license the facility for adult day care and the facility may not provide adult day care to nonnursing home clients.

### **DUAL LICENSURE OF ADULT DAY CARE CENTERS AND VOCATIONAL REHABILITATION FACILITIES**

#### **§ 6000.371. Dual licensure.**

(a) A facility should be licensed under both adult day care center and vocational facility regulations if the regulatory definitions of both sets of regulations are met. The main regulatory distinction between an adult day care center and a vocational facility is that an adult day care center, less than 20% of the client's programming is comprised of remunerative work experience. In a vocational

facility, 20% or more of the client's programming is comprised of remunerative work experience. The average percentage of remunerative work experience provided to each client over a 12-month period will be considered in this determination.

(b) If both adult day care center and vocational facility definitions are met, the following dual licensure procedures apply.

(1) Adult day care clients and vocational clients must be served in separate and distinct program areas or groups within the facility. Nonprogram areas such as bathrooms and dining areas can be shared.

(2) Apply both sets of regulations, completing two separate licensing inspection instrument scoresheets and two licensing inspection instruments.

(3) Apply adult day care and vocational regulations separately. For example, apply 1:7 ratio adult day care clients and 1:15 or 1:20 ratio for vocational facility clients.

(4) Issue two separate certificates. It is possible that the adult day care center could receive a regular certificate and the vocational facility could receive a provisional certificate.

(5) The facility will appear on licensing printouts as both an adult day care center and a vocational facility.

#### Subchapter D. [Reserved]

Sec.

6000.401—6000.404.	[Reserved].
6000.411—6000.414.	[Reserved].
6000.421—6000.427.	[Reserved].
6000.431—6000.435.	[Reserved].
6000.441—6000.445.	[Reserved].
6000.451 and 6000.452.	[Reserved].
6000.461—6000.474.	[Reserved].

#### §§ 6000.401—6000.404. [Reserved].

##### Source

The provisions of these §§ 6000.401—6000.404 adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715; reserved April 26, 2002, effective March 25, 2002, 32 Pa.B. 2117. Immediately preceding text appears at serial pages (213254) and (287093).

#### §§ 6000.411—6000.414. [Reserved].

##### Source

The provisions of these §§ 6000.411—6000.414 adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715; reserved April 26, 2002, effective March 25, 2002, 32 Pa.B. 2117. Immediately preceding text appears at serial pages (287094) and (213257).

**§§ 6000.421—6000.427. [Reserved].****Source**

The provisions of these §§ 6000.421—6000.427 adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715; reserved April 26, 2002, effective March 25, 2002, 32 Pa.B. 2117. Immediately preceding text appears at serial pages (213257) to (213258).

**§§ 6000.431—6000.435. [Reserved].****Source**

The provisions of these §§ 6000.431—6000.435 adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715; reserved April 26, 2002, effective March 25, 2002, 32 Pa.B. 2117. Immediately preceding text appears at serial pages (213257) to (213258).

**§§ 6000.441—6000.445. [Reserved].****Source**

The provisions of these §§ 6000.441—6000.445 adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715; reserved April 26, 2002, effective March 25, 2002, 32 Pa.B. 2117. Immediately preceding text appears at serial pages (213259) to (213260).

**§§ 6000.451 and 6000.452. [Reserved].****Source**

The provisions of these §§ 6000.451 and 6000.452 adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715; reserved April 26, 2002, effective March 25, 2002, 32 Pa.B. 2117. Immediately preceding text appears at serial page (213260).

**§§ 6000.461—6000.474. [Reserved].****Source**

The provisions of these §§ 6000.461—6000.474 adopted April 26, 2002, effective March 25, 2002, 32 Pa.B. 2117; reserved February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234. Immediately preceding text appears at serial pages (288022) to (288043).

**Subchapter E. ZONING REQUIREMENTS FOR  
LICENSURE OF INTERMEDIATE CARE FACILITIES  
FOR THE MENTALLY RETARDED**

Sec.  
6000.501. Removal of zoning approval as a prerequisite to licensing intermediate care facilities for the mentally retarded (ICFs/MR).

**Source**

The provisions of this Subchapter E adopted October 14, 1988, effective October 3, 1988, 18 Pa.B. 4687, unless otherwise noted.

**§ 6000.501. Removal of zoning approval as a prerequisite to licensing intermediate care facilities for the mentally retarded (ICFs/MR).**

(a) Prior to October 3, 1988, a provider who intended to operate a four to eight bed ICF/MR was required to obtain written approval from the local zoning authorities to occupy a single family dwelling with more than three unrelated people. Various zoning officials were reluctant to provide this approval, thus delaying the opening of certain ICFs/MR. By removing the zoning requirement, ICF/MR providers may obtain licensure in a more timely manner.

(b) Current and future providers who apply for certificates of compliance from the Department of Human Services to operate ICFs/MR are no longer required to submit documentation with the Application for a Certificate of Compliance that zoning approval for the ICF/MR sites has been obtained.

(c) The Office of Mental Retardation has informed Department of Health staff from the Division of Long Term Care that ICF/MR providers need not produce, during survey site visits, documentation that zoning has been approved in order for survey staff to recommend that the Department of Human Services license and certify the facilities.

**Subchapter F. ADMINISTRATION AND  
MANAGEMENT OF CLIENT FUNDS**

Sec.

6000.521. Administration and management of client funds.

**§ 6000.521. Administration and management of client funds.**

(a) The County Mental Health/Mental Retardation Administrator (Administrator) is responsible for compliance with the policies and procedures in this statement of policy.

(b) An Administrator should ensure that community residential facilities with which they contract establish policies and procedures on the administration and management of client funds consistent with this statement of policy. Administrators should review and approve the policies and procedures on client funds and monitor the implementation of these policies and procedures.

(c) Policies and procedures should include provision for a financial plan to be integrated into each client's Individual Program Plan to insure the satisfaction of current and future needs. The financial plan should include, at a minimum:

- (1) Documentation that a client has received assistance in applying for funds and benefits to which the client is entitled by establishing residential intake procedures that identify client eligibility for benefits from all resources and annually reviewing each client's eligibility for programs—for example,

rent rebate, food stamps and the like. A decision not to access benefits shall be approved by the Administrator.

(2) A forecast of cash flow, a budget plan and a review of proposed cash needs.

(3) A review and analysis of the client's investments, insurance policies, burial accounts and conserved resources identified by family—for example, burial plots and the like.

(4) Development of a room and board contract, if applicable, in accordance with Chapter 6200 (relating to room and board charges).

(5) An assessment of the client's need for supervision or training in money management, or both.

(6) Documentation of the client's desire to receive oversight/training in the management of personal funds.

(7) An assessment of the individual client's need for a representative payee based on the client's ability to manage the client's own monies.

(d) Policies and procedures should include provision for training clients in the management of personal funds. Training should include at a minimum:

(1) Assessing the client's skills in the management of funds and the need for specific skill training.

(2) Specifying goals related to training in the management of personal funds. Goals should be included in the client's Individual Program Plan, if appropriate.

(3) Monitoring of the training program via the client's Individual Program Plan.

(e) Policies and procedures should include provision for the creation of irrevocable burial accounts. The policies and procedures should include:

(1) Review of individual client balances and spending patterns to determine if the client has adequate funds to meet present and projected financial needs.

(2) Consultation, if appropriate, with the client/the client's family/interdisciplinary team about other available resources and whether a burial fund or other appropriate arrangements are in the client's best interests.

(3) Review of the client's insurance records to assure that the burial reserve plus cash surrender value of insurance policies would be adequate to meet anticipated client burial costs.

(4) Discussion of the nature of irrevocable burial funds—money can be withdrawn only for burial purposes.

(5) Establishment of a separate irrevocable burial reserve, interest-bearing account in the client's name ensuring the following:

(i) Burial reserve funds are deposited either on a one-time basis or through periodic deposits.

(ii) Bank statements are received at least annually.

(iii) The bank is notified of client address changes.

- (iv) Pertinent information on the existence of the burial reserve account is filed with the Case Management Unit and provider offices.
- (v) The client's family is notified about the existence of the burial reserve account, if appropriate.
- (vi) For SSI beneficiaries:
  - (A) The Social Security field representative is notified of plans to establish an irrevocable burial account.
  - (B) A brief memorandum is sent to the Social Security Administration field representative stating the client's name, referencing the initial discussion and attaching a copy of the irrevocable burial agreement.
  - (C) A standard agreement which meets the language requirements of the benefit-issuing agency is used.
- (f) Policies and procedures should include provision for safeguarding client funds. The policies and procedures should include:
  - (1) A monitoring system to assure continuing eligibility of client benefits.
  - (2) The reporting of changes in client income or living situations to the appropriate benefit-issuing agency.
  - (3) The prompt deposit of client-funds in bank accounts. Client funds in excess of immediate financial obligations should be deposited in interest-bearing accounts where interest is allocated to individual client accounts on at least a quarterly basis.
  - (4) A monitoring system of the client's checking account, savings account and cash on hand.
  - (5) Policies for client expenditures such as personal needs, movie tickets, vacations, newspaper, toll calls, cable TV and shared costs for fixed assets. A written rationale should be developed for client-shared costs.
  - (6) The establishment of procedures, including maintenance of an inventory, to safeguard client personal property.
  - (7) The maintenance of client funds in a secure manner.
  - (8) A procedure to meet client financial obligations and assure that client charges are made accurately and fairly.
  - (9) The documentation of—by receipt, invoice or expense record—client fund use.
  - (10) The maintenance, on an ongoing basis, of client financial records including, at a minimum, account balances, receipts, expenditures and reconciliations of client account balances.
    - (i) A client financial reconciliation should be completed monthly.
    - (ii) A periodic review of client funds should be conducted at least once a year.
  - (11) The establishment of criteria to determine and recommend payeeship responsibility and review individual assignment annually or as needed.
  - (12) The establishment of representative payee responsibility regarding documentation of money spent on client's behalf.

(13) The prohibition of the commingling of client funds with agency operational funds, the borrowing of funds between clients and staff and the use of client's money for rewards in behavior management programs.

(14) The establishment of procedures to be followed in the event of misappropriation or theft of clients funds or property as defined in Subchapter D (relating to unusual incidents and deaths).

(g) An Administrator should:

(1) Insure that Mental Retardation Bulletin # 99-87-18, issued November 23, 1987, titled "Case Management Services" is being followed in the area of safeguarding the use of client funds.

(2) Insure that policies and procedures specified in subsections (b)—(f) are in place and include reporting and auditing requirements.

(3) Monitor by random sampling at least 10% of client inventories against actual existence of the items.

(4) Ensure that, as part of the annual audit requirement for a provider, the system of internal control over client funds is evaluated and that a representative sample of individual client accounts are tested as part of the process.

#### **Subchapter G. [Reserved]**

#### **§ 6000.601. [Reserved].**

##### **Source**

The provisions of this § 6000.601 adopted August 25, 1989, effective August 10, 1989, 19 Pa.B. 3686; reserved March 29, 2013, effective March 30, 2013, 43 Pa.B. 1732. Immediately preceding text appears at serial pages (213264) to (213266).

#### **Subchapter H. QUALITY ENHANCEMENT POLICY**

Sec.

6000.621. County policy.

6000.622. Procedures.

6000.623. Action plan.

6000.624. The Office of Mental Retardation direct and independent review of county quality enhancement process.

#### **§ 6000.621. County policy.**

A county policy statement should contain the following elements:

(1) A statement of philosophy embracing the concept of quality in services for persons with mental retardation.



(2) A statement of methodology to be used by the county to conduct self-assessment. This methodology should support the consumer-oriented principles and practices and include involvement by family, friends, advocates and interested citizens.

(3) A description of the responsibility of providers, including staff and board, in enhancing quality in programs provided.

(4) A statement that the county and each of its providers will work cooperatively and within standards adopted by the county to develop the provider's policy on assessment of quality.

(5) A statement addressing the incorporation of appropriate components of the definition of quality into the contracts drawn between the county and the providers of the service.

(6) A provision that orientation to the concept of quality enhancement be incorporated into staff development programs.

(7) A provision to update and refine both county and provider policy on quality enhancement and a mechanism as a result of ongoing feedback from the implementation.

#### Source

The provisions of this § 6000.621 adopted November 11, 1989, effective July 1, 1990, 19 Pa.B. 4879.

#### § 6000.622. Procedures.

A county should formulate a separate procedures statement that utilizes its quality enhancement policy. Procedures should ensure that the process is consumer-centered. Procedures should address the methods the county will use to determine whether programs are having a positive effect on people's lives. At a minimum, these methods should address consumer growth and development and consumer satisfaction. These procedures should contain the following:

(1) Methods for conducting annual self-assessments that measure individual consumer concern including growth, development and satisfaction.

(2) Methods for conducting an annual self-assessment that measures the availability of services in the county system as a whole. This includes addressing not only the availability of existing services but the need for additional services.

(3) Methods for contract monitoring to assure that quality enhancement provisions are being met.

#### Source

The provisions of this § 6000.622 adopted November 11, 1989, effective July 1, 1990, 19 Pa.B. 4879.

**§ 6000.623. Action plan.**

Elements in the county action plan should include:

- (1) Identification of persons responsible for quality enhancement activities.
- (2) Establishment of priorities for implementation and the respective roles identified for members of the partnership.
- (3) A schedule for county and provider self-assessment, how that self-assessment is to be accomplished and the basis for the assessment. This assessment should include the County Mental Health and Mental Retardation Board and the members of the partnership, as well as provider staff and boards.
- (4) Time frames for implementation which detail all levels of involvement.
- (5) Strategy for utilizing the results of the self-assessment.
- (6) Identification of ways to continually improve the quality of service delivery.
- (7) Identification of the sources and recipients of technical assistance and training activities.

**Source**

The provisions of this § 6000.623 adopted November 11, 1989, effective July 1, 1990, 19 Pa.B. 4879.

**§ 6000.624. The Office of Mental Retardation direct and independent review of county quality enhancement process.**

- (a) Direct and independent review should include:
  - (1) A review of the county quality enhancement policy statement, county procedures to implement the policy and the county's most recent action plan.
  - (2) A review of the most recent county self-assessment.
  - (3) Application of the county self-assessment methodology with a sample of consumers including record review and program observation.
  - (4) Verification of the contract provisions addressing quality and reports resulting from contract monitoring by the county.
- (b) The Office of Mental Retardation will issue a written report in a timely manner as a result of the independent and direct review.

**Source**

The provisions of this § 6000.624 adopted November 11, 1989, effective July 1, 1990, 19 Pa.B. 4879.

**Subchapter I. [Reserved]****§§ 6000.641—6000.646. [Reserved].****Source**

The provisions of these §§ 6000.641—6000.646 adopted January 11, 1991, effective July 1, 1990, 21 Pa.B. 167; reserved March 29, 2013, effective March 30, 2013, 43 Pa.B. 1732. Immediately preceding text appears at serial pages (213268) to (213270).

**Subchapter J. [Reserved]****§§ 6000.661—6000.666. [Reserved].****Source**

The provisions of these §§ 6000.661—6000.666 adopted January 11, 1991, effective January 12, 1991, applies retroactively to January 2, 1991, 21 Pa.B. 167; reserved March 29, 2013, effective March 30, 2013, 43 Pa.B. 1732. Immediately preceding text appears at serial pages (213270) to (213273).

**Subchapter K. [Reserved]****§§ 6000.681—6000.689. [Reserved].****Source**

The provisions of these §§ 6000.681—6000.689 adopted January 11, 1991, effective January 12, 1991, and apply retroactively to January 2, 1991, 21 Pa.B. 169; reserved March 29, 2013, effective March 30, 2013, 43 Pa.B. 1732. Immediately preceding text appears at serial pages (213274) to (213276).

**Subchapter L. FAMILY-DRIVEN FAMILY SUPPORT SERVICES**

Sec.

6000.701. Definitions.

6000.702. Funding of family-driven family support services.

6000.703. Accounting for expenditures.

6000.704. Monitoring.

**§ 6000.701. Definitions.**

(a) Family support services include services defined in Chapter 6350 (relating to family resources services) and subsequent statements of policy such as Mental Retardation Bulletin No. 99-83-24, titled: DHS Policy on Support Services for Persons with Mental Retardation and Their Families and Mental Retar-

dation Bulletin No. 99-84-21, titled: Supplement Agreement to the DHS Policy on Support Services for Persons with Mental Retardation and Their Families.

(b) Family-driven is a method of providing family support services whereby the family or the person with mental retardation, rather than the service system, are given the responsibility for deciding which services will best address the family's specific needs. In a family-driven model, family members also have a primary responsibility for planning, implementing, evaluating and setting priorities on services to address their specific needs.

**Source**

The provisions of this § 6000.701 adopted January 18, 1991, effective January 19, 1991, and apply retroactively to July 1, 1990, 21 Pa.B. 260.

**§ 6000.702. Funding of family-driven family support services.**

Family-driven family support services (FD/FSS) pilot projects initiated in 1987/88 and 1989/90 are eligible for 100% State financial participation up to the level they were funded as pilot projects. They include only projects that were categorically funded as a result of their submission of a proposal in response to Mental Retardation Bulletin No. 00-87-15, issued October 6, 1987, and titled: Request for Proposals to Develop Family-Driven Family Support Services Pilot Projects, or Mental Retardation Bulletin No. 00-89-09, issued April 19, 1989, titled: Request for Proposals to Develop or Expand Family-Driven Family Support Services Pilot Projects. Funding for family support services which are not integrated into an approved family-driven project will continue to be reimbursed by the Department on a 90/10 matching basis.

**Source**

The provisions of this § 6000.702 adopted January 18, 1991, effective January 19, 1991, and apply retroactively to July 1, 1990, 21 Pa.B. 260.

**§ 6000.703. Accounting for expenditures.**

Counties sponsoring an approved 100% State-funded Family-Driven Family Support Services (FD/FSS) program should account for expenditures for that program separate from expenditures for family support services provided with 90/10 funding.

**Source**

The provisions of this § 6000.703 adopted January 18, 1991, effective January 19, 1991, and apply retroactively to July 1, 1990, 21 Pa.B. 260.

**§ 6000.704. Monitoring.**

The Office of Mental Retardation will monitor the progress of the projects on an ongoing basis to ensure that the family-driven nature of the projects is maintained.

**Source**

The provisions of this § 6000.704 adopted January 18, 1991, effective January 19, 1991, and apply retroactively to July 1, 1990, 21 Pa.B. 260.

**Subchapter M. [Reserved]**

## Sec.

6000.761—6000.765. [Reserved].

6000.771—6000.778. [Reserved].

**§§ 6000.761—6000.765. [Reserved].****Source**

The provisions of these §§ 6000.761—6000.765 adopted October 19, 1990, effective immediately but apply retroactively to July 1, 1990, 20 Pa.B. 5296; reserved March 29, 2013, effective March 30, 2013, 43 Pa.B. 1732. Immediately preceding text appears at serial pages (213278) to (213280).

**§§ 6000.771—6000.778. [Reserved].****Source**

The provisions of these §§ 6000.771—6000.778 adopted October 5, 1990, effective immediately but apply retroactively to July 1, 1990, 20 Pa.B. 5054; reserved March 29, 2013, effective March 30, 2013, 43 Pa.B. 1732. Immediately preceding text appears at serial pages (213280) to (213282) and (344653) to (344654).

**Subchapter N. [Reserved]****Source**

The provisions of this Subchapter N adopted August 23, 1991, effective immediately upon publication and apply retroactivity to July 1, 1991, 31 Pa.B. 3840; reserved June 26, 2009, effective July 1, 2009, 39 Pa.B. 3174. Immediately preceding text appears at serial pages (213284) to (213287).

**§§ 6000.781—6000.785. [Reserved].****Subchapter O. CRITERIA FOR APPROVAL OF NEW INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH MENTAL RETARDATION**

## Sec.

6000.821. Criteria for approval of new intermediate care facilities for people with mental retardation.

**Source**

The provisions of this Subchapter O adopted April 5, 1996, effective April 6, 1996, 26 Pa.B. 1563, unless otherwise noted.

**§ 6000.821. Criteria for approval of new intermediate care facilities for people with mental retardation.**

(a) The Office of Mental Retardation will review proposals for intermediate care facilities for people with mental retardation (ICFs/MR), as part of the certificate of need process, through an interdepartmental cooperative agreement with the Department of Health. The Department of Human Services (Department) will only support and approve Medicaid funding for ICFs/MR which meet the following criteria:

(1) Projects to convert community homes to ICFs/MR shall be budget neutral and approved in writing by the county mental health/mental retardation program and the Office of Mental Retardation.

(2) In-State referrals of individuals to ICFs/MR shall be approved by the county MH/MR program in the individual's county of residence in accordance with its responsibilities under Chapter 6201 (relating to county mental retardation services).

(3) The ICF/MR shall coordinate case management services with the appropriate county MH/MR program. Case management shall include cooperative planning to prevent prolonged institutional placement and to prepare the person for return to life at home in the community.

(4) Community-integrated day services shall be provided off the grounds of the ICF/MR, unless medically contraindicated by a physician.

(5) Non-State ICFs/MR shall be reimbursed in accordance with Chapter 6211 (relating to allowable cost reimbursement for non-State operated intermediate care facilities for people with mental retardation) and Medicare principals HIM-15.

(b) The Office of Mental Retardation does not currently support the development of new ICF/MR proposals. The Office will consider the following factors in determining whether to grant an exception to this policy:

(1) New residential settings shall be designed so that the building fits into the residential neighborhood and is limited to four people. Sites shall be dispersed within the community to foster social integration and participation with neighbors in the general population.

(2) Services in an ICF/MR shall be demonstrated to be the most programmatic and cost effective alternative for people with mental retardation who require an ICF/MR level of care.

**Subchapter P. [Reserved]**

Sec.  
6000.841. [Reserved].

6000-22

**Source**

The provisions of this Subchapter P adopted April 19, 1996, effective April 20, 1996, 26 Pa.B. 1829; reserved June 26, 2009, effective July 1, 2009, 39 Pa.B. 3174. Immediately preceding text appears at serial pages (213288) and (302961).

**§ 6000.841. [Reserved].**

**Subchapter Q. INCIDENT MANAGEMENT**

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- 6000.956. Supports coordinator supervisor/unit manager.
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- 6000.961. Standardized incident report.
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- 6000.981. Support to quality management.
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- 6000.983. Use of incident data.
- 6000.984. Provider incident management quarterly reports.
- 6000.985. County incident management reports.

#### **Source**

The provisions of this Subchapter Q adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234, unless otherwise noted.



**GENERAL PROVISIONS****§ 6000.901. Scope.**

(a) Individuals who are registered with a county mental retardation program or who receive supports and services from facilities licensed by the OMR are afforded the protections detailed in this subchapter.

(b) Providers who receive funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from a county mental retardation program and providers licensed by the OMR are reporters and are to file incident reports as specified in this subchapter.

(c) County mental retardation programs and their designated support coordination entities are reporters and are to file incident reports as specified in this subchapter.

**§ 6000.902. Purpose.**

The purpose of this subchapter is to specify the guidelines and procedures for the incident management process. The incident management process is a subset of a larger risk management process. Incident policies, procedures, training, response and reporting are all important components of the incident management process. Combined with other areas of risk assessment such as employee injuries, complaints, satisfaction surveys and hiring practices, incident management is an essential component of a comprehensive quality management process. See Appendix E (relating to incident management components).

**§ 6000.903. Licensing applicability.**

A facility must comply with Chapters 2380, 2390, 6400, 6500 and 6600. To the extent that this subchapter exceeds the requirements of Chapters 2380, 2390, 6400, 6500 and 6600, the use of this subchapter is optional for facilities. Because this subchapter meets or exceeds the regulatory requirements in Chapters 2380, 2390, 6400, 6500 and 6600, compliance with the reporting procedures in this subchapter will be accepted by the Department as meeting the regulatory requirements of §§ 2380.17, 2390.18, 6400.18 and 6500.20.

**§ 6000.904. Definitions.**

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

*Department*—The Department of Human Services of the Commonwealth.

*HCSIS*—The Home and Community Services Information System.

*OMR*—The Office of Mental Retardation of the Department.

**RESPONSIBILITY FOR REPORTING/INVESTIGATING****§ 6000.911. Providers.**

(a) Employees, contracted agents and volunteers of providers covered within the scope of this subchapter are to respond to events that are defined as an incident in this subchapter. When an incident is recognized or discovered by a provider, prompt action is to be taken to protect the individual's health, safety and rights. The responsibility for this protective action is assigned to the provider initial reporter and point person. The protection may include dialing 911, escorting to medical care, separating the perpetrator, calling ChildLine, arranging for counseling and referring to a victim assistance program. Unless otherwise indicated in the individual support plan, the provider point person or designee is to inform the individual's family within 24 hours, or within 72 hours for medication error and restraint, of the occurrence of an incident and to also inform the family of the outcome of any investigation.

(b) After taking all appropriate actions following an incident to protect the individual, the provider is to report all categories of incidents and complete an investigation as necessary whenever services or supports are:

(1) Rendered at the provider's site.

(2) Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer.

(3) Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home.

(c) In situations when multiple providers learn of an incident, the provider responsible for the individual at the time the incident occurred is to report the incident and conduct any required investigation. If it cannot reasonably be determined which provider had responsibility at the time of the incident, all providers who are aware of the incident are to report the incident and investigate.

(d) If, during an investigation, the certified investigator assigned by the provider determines that an alleged perpetrator is not an employee, a volunteer or an individual receiving services from the provider, the certified investigator is to complete the investigation summary in the HCSIS incident management application stating the reason why the investigation could not be concluded. The certified investigator is to review the protective action taken by the agency and ensure communication with county staff occurs, outside HCSIS, to alert the county that appropriate interventions may be needed to protect the individual.

(e) In addition, employees, contracted agents or volunteers of provider agencies are to report deaths, alleged abuse or neglect when they become aware of such incidents regardless of where or when these incidents occur. If the death, alleged abuse or neglect occurred beyond the provider's responsibility as specified in subsection (b)(1)—(3), the provider is not to report the incident in HCSIS, but instead should give notice of the incident, outside of HCSIS, to the individual's supports coordinator.

(f) Any person, including the victim, shall be free from intimidation, discriminatory, retaliatory or disciplinary actions exclusively for the reporting or cooperating with a certified investigation. These individuals have specific rights as defined by the Whistleblower Law (43 P.S. §§ 1421—1428) and the Older Adults Protective Services Act (35 P.S. § 10225.101—10225.5102). See Appendix F (relating to related laws, regulations and policies).

#### Cross References

This section cited in 55 Pa. Code § 6000.913 (relating to county mental health/mental retardation programs); 55 Pa. Code § 6000.925 (relating to categories of incidents to be investigated); and 55 Pa. Code § 6000.955 (relating to supports coordinator).

### § 6000.912. Individuals and families.

(a) Individuals and families are to notify the provider, when they feel it is appropriate, or their supports coordinator regarding any health and safety concerns they may have related to a service or support that they are receiving. If an individual or family member observes or suspects abuse, neglect or any inappropriate conduct, whether occurring in the home or out of the home, they should contact the provider or their supports coordinator, or both, and they may also contact the Office of Mental Retardation directly at 1 (888) 565-9435. As specified in this subchapter, the supports coordinator will either inform the involved provider of the incident or file an incident report. Once informed by the supports coordinator, the provider is subsequently responsible to take prompt action to protect the individual, complete an investigation as necessary and file an incident report. In the event of the death of an individual, the family is requested to notify the supports coordinator.

(b) When an individual or the individual's representative arrange his own supports through a payment agent or intermediary service organization and an incident occurs, the individual, the individual's family or his representative is to inform the provider, when it is appropriate, or the supports coordinator that an incident has occurred. The provider or supports coordinator will take prompt action to protect the individual, ensure a certified investigator is assigned as necessary and file an incident report in HCSIS.

### § 6000.913. County mental health/mental retardation programs.

(a) When an individual or family informs his supports coordinator that an event has occurred that can be defined as an incident and there is a relationship as specified in § 6000.911(b)(1)—(3) (relating to providers) the supports coordinator is to immediately notify the provider rendering the support or service. The provider is responsible for taking prompt action to protect the individual, completing an investigation as necessary and filing an incident report in HCSIS.

(b) When an individual or a family member informs the supports coordinator of an event that can be categorized as abuse or neglect as defined in this subchapter and there is no relationship as specified in § 6000.911(b)(1)—(3), the supports coordinator will take prompt action to protect the individual. Once the individual's health and safety are assured, the supports coordinator will ensure a certified investigator is assigned as necessary and file an incident report in HCSIS.

(c) When a family member of an individual informs the individual's supports coordinator of the death of the individual, the supports coordinator will determine if a report has been filed by a provider. If a provider is not required to file the report, the supports coordinator will file an incident report in HCSIS.

(d) In some circumstances, county mental retardation program staff may be required to report incidents. County staff are to report deaths and incidents of alleged abuse or neglect when a provider or supports coordinator relationship does not currently exist, or in circumstances when the process for reporting or investigating incidents, described in this subchapter, for providers or support coordination entities compromises objectivity.

(e) If a county incident manager or designee is informed that a provider's certified investigator suspects that abuse or neglect is occurring beyond the authority of the provider to investigate, the county is to take all available action to protect the health and safety of the individual. The county may need to employ the resources of law enforcement, ChildLine, area agency on aging, counselors or other protective service agencies to protect the individual.

#### REPORTABLE INCIDENTS

#### § 6000.921. Categories of incidents.

(a) The following are the categories of incidents to be responded to by staff who are knowledgeable about incident management processes and protecting individuals. After the immediate health and safety assurances have been met, these incidents are to be reported in HCSIS. The categories are divided into those that must be reported within 24 hours of discovery or recognition and those that are to be reported within 72 hours.

(b) For the incidents that require reporting within 24 hours, the first section of the incident report must be completed in HCSIS within 24 hours. The first section includes a minimum data set (individual and provider demographics, action taken to protect the individual and description of the incident and the category of incident). The final section of the incident report includes additional information about the incident, any required investigation and corrective actions. The final section is to be completed within 30 days of recognition or discovery of the incident.

(c) The second set of incidents requires reporting within 72 hours of recognition or discovery. These incidents are reported using abbreviated data entry screens in HCSIS.

(d) When multiple individuals associated with a provider/entity are involved in certain primary categories or secondary categories, or both, of incidents, the incident can be reported using a site report. Only those events designated in the list of reportable incidents as a site report may be filed in this manner. An individual who is part of a group involved in a site report and is injured must have a separate individual report completed using the proper classification.

(e) Providers, supports coordination entities, counties and OMR must be vigilant to report any incident when there is a suspected crime to law enforcement. When an individual is allegedly abused, neglected or the victim of a crime, the individual is to be offered the support of a victim's assistance program. See Appendix G (relating to victim's assistance programs).

**§ 6000.922. Incidents to be reported within 24 hours.**

(a) The following are categories of incidents to be reported within 24 hours after the occurrence of the incident:

(1) *Abuse*. The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported on from the victim's perspective, not on the person committing the abuse.

(i) *Physical abuse*. An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual.

(ii) *Psychological abuse*. An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(iii) *Sexual abuse*. An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.

(iv) *Verbal abuse*. A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(v) *Improper or unauthorized use of restraint*. A restraint not approved in the individual support plan or one that is not a part of an agency's emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.

(2) *Death*. All deaths are reportable.

(3) *Disease reportable to the Department of Health*. An occurrence of a disease on the *Pennsylvania Department of Health List of Reportable Diseases*. The current list can be found at the Department of Health's website, [www.health.state.pa.us](http://www.health.state.pa.us). An incident report is required only when the reportable disease is initially diagnosed.

(4) *Emergency closure*. An unplanned situation that results in the closure of a home or program facility for 1 or more days. This category does not apply to individuals who reside in their own home or the home of a family member. This may be reported as a site report.

(5) *Emergency room visit*. The use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable.

(6) *Fire*. A situation that requires the active involvement of fire personnel, that is, extinguishing a fire, clearing smoke from the premises, responding to a false alarm, and the like. Situations which require the evacuation of a facility in response to suspected or actual gas leaks or carbon monoxide alarms, or

both, are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. This may be reported as a site report.

(7) *Hospitalization.* An inpatient admission to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.

(8) *Individual-to-individual abuse.* An interaction between one individual receiving services and another individual receiving services resulting in an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Individual-to-individual abuse is reported on from the victim's perspective, not on the person committing the abuse.

(i) *Physical abuse.* An intentional physical act that causes or may cause physical injury to an individual, such as striking or kicking, or applying noxious or potentially harmful substances or conditions to an individual.

(ii) *Psychological abuse.* An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(iii) *Sexual abuse.* An act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Nonconsensual sex between individuals receiving services is abuse.

(iv) *Verbal abuse.* A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(9) *Injury requiring treatment beyond first aid.* Any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, and the like. Treatment beyond first aid includes lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an emergency room.

(10) *Law enforcement activity.* The involvement of law enforcement personnel is reportable in the following situations:

(i) An individual is charged with a crime or is the subject of a police investigation that may lead to criminal charges.

(ii) An individual is the victim of a crime, including crimes against the person or his property.

(iii) A crime such as vandalism or break-in that occurs at a provider site. This may be reported as a site report.

(iv) An on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation while on duty or volunteering. This is reported as a site report.

(v) A volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering. This is reported as a site report.

(vi) A crisis intervention involving police/law enforcement personnel.

(vii) A citation given to an agency staff person for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle, is reported as a site report.

(11) *Missing person.* A person is considered missing when they are out of contact with staff for more than 24 hours without prior arrangement or if they are in immediate jeopardy when missing for any period of time. A person may be considered in “immediate jeopardy” based on the person’s personal history and may be considered “missing” before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual or the police independently find and return the individual, or both, regardless of the amount of time the person was missing.

(12) *Misuse of funds.* An intentional act or course of conduct, which results in the loss or misuse of an individual’s money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual support plan is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.

(13) *Neglect.* The failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

(14) *Psychiatric hospitalization.* An inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation or treatment, or both, whether voluntary or involuntary. This includes admissions for “23 hour” observation and those for the review or adjustment, or both, of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors.

(15) *Rights violation.* An act which is intended to improperly restrict or deny the human or civil rights of an individual including those rights which are specifically mandated under applicable regulations. Examples include the unauthorized removal of personal property, refusal of access to the telephone, privacy violations and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.

(16) *Suicide attempt*. The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats.

**§ 6000.923. Incidents to be reported within 72 hours.**

(a) The following are categories of incidents to be reported within 72 hours after the occurrence of the incident:

(1) *Medication error*. Any nonconforming practice with the "Rights of Medication Administration" as described in the OMR Medication Administration Training Course. This includes omission, wrong dose, wrong time, wrong person, wrong medication, wrong route, wrong position, wrong technique/method and wrong form. Over the counter medication is excluded. Treatment procedures (for example, skin creams, shampoo, eye drops, and the like) that do not contain a prescription medication are excluded. A medication error occurring during a home visit, when the family is responsible for the administration, is not reportable. An individual's refusal to take medication is not reportable. See Appendix H (relating to abbreviated incident report, medication error).

(2) *Restraints*. Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual's body, including those that are approved as part of an individual support plan or those used on an emergency basis. Improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category. See Appendix I (relating to abbreviated incident report, restraint).

(i) *Physical*. A physical or manual restraint is a physical hands-on technique that lasts 30 seconds or more, used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body such as a basket hold and prone or supine containment.

(ii) *Mechanical*. A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices. A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as a wheelchair belt or helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

(iii) *Chemical*. A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual. A drug ordered by a licensed practitioner as part of an on-going treatment program or pretreatment prior to medical or dental examination or treatment is not a chemical restraint. Medications prescribed on a Pro Re Nata (PRN) basis for the treatment of episodically occurring and well-defined symptoms of an underlying disorder (such as an anxiety disorder, auditory hallucinations, and the like) and not simply for behavior control, are not considered chemical restraints. For further clarification see Mental Retardation Bulletin



00-02-09, issued July 11, 2002, titled *Pro Re Nata Medication Usage for Psychiatric Treatment—Clarification of Interpretation*.

**§ 6000.924. Incident management contingency plan.**

Reportable incidents are to be submitted electronically by means of the HCSIS, a web-based system developed by the Department. In the event that HCSIS is unavailable, the submission of incidents is to occur by following the directions in the Incident Management Contingency Plan. See Appendix J (relating to incident management contingency plan).

**§ 6000.925. Categories of incidents to be investigated.**

The following chart indicates those incidents to be investigated by the provider, the county and OMR. The investigation process does not preclude investigations by law enforcement or other agencies responsible to investigate.

<i>Primary Category</i>	<i>Secondary Category</i>	<i>Entity Responsible for Investigation</i>
Abuse	All	Provider
	Improper or unauthorized use of restraint	Provider and County
Neglect	All	Provider
Rights Violation	All	Provider
Misuse of Funds	All	Provider
Death	When an individual is receiving services from a provider/entity. (See § 6000.911(b)(1)—(3).)	Provider and OMR or Department of Health (county participation as requested by OMR)
Hospitalization	Accidental Injury	Provider
	Unexplained Injury	Provider
	Staff to Individual Injury	Provider
Individual to Individual Abuse	Injury Resulting from Individual to Individual Abuse	Provider
	Injury Resulting from Restraint	Provider and County
Emergency Room Visit	Unexplained Injury	Provider
	Staff to Individual Injury	Provider
	Injury Resulting from Individual to Individual Abuse	Provider

<i>Primary Category</i>	<i>Secondary Category</i>	<i>Entity Responsible for Investigation</i>
	Injury Resulting from Restraint	Provider and County
Injury requiring treatment beyond first aid	Staff to Individual Injury Resulting from Individual to Individual Abuse	Provider Provider
	Injury Resulting from Restraint	Provider and County
Individual to Individual Abuse	Sexual Abuse	Provider

### SEQUENCE OF REPORTING

#### § 6000.931. Multiple categories and sequences.

(a) Many real life occurrences may result in events that may be classified under multiple categories of incidents. In an attempt to assist the point person in identifying an appropriate order for reporting incidents that may be classified under multiple categories, the following sequence is suggested. This sequence may not be appropriate in all situations, but should be used as a guide in selecting the most appropriate category.

(1) *24-Hour Reporting Primary Incident Category.*

- (i) Death.
- (ii) Suicide attempt.
- (iii) Hospitalization.
- (iv) Psychiatric hospitalization.
- (v) Emergency room visit.
- (vi) Abuse.
- (vii) Individual to individual abuse.
- (viii) Neglect.
- (ix) Missing person.
- (x) Injury requiring treatment beyond first aid.
- (xi) Disease reportable to the Department of Health.
- (xii) Fire.
- (xiii) Misuse of funds.
- (xiv) Rights violation.
- (xv) Law enforcement activity.
- (xvi) Emergency closure.

(2) *72-Hour Reporting Primary Incident Category.*

- (i) Medication error.
- (ii) Restraint.

(b) If a death, hospitalization, psychiatric hospitalization, emergency room visit or injury requiring treatment beyond first aid is the result of a medication error or the use of a restraint, a report is to be initiated within 24 hours using the

corresponding primary category. Data about the medication error or the restraint is also to be recorded within 72 hours in the abbreviated HCSIS data entry screens for medication error or restraint.

#### INCIDENT MANAGEMENT PROCESS

##### § 6000.941. Administrative structure.

Providers, supports coordination entities and counties are to create an administrative structure that is sufficient to implement the requirements of this subchapter. Specifically, they shall:

- (1) Assign an individual with overall responsibility for incident management.
- (2) Develop a policy for incident management.
- (3) Ensure that staff, individuals and families are trained on incident management policies and procedures.
- (4) Assign roles within their organization for reporting and investigation of incidents.
- (5) Assure corrective action to individual incidents.
- (6) Conduct analysis of data on incidents and the quality of investigations.
- (7) Identify and implement individual and systemic changes based on risk management analysis.

#### ROLES

##### § 6000.951. Initial reporter.

The initial reporter is any person who witnesses the incident or is the first to discover or be made aware of the signs of an incident. The initial reporter first responds to the situation by taking prompt action to protect the individual's health, safety and rights. The protection may include dialing 911, escorting to medical care or calling ChildLine. As soon as the immediate needs of the person have been met, the initial reporter notifies the provider point person of the incident and receives instructions on next steps to take. The initial reporter documents his observations in a narrative report which is kept in the provider/entity's files. In cases of alleged abuse or neglect, the initial reporter will comply with the applicable laws and regulations. See Appendix F (relating to related laws, regulations and policies).

##### § 6000.952. Point person.

A point person is assigned and authorized to perform specific duties as described in provider/entity or county policy. In general, a point person is to receive verbal or other reports or allegations of incidents from individuals, families and initial reporters. They are to safeguard the individual, ensure that HCSIS Incident Reports are submitted, communicate with others involved in investigations, follow-up and review of incidents. This role is pivotal in the incident management process. When an incident is reported, the point person, as a representative of the agency, is to:

- (1) First confirm that appropriate actions have been taken or order additional actions to secure the safety of the individual involved in the incident.

- (2) Separate the individual from the target when the individual's health and safety may be jeopardized.
- (3) Ensure notification requirements of the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and 23 Pa.C.S. §§ 6301—6384 (relating to Child Protective Services Law) are met.
- (4) Determine whether an investigation or other follow-up is needed.
- (5) Secure the scene of an incident when an investigation may be required.
- (6) Ensure that, when needed, a certified investigator is promptly assigned.
- (7) Notify appropriate supervisory/management personnel within 24 hours of the incident, as specified in provider/entity or county policies.
- (8) Initiate a HCSIS Incident Report within 24 or 72 hours as described in the Reportable Incident section of this bulletin.
- (9) Notify the family within 24 hours (72 hours for medication error and restraint) unless otherwise indicated in the individual support plan.

**§ 6000.953. Incident management representative.**

The incident management (IM) representative is the person designated by the provider with overall responsibility for incident management. This includes the assurance that the activities of the initial reporter and point person have been completed. In addition, the IM representative is responsible for the finalization of the incident report within 30 days of the incident. The IM representative is responsible to evaluate the quality of incident investigations as described in the *Pennsylvania Certified Investigators Manual*, Labor Relations Alternatives, Inc.

**§ 6000.954. Certified investigator.**

A certified investigator is a person who has been trained and received a certificate in investigation from OMR as communicated via Mental Retardation Bulletin 00-01-06, issued September 6, 2001, titled *Announcement of Certified Investigator Training*. Certified investigators are to promptly begin an investigation, when assigned, and are to enter a summary of their investigation findings in the HCSIS Incident Report.

**§ 6000.955. Supports coordinator.**

(a) A support coordinator is a person who is responsible for the coordination of services for an individual and who receives reports from an individual or family. When an individual or a family member informs the supports coordinator of an event that can be categorized as abuse or neglect as defined in this subchapter and there is no relationship as specified in § 6000.911(b)(1)—(3) (relating to providers), the supports coordinator functioning in the point person role is to take prompt action to protect the individual. Once the individual's health and safety are assured, the supports coordinator will ensure a certified investigator is assigned, as necessary, and file a HCSIS Incident Report.

(b) When a family informs their supports coordinator of the death of a relative, the supports coordinator will determine if a report has been filed by a provider. If no provider is required to file the report, the supports coordinator will file a HCSIS Incident Report.

**§ 6000.956. Supports coordinator supervisor/unit manager.**

The supports coordinator supervisor and the supports coordinator unit manager are responsible for the finalizing of HCSIS Incident Reports filed by the supports coordinator.

**§ 6000.957. County incident manager.**

The county incident manager is the person designated by the county with overall responsibility for incident management within his county program. This responsibility includes a review to ensure that incidents are managed and reported in accordance with the process described in this statement of policy and to approve or not approve HCSIS Incident Reports submitted by the provider or supports coordination entity. In addition, the county incident manager is responsible for the final submission of HCSIS Incident Reports filed by the county point person.

**§ 6000.958. Regional incident manager.**

The regional incident manager is the person designated by OMR with overall responsibility for incident management within his region. This responsibility includes a review to ensure that incidents are managed and reported in accordance with the process described in this subchapter and to approve or not approve HCSIS Incident Reports.

**§ 6000.959. Bureau of State Operated Facilities (BSOF) incident manager.**

The BSOF incident manager is the person designated by OMR with overall responsibility for incident management for incidents filed by State-operated facilities. This responsibility includes a review to ensure that incidents are managed and reported in accordance with the process described in this subchapter and to approve or not approve HCSIS Incident Reports.

**TYPES OF INCIDENT REPORTS****§ 6000.961. Standardized incident report.**

The following process applies to the primary incident category to be reported within 24 hours.

(1) The first section of the incident report is to include individual and provider demographics, incident categorization, actions taken to protect the health and safety of the individual, and a description of the incident. See Appendix K (relating to standardized incident report). The first section is to be submitted through HCSIS within 24 hours of the incident being recognized or discovered.

(2) The certified investigator is responsible for conducting certified investigations, completing investigation records and for entering the summary of the investigator's findings into HCSIS. The summary is the compilation of the analysis and findings section of the investigation report. For more information on the analysis and findings section, see the *Pennsylvania Certified Investigation Manual*. The final section of the incident report will retain all of the information

(3) The final section of the incident report will retain all of the information from the first section and will add additional information relevant to the inci-

dent. See Appendix K. The final section is to be submitted through HCSIS within 30 days of the incident being recognized or discovered. If the provider agency determines it will not be able to meet the 30-day reporting timeframes for completion of the final section, notification of an extension is to be made to the county and the regional office of OMR by means of HCSIS prior to the expiration of the 30-day period.

(4) When multiple individuals associated with a provider or entity are involved in certain primary categories and secondary categories of incidents, the incident can be reported using a site report. Only those events designated in the list of reportable incidents as a site report may be filed in this manner.

**§ 6000.962. Abbreviated incident report.**

(a) The following process applies to the primary incident categories requiring reporting within 72 hours. These incidents are not individually approved by the county, OMR regional office or Bureau of State Operated Facilities, but are to have a 30-day analysis completed and maintained by the provider/entity. Analysis of these incidents is to be included in the quarterly report.

(b) Medication errors and the use of restraints are to be reported using the abbreviated HCSIS incident management data entry screens, designed to gather relevant data about these incidents. Data is to be input within 72 hours of the recognition or discovery of the event.

**REVIEW PROCESS**

**§ 6000.971. County review process.**

(a) Within 24 hours of the submission of the first section of the incident report, designated county staff are to review the incident to determine that appropriate actions to protect the individual's health, safety and rights occurred. If the appropriate actions have not taken place, the county staff should immediately communicate their concerns to the appropriate provider/entity staff.

(b) After the provider or entity submits the final section of the HCSIS Incident Report, county staff are to perform a management review within 30 days. Counties will conduct the management review process so that at least 90% of the submitted incident reports are approved or not approved within 30 days of finalization by the provider or supports coordination entity. The management review process is to review the full report and approve or not approve the incident report. This process will include a determination that:

- (1) The appropriate action to protect the individual's health, safety and rights occurred.
- (2) The incident categorization is correct.
- (3) A certified investigation occurred when needed.
- (4) Proper safeguards are in place.
- (5) Corrective action in response to the incident has, or will, take place.

**§ 6000.972. OMR regional office review process.**

(a) Within 24 hours of the submission of the first section of the incident report, designated OMR regional office staff are to review the incident to determine that appropriate action to protect the individual's health, safety and rights

occurred. If the appropriate actions have not taken place the OMR regional office staff should immediately communicate their concerns to the appropriate provider/entity and county staff.

(b) After the county approves the incident report, regional OMR staff are to perform a management review within 30 days. The OMR regional office will conduct the management review process so that at least 90% of the county approved incident reports are approved or not approved within 30 days. The management review process is to review the full report, including the county's response, and approve or not approve the incident report. This process will include a determination that:

- (1) The appropriate action to protect the individual's health, safety and rights occurred.
- (2) The incident categorization is correct.
- (3) A certified investigation occurred when needed.
- (4) Proper safeguards are in place.
- (5) Corrective action in response to the incident has, or will, take place.

#### QUALITY MANAGEMENT

##### § 6000.981. Support to quality management.

The incident management policy described in this subchapter is designed to support provider/entity, county and OMR quality management and risk management structures and practices. As a part of OMR's quality initiatives, the incident management policy is a key component of the OMR Quality Framework and is integral to maintaining OMR's assurance to the Federal Centers for Medicare and Medicaid Services that the health and safety of individuals receiving services will be protected.

##### § 6000.982. Purpose of quality management.

The purpose of quality management within the mental retardation system is to advance the quality of life of people served and supported. OMR assures that through the application of standardized incident management processes, systematic safeguards are in place to protect persons from events that place them at risk. Therefore, each provider and entity covered under the scope of this subchapter is to develop specific policy and procedures to implement a continuous quality improvement process, which includes a risk management and an incident management component. Since there is a wide diversity of agencies/entities responsible for the protection of individuals, the approach to quality management must be tailored to the unique structure of the organization. Agencies should employ standardized approaches to quality management and incident management.

##### § 6000.983. Use of incident data.

(a) HCSIS produces a set of standardized online reports that are available to providers/entities, counties and OMR. In addition to the online reports, providers and counties may request an electronic extract of incident management data through HCSIS.

(b) To assure effective quality and risk management processes, data is collected, aggregated, analyzed and utilized to make improvement decisions. Data

and information in HCSIS are to be continuously, as well as systemically, assessed and analyzed by those individuals responsible for risk management, a risk management group or a risk management committee. The responsibility is to review a representative sample of individual incidents for information about the events, the response to the incident including timeliness, thoroughness and the appropriateness of the corrective actions. This responsibility also includes analysis of data and information using standardized methodology and processes. There are a variety of quality management tools for analysis and trending. These tools assist in either defining, analyzing and preventing incidents or in sustaining improvements already implemented. OMR has begun to conduct training introducing some of these quality management tools and to demonstrate how to use them effectively. The outcome of this assessment and analysis process is to identify strategies for prevention.

**§ 6000.984. Provider incident management quarterly reports.**

(a) Within 60 days following the end of a calendar quarter, a provider/entity is to submit to each county with whom the provider contracts, a qualitative report that describes the analysis of incidents and the systemic interventions implemented to improve the health and safety protections afforded to the individuals served. Supporting data is to be included with the report.

(b) OMR recognizes that providers desire a uniform format for quarterly reporting. A general template will be disseminated by OMR which will give structure to the design of the provider's qualitative quarterly report. This template will be flexible enough to accommodate the wide diversity of agencies/entities involved in the incident management process. Training on this template will occur prior to the first quarterly report due date.

**§ 6000.985. County incident management reports.**

(a) The county MH/MR program is to submit to his respective regional office a semiannual qualitative report on June 1 and December 1 of each year. A general template will be disseminated by OMR which will give structure to the design of the county's qualitative semi-annual report. The report is to describe the analysis of all incidents for individuals registered with the county mental retardation program. The county is to explain the systemic interventions implemented and document instructions to providers that will improve the health and safety protections afforded to the individuals served. Supporting data is to be included with the report. Training on this template will occur prior to the first semi-annual report due date.

(b) OMR will review data on all reported incidents at least semiannually to determine what trends may be developing Statewide, or by county, and take appropriate administrative steps to intervene. OMR will issue an annual report reviewing statewide incident trends.

(c) The following is a review schedule for quality incident management reporting:



<i>Report Period</i>	<i>Provider Report Due to County</i>	<i>County Report Due to OMR Region</i>
July 1—September 30	November 30	June 1
October 1—December 31	February 28	
January 1—March 31	May 31	December 1
April 1—June 30	August 31	

### **Subchapter R. PROCEDURES FOR SURROGATE HEALTH CARE DECISION MAKING**

#### **GENERAL PROVISIONS**

- Sec.  
6000.1001. Scope.  
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#### **HEALTH CARE DECISION MAKING**

- 6000.1011. Competent Individuals.  
6000.1012. Individuals who are not competent and need emergency treatment.  
6000.1013. Individuals who are not competent and who do not have end-stage medical conditions or are not permanently unconscious.  
6000.1014. Individuals who are not competent and who have either end-stage medical conditions or are permanently unconscious.  
6000.1015. Health care power of attorney.  
6000.1016. Limitations on authority of the surrogate health care decision maker.  
6000.1017. Guidance for individuals without family or an advocate.  
6000.1018. Intermediate Care Facility for the Mentally Retarded (ICF/MR) facility director as a guardian.

#### **RECORDS**

- 6000.1021. Access to records.

#### **STATUTES**

- 6000.1031. Applicable statutes.  
6000.1032. Applicability of section 417(c) of the MH/MR Act to health-care decisions.

#### **Source**

The provisions of this Subchapter R adopted January 14, 2011, effective January 15, 2011, 41 Pa.B. 352, unless otherwise noted.

#### **GENERAL PROVISIONS**

##### **§ 6000.1001. Scope.**

Administrative entity administrators and directors, county MH/MR administrators, supports coordination organization directors and providers of MR services

may consider this subchapter with respect to the decisions of surrogate health care decision makers identified under law of the Commonwealth.

**§ 6000.1002. Purpose.**

The purpose of this subchapter is to clarify surrogate health care decision making procedures applicable to individuals with MR who are 18 years of age or older in light of Act 169 and other applicable law.

**§ 6000.1003. Definitions.**

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

*Act 169*—Act 2006-169, which added 20 Pa.C.S. Chapter 54 (relating to health care).

*Act 28 facility*—A nursing home, personal care home, domiciliary care home, community residential facility, State-operated intermediate care facility for the mentally retarded, privately operated intermediate care facility for the mentally retarded, adult daily living center, home health agency or home health service provider whether licensed or not. See 18 Pa.C.S. § 2713 (relating to neglect of care-dependent person).

*Advance health care directive*—The term as defined in 20 Pa.C.S. § 5422 (relating to definitions). An advance health care directive is a signed and witnessed document which directs health care in the event that the individual (the principal) is incompetent and has an end-stage medical condition or is permanently unconscious. It also may designate a person to carry out the individual's wishes regarding health care at the end of life.

*CPR—Cardiopulmonary Resuscitation*—The term as defined in 20 Pa.C.S. § 5422.

*Competent*—The term as defined in 20 Pa.C.S. § 5422. Under Act 169, the attending physician determines competency.

*DNR Order—Do not resuscitate order*—An order in the individual's medical record that CPR should not be provided to the individual.

*End stage medical condition*—The term as defined in 20 Pa.C.S. § 5422.

*Facility director*—

(i) For those facilities that are MR facilities as defined in the MH/MR Act, the facility director is the administrative head of a facility.

(ii) In facilities licensed under Chapter 6400 (relating to community homes for individuals with mental retardation), the term means the chief executive officer under § 6400.43 (relating to chief executive officer).

(iii) In facilities licensed under Chapter 6500 (relating to family living homes), the term means the chief executive officer under § 6500.42 (relating to chief executive officer).

(iv) In intermediate care facilities for persons with mental retardation, the term means the administrator appointed under 42 CFR 483.410(a)(3) (relating to condition of participation: governing body and management).

(v) In facilities licensed under Chapter 5310 (relating to community residential rehabilitation services for the mentally ill), the term means the director selected under § 5310.11 (relating to governing body).

(vi) In facilities licensed under Chapter 5320 (relating to requirements for long-term structured residence licensure), the term means the program director selected under § 5320.22 (relating to governing body).

*Health care*—The term as defined in 20 Pa.C.S. § 5422.

*Health care agent*—The term as defined in 20 Pa.C.S. § 5422.

*Health care decision*—The term as defined in 20 Pa.C.S. § 5422.

*Health care power of attorney*—The term as defined in 20 Pa.C.S. § 5422.

A health care power of attorney is the actual document declaring an individual to make health care decisions for the principal. The person designated in a health care power of attorney is sometimes referred to as the “health care agent.”

*Health care provider*—The term as defined in 20 Pa.C.S. § 5422.

*Health care representative*—The term as defined in 20 Pa.C.S. § 5422. In addition, Act 169 specifies the following limitation on designation of the health care representative: Unless related by blood, marriage or adoption, a health care representative may not be the principal’s attending physician or other health care provider, not an owner, operator or employee of a health care provider in which the principal receives care.

*Incompetent*—The term as defined in 20 Pa.C.S. § 5422.

*Living will*—The term as defined in 20 Pa.C.S. § 5422.

*MH/MR Act*—The Mental Health and Mental Retardation Act of 1966 (50 P. S. §§ 4101—4704).

*MH*—Mental health.

*MR*—Mental retardation.

*Mental health advance directive*—A document that directs MH services and supports that an individual might want to receive during a crisis if the individual is unable to make decisions because of the individual’s mental illness. This is a separate document from an advance health care directive. See 20 Pa.C.S. Chapter 58 (relating to mental health care).

*Permanently unconscious*—The term as defined in 20 Pa.C.S. § 5422.

*Person*—The term as defined in 1 Pa.C.S. § 1991 (relating to definitions).

*Principal*—The term as defined in 20 Pa.C.S. § 5422. The principal is at least 18 years of age, has graduated from high school, has married or is an emancipated minor.

*Surrogate health care decision maker*—A person that makes health care decisions for another individual.

### HEALTH CARE DECISION MAKING

#### § 6000.1011. Competent individuals.

(a) The health care or end of life decisions of an individual who is competent should be honored.

(b) Competent individuals may also execute advance health care directives in accordance with 20 Pa.C.S. Chapter 54 (relating to health care).

(c) Competent individuals should be encouraged to make advance health care directives which will become operative if they lose competency unless revoked in accordance with 20 Pa.C.S. Chapter 54.

(d) Advance health care directives should be reviewed and updated in writing periodically.

**§ 6000.1012. Individuals who are not competent and need emergency treatment.**

Consent is implied in law for emergencies and there is no need to seek a surrogate health care decision maker before providing emergency medical treatment. See the Medical Care Availability and Reduction of Error (MCARE) Act (40 P.S. §§ 1303.101—1303.1115); *In re Dorone*, 534 A.2d 452 (Pa. 1987).

**§ 6000.1013. Individuals who are not competent and who do not have end-stage medical conditions or are not permanently unconscious.**

(a) If an individual is not competent to make a particular nonemergent health care decision, another person must make that decision on the individual's behalf.

(b) Under Act 169, when a guardian, health care agent or health care representative will be making the decision, the attending physician determines whether an individual has an end stage medical condition or is permanently unconscious.

(c) When a surrogate health care decision maker is needed to make a non-emergent health care decision for an individual who neither has an end-stage medical condition nor is permanently unconscious, the health care decision maker should be chosen in the following order:

(1) *Health care agent.* If the individual, while competent, has executed a valid advance health care directive that designates a health care agent and the health care agent is available and willing to make the decision, the health care agent should make the health care decision for the individual. See 20 Pa.C.S. Chapter 54, Subchapter C (relating to health care agents and representatives).

(2) *Guardian of the individual's person.*

(i) If, under Pennsylvania's guardianship statute (20 Pa.C.S. Chapter 55 (relating to incapacitated persons)), a court has already appointed a guardian to make health care decisions on the individual's behalf, the guardian should make those decisions for the individual.

(ii) If a person who executed a valid health care power of attorney is later adjudicated an incapacitated person and a guardian of the person is appointed by the court to make health care decisions, the health care agent named in the health care power of attorney is accountable to both the guardian and the individual.

(iii) The guardian has the same power to revoke or amend the appointment of a health care agent as the individual would have if he were not incapacitated, but may not revoke or amend the instructions in an advance health

care directive absent judicial authorization. See 20 Pa.C.S. § 5460(a) (relating to relation of health care agent to court-appointed guardian and other agents).

(3) *Health care representative.*

(i) In the absence of a health care agent designated under a valid advance health care directive or a court-appointed guardian of the person with authority to make health decisions, an available and willing health care representative should make the health care decision.

(ii) In descending order of priority, the following persons can act as health care representatives for individuals:

(A) A person chosen by the individual (in a signed writing or by informing the individual's attending physician) while the individual was of sound mind.

(B) The individual's spouse (unless a divorce action is pending).

(C) The individual's adult child.

(D) The individual's parent.

(E) The individual's adult brother or sister.

(F) The individual's adult grandchild.

(G) An adult who has knowledge of the individual's preferences and values. See 20 Pa.C.S. Chapter 54, Subchapter C.

(4) *Facility director.*

(i) In the absence of any other appointed decision maker or willing next of kin, the facility director becomes the health care decision maker under the MH/MR Act.

(ii) Under the MH/MR Act, the director of a facility may, with the advice of two physicians not employed by the facility, determine when elective surgery should be performed upon any mentally disabled person admitted or committed to the facility when the person does not have a living parent, spouse, issue, next of kin or legal guardian as fully and to the same effect as if the director had been appointed guardian and had applied to and received the approval of an appropriate court therefor.

(iii) Section 417(c) of the MH/MR Act (50 P.S. § 4417(c)) specifies that the facility director may authorize elective surgery, but the Department has consistently interpreted that section to recognize that the facility director's authority also encompasses health care decisions generally.

(iv) The facility director may authorize elective surgery and other treatment only with the advice of two physicians not employed by the facility.

(v) When the facility director becomes the surrogate health care decision maker for an individual who does not have an end-stage medical condition or is not permanently unconscious, the director should first review the individual's support plan and relevant medical history and records to help identify the individual's medical status historically and immediately prior to making a surrogate health care decision.

(vi) The facility director should be informed of the decision to be made and gather information based on the direct knowledge of those familiar with the individual.

(vii) In this manner, the facility director will have sufficient information to make the decision that the individual would make if able to do so.

(viii) Even when another surrogate health care decision maker is identified, the facility director should continue to monitor the situation to ensure that decisions are made with the best interest of the individual as the paramount concern.

(ix) In the event of a short-term absence of the facility director, the director may assign a designee to perform these functions.

(x) The assigned designee may only be a person authorized to perform the facility director's functions in the director's absence.

(xi) The facility director may not authorize a DNR order for a person who is not competent and does not have an end-stage medical condition.

**§ 6000.1014. Individuals who are not competent and who have either end-stage medical conditions or are permanently unconscious.**

(a) Under Act 169, when a guardian, health care agent or health care representative will be making the decision, the attending physician determines whether an individual has an end stage medical condition or is permanently unconscious.

(b) In contrast, the MH/MR Act, which applies to health care decisions by facility directors, requires the advice of two physicians for recommended treatment of health care conditions, including end stage medical conditions.

(c) When a surrogate health care decision maker is needed to make a non-emergent health care decision for an individual who has an end-stage medical condition or is permanently unconscious and who has not executed a valid living will that governs the decision, the surrogate health care decision maker should be chosen in the following order:

(1) *Health care agent.* If the individual, while competent, has executed a valid advance health care directive that designates a health care agent and the health care agent is available and willing to make the decision, the health care agent should make health care decisions for the individual.

(2) *Guardian of the individual's person.*

(i) If, under Pennsylvania's guardianship statute, a court has already appointed a guardian of the person to make health care decisions on the individual's behalf, the guardian should make the decisions for the individual.

(ii) If a person who executed a valid health care power of attorney is later adjudicated an incapacitated person and a guardian of the person is appointed by the court to make medical decisions, the health care agent named in the health care power of attorney is accountable to both the guardian and the individual.

(iii) The guardian has the same power to revoke or amend the appointment of a health care agent as the individual would have if he were not incapacitated, but may not revoke or amend the instructions in an advance health care directive absent judicial authorization.

(3) *Health care representative.*

(i) In the absence of a health care agent designated under a valid advance health care directive or a court-appointed guardian of the person

with authority to make health care decisions, an available and willing health care representative should make the health care decision.

(ii) In descending order of priority, the following individuals can act as health care representatives for individuals:

(A) A person chosen by the individual (in a signed writing or by informing the individual's attending physician) while the individual was of sound mind.

(B) The individual's spouse (unless a divorce action is pending).

(C) The individual's adult child.

(D) The individual's parent.

(E) The individual's adult brother or sister.

(F) The individual's adult grandchild.

(G) An adult who has knowledge of the individual's preferences and values.

(4) *Facility director.*

(i) In the absence of any other appointed decision maker or willing next of kin, the facility director in his discretion becomes the surrogate health care decision maker under section 417(c) of the MH/MR Act.

(ii) Section 417(c) of the MH/MR Act specifies that the facility director may authorize elective surgery, but the Department has consistently interpreted that section to recognize that the facility director's authority also encompasses health care decisions generally.

(iii) The facility director may authorize elective surgery and other treatment only with the advice of two physicians not employed by the facility.

(iv) When the facility director becomes the surrogate health care decision maker for an individual who has an end-stage medical condition or is permanently unconscious, the director shall first review the individual's support plan and relevant medical history and records to help identify the individual's medical status historically and immediately prior to making a surrogate health care decision.

(v) The facility director must be informed of the decision to be made and gather information based on the direct knowledge of those familiar with the individual.

(vi) In this manner, the facility director will have sufficient information to make the decision that the individual would make if able to do so.

(vii) For a decision to withdraw treatment or life-sustaining care for a person who is not competent who has an end-stage medical condition or is permanently unconscious, the Department recommends a facility director seek judicial authorization prior to the withdrawal of treatment or life-sustaining care due to a risk of conflict of interest claims.

(viii) For a DNR order for a person who is not competent who has an end-stage medical condition or is permanently unconscious, the Department recommends a facility director seek judicial authorization prior to requesting the issuance of a DNR order due to a risk of conflict of interest claims.

(ix) Pending the judicial authorization under subparagraphs (vii) and (viii), the Department recommends a facility director direct that treatment or

life-sustaining care be continued for a person who is not competent who has an end-stage medical condition or is permanently unconscious.

(x) Even when another surrogate health care decision maker is identified, the facility director should continue to monitor the situation to ensure that decisions are made with the best interest of the individual as the paramount concern.

(xi) In the event of a short-term absence of the facility director, the director may assign a designee to perform these functions.

(xii) The assigned designee may only be a person authorized to perform the facility director's functions in the director's absence.

(d) In the rare circumstance that the individual with an end-stage medical condition or who is permanently unconscious does not have a living will, health care agent, court-appointed guardian, available and willing health care representative or facility director, then a court should appoint a guardian with authority to act. Appropriate medical care should be provided pending the appointment of a guardian.

(e) In reaching decisions about appropriate care, the following may be helpful:

(1) Holding a team meeting including the health care provider, the family/health care representative, the mental retardation service provider and any other interested parties to clarify the issues and each party's understanding of the situation.

(2) Involving the palliative care team, the patient advocate, or both, at a hospital to act as an objective party and help communicate issues and assist each party in understanding the situation.

(3) Using hospital ethics committees to review situations.

(4) Having a second medical or surgical opinion, which can sometimes clarify the prognosis or possible treatments for a particular condition.

(5) As a last resort, pursuing resolution through the courts.

#### **§ 6000.1015. Health care power of attorney.**

(a) Unless otherwise specified in the health care power of attorney, a health care power of attorney becomes operative when the following occurs:

(1) A copy is provided to the attending physician.

(2) The attending physician has determined that the principal is incompetent. See 20 Pa.C.S. §§ 5422 and 5454(a) (relating to definitions; and when health care power of attorney operative).

(b) Unless otherwise specified in the health care power of attorney, a health care power of attorney becomes inoperative when, in the determination of the attending physician, the principal is competent.

#### **§ 6000.1016. Limitations on authority of the surrogate health care decision maker.**

(a) A surrogate health care decision maker may not execute an advance health care directive or name a health care agent on behalf of an incompetent individual.



(b) Under 20 Pa.C.S. Chapter 54 (relating to health care) and applicable case law (see *In re D.L.H.*, 2 A.2d. 505 (Pa. 2010)), neither a health care representative nor a guardian nor a facility director has authority to refuse life-preserving care for a person who has a life-threatening medical condition, but is neither in an end-stage medical condition nor permanently unconscious.

(c) Title 20 Pa.C.S. § 5462(c)(1) (relating to duties of attending physician and health care provider) provides:

“Health care necessary to preserve life shall be provided to an individual who has neither an end-stage medical condition nor is permanently unconscious, except if the individual is competent and objects to such care or a health care agent objects on behalf of the principal if authorized to do so by the health care power of attorney or living will.”

(d) A residential facility as defined by Act 28 must provide necessary treatment, care, goods or services to an individual except where otherwise permitted under 18 Pa.C.S. § 2713(e) (relating to neglect of care-dependent person) as follows:

(1) The caretaker’s, individual’s, or facility’s lawful compliance with a care-dependent person’s living will as provided in 20 Pa.C.S. Chapter 54.

(2) The caretaker’s, individual’s, or facility’s lawful compliance with a care-dependent person’s written, signed, and witnessed instructions, executed when the care-dependent person is competent as to the treatment he wishes to receive.

(3) The caretaker’s, individual’s or facility’s lawful compliance with the direction of one of the following:

(i) An agent acting under a lawful durable power of attorney under 20 Pa.C.S. Chapter 56 (relating to powers of attorney), within the scope of that power.

(ii) A health care agent acting under a health care power of attorney under 20 Pa.C.S. Chapter 54, Subchapter C (relating to health care agents and representatives), within the scope of that power.

(4) The caretaker’s, individual’s, or facility’s lawful compliance with a DNR order written and signed by the care-dependent person’s attending physician. Generally, a DNR order is appropriate in the presence of an end-stage medical condition.

(5) The caretaker’s, individual’s, or facility’s lawful compliance with the direction of a care-dependent person’s health care representative under 20 Pa.C.S. § 5461 (relating to decisions by health care representative), provided the care dependent person has an end-stage medical condition or is permanently unconscious as these terms are defined in 20 Pa.C.S. § 5422 (relating to definitions) as determined and documented in the person’s medical record by the person’s attending physician.

### **§ 6000.1017. Guidance for individuals without family or an advocate.**

(a) For individuals that may not have living family members or anyone that is currently advocating for them, the county or administrative entity, supports coordination organization, or the provider agency working with the individual

should help the individual identify someone who knows the individual and would be willing to act as the individual's health care representative.

(b) The health care representative may be a friend, a family friend, someone in the individual's church or neighborhood, or someone that has worked with the individual in the past, but is no longer actively providing their services.

**§ 6000.1018. Intermediate Care Facility for the Mentally Retarded (ICF/MR) facility director as a guardian.**

The prohibition in 20 Pa.C.S. § 5461(f) (relating to decisions by health care representative) on a health care provider's being a health care representative is not applicable to a facility director under section 417(c) of the MH/MR Act (50 P.S. § 4417(c)), regarding powers and duties of directors, because a facility director is made a guardian under that section, not a health care representative.

### RECORDS

**§ 6000.1021. Access to records.**

Under the Health Insurance Portability and Accountability Act (HIPAA), guardians, agents or representatives as medical surrogates have the same access to medical records that the principal does. See 45 CFR 164.502(g) and 164.510(b)(3) (relating to uses and disclosures of protected health information: general rules; and uses and disclosures requiring an opportunity for the individual to agree or to object).

### STATUTES

**§ 6000.1031. Applicable statutes.**

Several other statutes also govern health care decision making, and were not repealed by Act 169. Accordingly, they remain in effect. These statutes include the following:

- (1) Title 18 Pa.C.S. § 2713 (relating to neglect of care-dependent person).
- (2) Title 20 Pa.C.S. Chapter 55 (relating to incapacitated persons).
- (3) The Medical Care Availability and Reduction of Error (MCARE) Act (40 P.S. §§ 1303.101—1303.115).
- (4) Section 417(c) of the MH/MR Act (50 P.S. § 4417(c)), regarding powers and duties of directors.

**§ 6000.1032. Applicability of section 417(c) of the MH/MR Act to health-care decisions.**

(a) Notwithstanding that section 417(c) of the MH/MR Act (50 P.S. § 4417(c)), regarding powers and duties of directors, explicitly references only "elective surgery," that section should be read as applicable to health care decisions generally.

(b) A facility director's authority under section 417(c) of the MH/MR Act should be construed to include authority to make decisions regarding palliative care for persons in an end-stage (terminal) condition.

(c) For care provided in the MR facility itself, no surrogate consent is needed because 18 Pa.C.S. § 2713 (relating to neglect of care-dependent person) requires that necessary care and treatment be provided without it.

(d) For care outside the mental retardation facility, such as a doctor's office or hospital, the primary care physician (PCP) and the specialist performing the procedure can serve as the two physicians (except in the rare circumstance where the PCP is a payroll employee of the MR facility) required under section 417(c) of the MH/MR Act.

#### APPENDIX A. [Reserved]

##### Source

The provisions of this Appendix A adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3703; reserved August 9, 1991, effective November 8, 1991, 21 Pa.B. 3595. Immediately preceding text appears at serial pages (131329) to (131333).

#### APPENDIX B LICENSING WEIGHTING SYSTEM FOR VOCATIONAL FACILITIES WEIGHTS OF REGULATIONS

<i>General Requirements</i>	<i>Subject</i>	<i>Weight</i>	<i>Rounded Weight</i>
2390.11	Application	5.12	5
2390.14(a)	Labor & Industry—Fire Safety Approval	8.33	8
2390.14(b)	Written Annual Verification	6.61	7
2390.15(a)	Interstate Commerce—Fed. Wage & Hour Certificate	5.58	6
2390.15(b)	Intrastate Commerce—State Certificate	5.30	5
2390.15(c)	Interstate & Intrastate Commerce—Fed./State Certificate	5.01	5
2390.16	Public Eating & Drinking Certificate	7.38	7
2390.17	Written Statement of Purpose	4.49	4
2390.18(a)	Unusual Incident Report	6.87	7
2390.18(a)	Unusual Incident Report—24 hours	5.78	6
2390.18(b)	Unusual Incident Report—weekend	5.71	6
2390.19(a)	Abuse—Past 12 months	8.81	9
2390.19(b)	Abuse Reported—24 hours	8.64	9
2390.19(c)	Investigated Abuse—24 hours	7.86	8
2390.19(c)	Abuse Report—Support or Deny Allocation	7.55	8
2390.19(c)	Implement Change—Prevent Abuse	8.60	9
2390.19(d)	Criminal Abuse Reported Immediately	8.76	9
2390.20	Written Accident Prevention Policy	7.87	8
2390.21(a)	Discrimination	7.28	7
2390.21(a)	Civil & Legal Rights	7.68	8
2390.21(b)	Civil Rights Policy & Procedure	6.92	7
2390.22(a)	Governing Body	4.87	5
2390.22(b)	Governing Body—Financial Benefit	4.08	4
2390.22(c)	Conflict of Interest	4.21	4
2390.22(d)	Governing Body—Quarterly Meeting	3.49	3
2390.22(e)	Financial Reports—Review/Approval	3.82	4
2390.22(f)	Annual Program Report—Review/Approval	4.12	4
2390.23	Sound & Ethical Pract.	4.90	5
			<i>Rounded</i>
<i>Staffing</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.32(a)	Chief Executive Officer/Employed	5.49	5
2390.32(a)	Chief Executive Officer/Designee	5.33	5

<i>General Requirements</i>	<i>Subject</i>	<i>Weight</i>	<i>Rounded Weight</i>
2390.32(b)	Chief Executive Officer/Responsibilities	6.34	6
2390.32(c)	Chief Executive Officer/Qualifications	4.60	5
2390.33(a)	1:45 Program Specialist/Client Ratio	6.12	6
2390.33(b)	Program Specialist Responsibility	5.91	6
2390.33(c)	Program Specialist Qualification	5.21	5
2390.34(a)	One Production Manager	5.58	6
2390.34(b)	Production Manager Responsibility	5.26	5
2390.34(c)	Production Manager Qualifications	4.67	5
2390.35(a)	1:15 Floor Supervisor Ratio	6.60	7
2390.35(b)	Floor Supervisor Physically Present	6.56	7
2390.35(c)	Floor Supervisor Responsibility	6.95	7
2390.35(d)	Floor Supervisor Qualifications	5.11	5
2390.36(a)	1:10 Trainer Ratio	6.29	6
2390.36(b)	Trainer Responsibilities	6.00	6
2390.36(c)	Trainer Qualifications	5.06	5
2390.37(a)	Vocational Evaluator Employed	5.53	6
2390.37(b)	Vocational Evaluator Responsibilities	5.40	5
2390.37(c)	Vocational Evaluator Qualifications	5.09	5
2390.38(a)	Program Specialist & Floor Supervisor (ten or more clients)	5.67	6
2390.38(b)	Qualifications—2 Staff Positions	5.40	5
2390.39(a)	2 Staff Present—10 or More Clients	6.97	7
2390.39(b)	1 Staff Present—Fewer than 10 Clients	7.74	8
2390.39(c)	1 Qualified Program Specialist—20 or more clients	5.94	6
2390.40(a)	Orientation for Staff	6.54	7
2390.40(b)	24 Hrs Staff Training	5.42	5
2390.40(c)	Records of Training on file	4.15	4
			<i>Rounded</i>
<i>Physical Site</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.51	Accommodations for Physically Handicapped	7.91	8
2390.52(a)	80 Sq. Ft. Indoor Floor Space	5.69	6
2390.52(b)	60 Sq. Ft. Indoor Floor Space	5.64	6
2390.53	Outside Walks—Free of Hazards	8.17	8
2390.54	Combustible Supplies	8.59	9
2390.55(a)	Trash Removed—Once/Week	6.97	7
2390.55(b)	Insects/Rodents	7.64	8
2390.56	Hot & Cold Water—Bathroom & Kitchen	7.87	8
2390.57	Indoor Temperature—65° F-90° F	7.22	7
2390.58	Operable, Non-Coin Telephone	6.64	7
2390.59	Emergency Numbers Posted	7.72	8
2390.60(a)	First Aid Area	6.50	7
2390.60(b)	First Aid Area/Equipment	7.12	7
2390.60(c)	First Aid Accessible to Staff	7.33	7
2390.60(d)	First Aid Kit Contents	7.32	7
2390.61	Surfaces—Free of Hazards	7.36	7
2390.62	Sanitary Conditions Maintained	7.79	8
2390.63	Adequate Lighting	8.08	8
2390.64	Well-Secured Handrails	8.06	8
2390.65	Interior Stairs—Nonskid Surfaces	7.65	8

<i>General</i>		<i>Rounded</i>	
<i>Requirements</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.66	Landings Provided	7.33	7
2390.67	Conditions—Safe & Sanitary	7.32	7
2390.68	Hazardous Equipment—Guard & Safety Devices	8.64	9
2390.69	Protective Equipment Worn	8.65	9
2390.70	Equipment—Visual, Auditory & Tactile Signals	8.13	8
2390.71(a)	Ventilation	7.32	7
2390.71(b)	Mechanical Exhaust—Toxic, Dust & Odor	8.49	8
2390.72(a)	Passages & Work Aisles—& Unobstructed	7.76	8
2390.72(b)	Work aisles—36 inches wide	6.45	6
2390.72(c)	Work aisles—marked—2" wide	5.62	6
2390.72(c)	Visually Handicapped—Tactile Guides	6.24	6
2390.73	Elevator—labor & industry approval	7.88	8
2390.74(a)	Lavatories—physically handicapped	7.36	7
2390.74(b)	1:30 Toilet Ratio	6.44	6
2390.74(c)	Separate Lavatories for Men & Women	5.92	6
2390.74(d)	Lavatory—Required Equip.	6.37	6
2390.75(a)(1)	Food Protection & Storage	8.37	8
2390.75(a)(2)	Food—Proper Temperatures	8.17	8
2390.75(a)(3)	Utensils—washed with mechanical dishwasher	7.24	7
2390.75(a)(4)	Mechanical dishwasher—required temperatures	7.67	8
2390.75(a)(5)	Mechanical dishwasher—manufacturers instructions	6.92	7
2390.75(b)	Dining Area	5.33	5
2390.75(b)(1)	Dining Area Clear	6.88	7
2390.75(b)(2)	Dining Area—Table & Chairs	5.82	6
<i>Fire Safety</i>		<i>Rounded</i>	
	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.81	Corridors & Exits Unobstructed	8.42	8
2390.82(a)	Emergency Evacuation Procedures	7.88	8
2390.82(b)	Fire Safety Inspection or Notification	7.92	8
2390.83(a)	Operable Fire Alarm	8.56	9
2390.83(b)	Fire Alarm Checked	7.94	8
2390.83(b)	Written Record of Fire Alarm Check	7.01	7
2390.83(c)	Notification for Repair 24 Hours	7.85	8
2390.83(c)	Written Procedure—Fire Safety	7.58	8
2390.84(a)	10 ABC Fire Extinguishers	8.14	8
2390.84(b)	Fire Extinguishers—100 Feet	7.86	8
2390.84(c)	10B Fire Extinguishers—Kitchen	8.24	8
2390.84(d)	Fire Extinguisher Under 45 Pounds—Mounted	7.59	8
2390.84(e)	Fire Extinguisher Over 45 Pounds—Wheeled Unit	7.42	7
2390.84(f)	Fire Extinguisher—Accessible	8.14	8
2390.84(g)	Fire Extinguisher—Inspection & Approval	8.04	8
2390.85(a)	Fire Drill—Every 90 Days	7.73	8
2390.85(a)	Written Fire Drill Record	6.45	7
2390.85(b)	Fire Drills—Different Times	6.31	6
2390.85(b)	Hypothetical Location—Different	6.44	6
2390.85(c)	Clients Evacuation—Fire Drill	7.40	7
2390.85(d)	Fire Alarms Tested	7.56	8
2390.86	Signs—EXIT—Plain and Legible	7.90	8

		<i>Rounded</i>	
<i>Fire Safety</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.86	Exits Marked	7.83	8
2390.86	Exits Sign Letters—3/4 Inches Wide	6.76	7
2390.86	Tactile Exit Markings	7.18	7
2390.87	Instructed in General Fire Safety	7.40	7
		<i>Rounded</i>	
<i>Program</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.91	Activities for Clients	5.99	6
2390.91	Individual Written Program Plan Provided	5.94	6
2390.92	20% Remunerative Work	5.29	5
2390.93	Work Training—Development Program	5.54	6
2390.94(a)	Written Assessment—20 Days	5.24	5
2390.94(b)	Initial Assessment by Program Specialist or Vocational Evaluator	5.10	5
2390.94(c)	Copy of Initial Assessment	4.92	5
2390.94(d)(1)	Document of Client’s Disability	6.40	6
2390.94(d)(2)	Level of Vocational Functioning	5.55	6
2390.94(d)(3)	Vocational Interests	5.17	5
2390.94(d)(4)	Ability for Instructions	5.95	6
2390.94(d)(5)	Recommendations for Specific Areas of Training	5.76	6
<i>General Requirements</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.94(e)	Written Statement Signed	5.14	5
2390.95(a)	Individual Written Program Plan (IWPP) Developed—30 Days	5.62	6
2390.95(b)	IWPP Developed—Interdisciplinary Team	5.44	5
2390.95(b)	IWPP—Signature and Dated—Interdisciplinary Team	4.44	4
2390.96(1)	IWPP—Short Term Objectives	5.60	6
2390.96(2)	IWPP—Current Skill Level	5.63	6
2390.96(3)	IWPP—Time Frames	5.13	5
2390.96(4)	IWPP—Method of Evaluation	5.21	5
2390.96(5)	IWPP—Service Areas	5.27	5
2390.96(6)	IWPP—Staff Responsible	5.42	5
2390.96(7)	IWPP—Placement Potential	5.23	5
2390.97(a)	IWPP—Reviewed and Updated—65 days	5.24	5
2390.97(b)	IWPP—Reviewed and Updated—20 days	4.95	5
2390.97(c)	IWPP—Signed by Program Specialist & Client	5.40	5
2390.97(d)	IWPP—Reviewed and Rewritten Annually	5.77	6
2390.97(d)	IWPP—Signed and Dated Revised IWPP	4.65	5
2390.98(a)	IWPP—Copy in Client’s File	5.18	5
2390.98(b)	IWPP—Invitation to Client or Parent	4.96	5
2390.98(c)	IWPP—Provided Copy	4.81	5
2390.99	IWPP—Client Needs Met	5.73	6
2390.100(1)	Vocational Evaluation by Vocational Evaluator	5.24	5
2390.100(2)	Vocational Evaluation in Client’s File	5.19	5
2390.100(3)(i)	Vocational Evaluation of Client’s Vocational Level	5.44	5
2390.100(3)(ii)	Vocational Evaluation—Include Employers Objectives	5.23	5
2390.100(3)(iii)	Vocational Evaluation—Include Vocational Interests	5.15	5

<i>General</i>		<i>Weight</i>	<i>Weight</i>
<i>Requirements</i>	<i>Subject</i>		
2390.100(3)(iv)	Vocational Evaluation—Include Client's Personal & Social Adjustment Level	5.40	5
2390.100(3)(v)	Vocational Evaluation—Work Attitude	5.31	5
2390.100(3)(vi)	Vocational Evaluation—Include Fatigue Level	5.88	6
2390.100(3)(vii)	Vocational Evaluation—Include Client's Ability to Follow Instructions	6.08	6
2390.100(3)(viii)	Vocational Evaluation—Recommendation for Specific Areas	5.72	6
2390.100(4)	Vocational Evaluation—Signed Statement	5.37	5
			<i>Rounded</i>
<i>Health</i>		<i>Weight</i>	<i>Weight</i>
	<i>Subject</i>		
2390.101	Communicable Disease	8.37	8
2390.102	First Aid Technique—1 Certified Staff Member	8.15	8
2390.103	Written Emergency Medical Plan	7.92	8
2390.104	Emergency Information Accessible	8.27	8
2390.104	Emergency Medical Information	8.32	8
			<i>Rounded</i>
<i>Admission and Placement</i>		<i>Weight</i>	<i>Weight</i>
	<i>Subject</i>		
2390.111(a)	Client—Preadmission Interview	5.24	5
2390.111(b)	Notification—30 Days	4.41	4
2390.111(b)	Notification—Specify Service and Reason for Decision	4.62	5
2390.111(c)	Kept on File for 3 Years	3.36	3
2390.112(a)	Clients Oriented to Facility	6.27	6
2390.112(a)	Orientation Date—Client's Record	4.21	4
2390.112(b)	Written Information Upon Admission	5.81	6
2390.112(b)	Written Statement in Client's Record	5.17	5
2390.113(b)	Arrangements for Placement Services	5.94	6
2390.113(b)	Placement Services—Staff Responsibility	5.46	5
2390.113(c)(1)	Placement Services—Employer Information	5.54	6
2390.113(c)(2)	Placement Services—Notification	5.56	6
2390.113(c)(3)	Placement Services—Client Participation	5.95	6
2390.113(c)(4)	Placement Services—Clients Abilities	6.29	6
2390.113(c)(5)	Placement Services—Follow-Up Activities	6.47	6
2390.113(d)	Documents of Competitive Employment	5.08	5
2390.113(e)	Placement Services Component Written	4.67	5
			<i>Rounded</i>
<i>Client Records</i>		<i>Weight</i>	<i>Weight</i>
	<i>Subject</i>		
2390.121	Individual Record	6.44	6
2390.121	Legible, Dated and Signed	5.81	6
2390.122	Records Kept at Facility	6.01	6
2390.122	Records Kept 3 Years	4.23	4
2390.123	Confidential & Locked	6.87	7
2390.124	Information—Records	6.60	7
2390.125	Policy on Access to Records	5.89	6
2390.126(a)	Client/Parent/Guardian Access	6.01	6
2390.126(b)	Facility Responsible	6.32	6
2390.127	Written Consent—Release of Information	6.46	6

			<i>Rounded</i>
<i>Client Records</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
<i>Handicapped</i>			<i>Rounded</i>
<i>Employment</i>	<i>Subject</i>	<i>Weight</i>	<i>Weight</i>
2390.141	Written Documentation—Individual Client	5.16	5
2390.143(a)	Completed Work Performance Review	5.30	5
2390.143(b)(1)	Work Performance Review Quantity and Quality	5.30	5
2390.143(b)(2)	Work Performance Review Changes in Production	5.07	5
2390.143(b)(3)	Upward Movement to Competitive Employment	5.41	5
2390.143(b)(4)	Work Related Problems	5.53	6
2390.143(c)	Copy Provided	4.93	5
2390.144	1:20 Floor Supervisor Ratio	6.41	6

**Source**

The provisions of this Appendix B adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3703.

**Cross References**

This appendix cited in 55 Pa. Code § 6000.311 (relating to computation of weighted score).



## APPENDIX C

<b>INCIDENT OR UNUSUAL INCIDENT REPORT</b>		DATE OF REPORT:	TIME:
NAME OF CLIENT (Last, First, M.I.)		PROVIDER NAME:	
ADDRESS:		ADDRESS:	
CITY	STATE	ZIP CODE	CITY STATE ZIP CODE
PHONE:		PHONE:	
BSU NUMBER: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		COUNTY WHERE FACILITY IS LOCATED:	
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF ADMISSION:	
LEVEL OF MENTAL RETARDATION:		DATE OF INCIDENT:	TIME: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
LOCATION OF INCIDENT (Bathroom, Hall, Program Area, etc.):		FACILITY/AGENCY LICENSE NUMBER:	
DESCRIBE IN DETAIL EXACTLY WHAT HAPPENED AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE INCIDENT/UNUSUAL INCIDENT: (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
DESCRIPTION OF ANY INJURY:			
PHYSICIAN'S NAME AND STATEMENT (if applicable) - INCLUDE TREATMENT AND FOLLOW-UP ACTION:			
ACTION TAKEN:			
OTHER PERTINENT INFORMATION (Seizures, Visual Impairment, Safety Conditions, etc.):			
RELATIVE OR GUARDIAN NOTIFIED:	RELATIONSHIP:	ADDRESS:	PHONE:
TYPED/PRINTED NAME AND SIGNATURE OF PERSON REPORTING:		TITLE:	PHONE:
TYPED NAME:	SIGNATURE:		
DATE MAILED TO:			
_____ REGIONAL OFFICE OF MENTAL RETARDATION	_____ OFFICE OF CHILDREN, YOUTH & FAMILIES (Early Intervention)		
_____ COUNTY MENTAL RETARDATION OFFICE	_____ DEPARTMENT OF HEALTH (ICF/MR)		
_____ FUNDING AGENCY (Specify) _____			
DATE AND TIME NOTIFIED IF ABUSE OR SUSPECTED ABUSE OF A CLIENT; AN INCIDENT REQUIRING THE SERVICES OF A FIRE DEPARTMENT OR A LAW ENFORCEMENT AGENCY; OR CONDITIONS RESULTING IN CLOSURE FOR MORE THAN ONE DAY OF OPERATION OCCURS:			
_____ REGIONAL OFFICE OF MENTAL RETARDATION	_____ OFFICE OF CHILDREN, YOUTH & FAMILIES (Early Intervention)		
_____ COUNTY MENTAL RETARDATION OFFICE	_____ DEPARTMENT OF HEALTH (ICF/MR)		
_____ FUNDING AGENCY (Specify) _____			

00245A

MR 8 7/88

## Source

The provisions of this Appendix C adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715.

6000-57

(381793) No. 502 Sep. 16

**APPENDIX D**

<b>DEATH REPORT</b>			DATE OF REPORT:	TIME:
NAME OF CLIENT (Last, First, M.I.)			PROVIDER NAME:	
ADDRESS:			ADDRESS:	
CITY	STATE	ZIP CODE	CITY	STATE ZIP CODE
PHONE:			PHONE:	
BSU NUMBER: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			COUNTY WHERE FACILITY IS LOCATED:	
DATE OF BIRTH:	DATE OF ADMISSION:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	PROVIDER SITE LICENSE NUMBER:	
LEVEL OF MENTAL RETARDATION:			DATE OF DEATH:	TIME: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
LOCATION OF DEATH:			AUTOPSY: <input type="checkbox"/> YES <input type="checkbox"/> NO	CORONER NOTIFIED: <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIMARY CAUSE OF DEATH:				
DETAILS SURROUNDING THE DEATH (Mention Cause, Treatment and General Circumstances):				
PREVIOUS RELATED ILLNESS OR CONDITION:				
OTHER PERTINENT INFORMATION:				
RELATIVE OR GUARDIAN NOTIFIED:		RELATIONSHIP:	ADDRESS:	PHONE:
TYPED/PRINTED NAME AND SIGNATURE OF PERSON REPORTING:			TITLE:	PHONE:
TYPED NAME:		SIGNATURE:		
DATE MAILED TO:				
_____ REGIONAL OFFICE OF MENTAL RETARDATION		_____ OFFICE OF CHILDREN, YOUTH & FAMILIES (Early Intervention)		
_____ COUNTY MENTAL RETARDATION OFFICE		_____ DEPARTMENT OF HEALTH (ICF/MR)		
_____ FUNDING AGENCY (Specify) _____				
DATE AND TIME NOTIFIED IF AN UNEXPECTED DEATH OF A CLIENT OCCURS:				
_____ REGIONAL OFFICE OF MENTAL RETARDATION		_____ OFFICE OF CHILDREN, YOUTH & FAMILIES (Early Intervention)		
_____ COUNTY MENTAL RETARDATION OFFICE		_____ DEPARTMENT OF HEALTH (ICF/MR)		
_____ FUNDING AGENCY (Specify) _____				

00973A

MR 8-A 7/88

**Source**

The provisions of this Appendix D adopted August 19, 1988, effective October 1, 1988, 18 Pa.B. 3715.

6000-58

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**APPENDIX E**  
**INCIDENT MANAGEMENT COMPONENTS**

PROVIDERS/ENTITIES ARE TO:

- Promote the health, safety, rights and enhance the dignity of individuals receiving services.
- Develop provider-specific policy/procedures for incident management.
- Ensure that staff and others associated with the individual have proper orientation and training to respond to, report and prevent incidents.
- Provide ongoing training to individuals and families on the recognition of abuse and neglect.
- Ensure when incidents occur that affect a person's health, safety or rights, that the people who are present:
  - Take prompt action to protect the person's health, safety and rights. This includes separation of the target when the individual's health and safety are jeopardized. This separation shall continue until an investigation is completed. In addition, the target shall not be permitted to work directly with any other service recipient during the investigation process. When the target is another individual receiving supports or services, and complete separation is not possible, the provider shall institute additional protections.
  - Notify the responsible person designated in provider policy.
- Assign trained individual(s) Point Person(s) to whom incidents are reported when they occur and who will make certain that all immediate steps to assure health and safety have been implemented and follow the incident through closure.
  - Contact appropriate law enforcement agencies when there is suspicion that a crime has occurred.
  - Comply with all applicable laws, regulations and policies.
  - Conduct certified investigations.
  - Analyze the quality of investigations.
  - Respond to concerns from individuals/family about the reporting and investigation processes.
  - Inform the family of the incident unless otherwise indicated in the individual's plan.
  - Notify the family of the findings of any investigation unless otherwise indicated in the individual's plan.
  - Maintain an investigation file within the agency.
  - Create an incident management process which:
    - Designates an individual with overall responsibility for incident management.
    - Considers possible immediate and long-term effects to the individual resulting from an incident or multiple incidents.
    - Uses trend analyses to identify systemic issues.
    - Analyzes and shares information with relevant staff, including direct care staff.
    - Periodically assesses the effectiveness of the incident management process.

— Monitors quality and responsiveness of all ancillary services (such as health, therapies, etc.) and acts to change vendors or subcontractors, or assists the individual to file available grievances or appeals procedures to secure appropriate services.

COUNTIES ARE TO:

- Promote the health, safety, rights and dignity of individuals receiving services.
- Develop county policies and procedures necessary to implement this bulletin.
- Have an administrative structure sufficient to meet mandates of this bulletin:
  - Designate an individual with overall responsibility for incident management.
  - Train staff in incident management procedures.
  - Assure that supports coordinators have proper orientation and training to respond to, document and prevent incidents.
  - Support providers with appropriate training and resources to meet the mandates of the bulletin.
- Provide ongoing training to individuals, families, guardians, and advocates regarding their rights, roles and responsibilities that are outlined in this bulletin.
  - Provide training to individuals and families on the recognition of abuse and neglect.
  - Have the Incident Management Processes in this bulletin referenced in county/provider contracts.
  - Maintain an investigation file within the county.
  - Create an incident management process which:
    - Assures accuracy of incident reports.
    - Reviews and closes all provider generated incidents.
    - Reviews and analyzes data.
    - Identifies and implements individual and systemic changes based on data analysis.
    - Analyzes and shares information with relevant staff.
    - Regularly reviews trend and occurrence data compiled by providers.
    - Assesses provider's incident management and investigative processes.
    - Assures provider compliance with plans of correction resulting from incidents and investigations.
  - Conduct certified investigations.
  - Analyze the quality of investigations.
  - Respond to concerns from individuals/family about the reporting and investigation processes.
    - In collaboration with the individual's planning team, revise the individual's plan as needed in response to issues identified through the incident management process.
  - Comply with all applicable laws, regulations and policies.
  - Coordinate with other agencies as necessary.
  - In those instances where the county is the initial reporter of the incident, the county will assume the responsibility of the point person.

THE OFFICE OF MENTAL RETARDATION IS TO:

- Promote the health, safety, rights and dignity of individuals receiving services.
- Create an incident management review process which:
  - Maintains the statewide data system.
  - Analyzes data for statewide trends and issues.
  - Identifies issues and initiates systemic changes and provides periodic feedback.
  - Evaluates county and provider reports and analysis of trends.
- Monitor implementation of this bulletin.
- Support providers and counties with appropriate training to meet the mandate of the bulletin.
- Certify investigators.
- Provide support and technical assistance to counties to implement the incident reporting system.
- Conduct certified investigations.
- Analyze the quality of investigations.
- Respond to concerns from individuals/families about the reporting and investigation processes.
- Review and revise this bulletin as needed.
- Ensure compliance with all applicable laws, regulations and policies.
- Coordinate with other agencies as necessary.

**Source**

The provisions of this Appendix E adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234.

**Cross References**

This appendix cited in 55 Pa. Code § 6000.902 (relating to purpose).

**APPENDIX F  
RELATED LAWS, REGULATIONS AND POLICIES**

The incident management and reporting detailed in this subchapter are related to a variety of laws, regulations and policies. The applicable licensing regulations (and facilities licensed under those regulations) include:

*Related Laws:*

- The Mental Health and Mental Retardation Act of 1966 (50 P.S. §§ 4101—4704)
- Title XIX Social Security Act (42 U.S.C.A. §§ 1396—1396v)
- 18 Pa.C.S. § 2713 (relating to the neglect of care-dependent person)
- The Child Protective Services Law (23 Pa.C.S. §§ 6301—6385)
- The Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102)
- Elder Care Payment Restitution Act (35 P.S. §§ 10226.101—10226.107)
- Early Intervention Services System Act (11 P.S. §§ 875.101—875.503)
- The Whistleblower Law (43 P.S. §§ 1422—1428)

*Title 55 of the Pennsylvania Code.*

- Chapter 20—Relating to Licensure or Approval of Facilities and Agencies

- Chapter 2380—Relating to Adult Training Facilities
- Chapter 2390—Relating to Vocational Facilities
- Chapter 3490—Relating to Child Protective Services
- Chapter 3800—Relating to Child Residential and Day Treatment Facilities
- Chapter 5310—Relating to Community Residential Rehabilitation Services for the Mentally Ill
- Chapter 6400—Relating to Community Homes for Individuals with Mental Retardation
- Chapter 6500—Relating to Family Living Homes
- Chapter 6600—Relating to Intermediate Care Facilities for the Mentally Retarded

*Title 6 of the Pennsylvania Code (Aging).*

- Chapter 11—Relating to Older Adult Daily Living Centers

*Related Policy Guidelines:*

- Medical Assistance Bulletin—Revised Medical and Treatment Self-Directive Statement: Your Rights As a Patient In Pennsylvania: Making Decisions About Your Care and Treatment (effective June 19, 1998)
- Mental Retardation Bulletin 00-98-08—Procedures for Substitute Health Care Decision Making (effective November 30, 1998)
- Mental Retardation Bulletin 00-94-32—Assessments: Lifetime Medical History (effective December 6, 1994)
- Mental Retardation Bulletin 00-03-01—Passage of Act 171 relating to the Older Adults Protective Services Act (OAPSA)

**ADDITIONAL REPORTING:**

In addition to the reporting methodologies described in this statement of policy, the following is provided as a guide to assist in identifying additional reporting. This does not fully define, nor is it intended to substitute for, the applicable statutes and regulations.

Reportable incidents involving individuals who reside in facilities licensed as ICF/MRs (both state and privately-operated), are to be reported to the appropriate Regional Field Office of the Pennsylvania Department of Health, Division of Intermediate Care Facilities.

Reportable incidents that occur in facilities licensed by OMR, involving individuals whose support needs are not funded through the Commonwealth or county mental retardation systems, are to be reported to whomever funds the individual's support and to the Commonwealth/Regional Office of Mental Retardation. This includes individuals from other states, individuals who are funded by agencies not part of the mental retardation system and individuals whose support needs are privately funded.

**Neglect of care-dependent person (18 Pa.C.S. § 2713)**

The neglect of care-dependent person 18 Pa.C.S. § 2713 covers any adult who, due to physical or cognitive disability or impairment, requires assistance to meet his needs for food, shelter, clothing, personal care or health care. 18 Pa.C.S.

§ 2713 extends to certain listed facilities and to home health services provided to care-dependent persons in their residence. The statute criminalizes intentional, knowing or reckless conduct by a caregiver which results in bodily injury or serious bodily injury to a care-dependent person by the failure to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person for whom the caregiver is responsible to provide care. A caregiver may also be prosecuted if he intentionally or knowingly uses a physical restraint, a chemical restraint or medication on a care-dependent person, or isolates that person, contrary to law or regulation, such that bodily or serious bodily injury results.

Anyone aware of possible violations of this may make a report to the appropriate law enforcement authorities. The reporting requirements of this bulletin are to be followed even if a report of a possible violation of this statute is made to law enforcement authorities. Copies of the statute were distributed via Mental Retardation Bulletin 00-95-25, issued December 26, 1995 and Mental Retardation Bulletin 00-97-06, issued August 29, 1997.

**The Child Protective Services Law (23 Pa.C.S. §§ 6301—6385)**

The Child Protective Services Law (CPSL) establishes procedures for the reporting and investigation of suspected child abuse. Certain types of suspected child abuse must be reported to law enforcement officials for investigation of criminal offenses. Children under the age of 18 are covered by the act including those who receive supports and services from the mental retardation system. Providers covered within the scope of this bulletin are required to report suspected child abuse in accordance with the procedures established in the CPSL and the Protective services Regulations. The CPSL defines child abuse as any of the following when committed upon a child under 18 years of age by a parent, person responsible for a child's welfare, an individual residing in the same home as a child or a paramour of a child's parent.

- Any recent act or failure to act that causes non-accidental serious physical injury.
- Any act or failure to act that causes nonaccidental serious mental injury or sexual abuse or sexual exploitation.
- Any recent act or series of such acts or failures to act that creates an imminent risk of serious physical injury or sexual abuse or sexual exploitation.
- Serious physical neglect constituting prolonged or repeated lack of supervision or the failure to provide essentials of life including adequate medical care which endangers a child's life or development or impairs the child's functioning.

Reports of suspected abuse are received by the Department of Human Service's (DHS) ChildLine and Abuse Registry (800) 932-0313, which is the central register for all investigated reports of abuse. Individuals who come into contact with children in the course of practicing their profession are required to report when they have reasonable cause to suspect on the basis of their medical, professional or other training or experience, that a child is an abused child. Every facility or agency is required by the CPSL to funnel reports to the director or a designee to be promptly reported to ChildLine. The reporting, investigation and documentation requirements of this statement of policy must also be followed when a report

of suspected child abuse is made. It must be noted that the definition of abuse found in the CPSL differs greatly from the definition promulgated in this statement. Because of this difference it is possible that an allegation may be “unconfirmed” in terms of the CPSL but still substantiated with reference to these guidelines. Likewise, the scope of reports subject to investigation differs so it is important to be familiar with the requirements of the CPSL.

**The Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102)**

The Older Adults Protective Services Act (OAPSA) of 1987 was enacted to protect all Pennsylvanians age 60 and older. The OAPSA established a detailed system for reporting and investigating suspected abuse, neglect, exploitation, and abandonment for care-dependent individuals. Act 13 was signed into law in 1997 as an amendment to the OAPSA. Unlike the other provisions of OAPSA that applied only to adults age 60 and above, Act 13 applied to adults age 18 and above who were considered “care-dependent” individuals and to “care-dependent” individuals under age 18 if they resided in a facility serving individuals over 18. Employees or administrators of a covered entity reported suspected abuse incidents to the local Area Agency on Aging, where indicated, to the Pennsylvania Department of Aging and to local law enforcement pursuant to Chapter 7 of the OAPSA. These requirements existed in addition to the reporting procedures contained in this Bulletin. In 2002, the OAPSA was further amended by the Elder Care Payment Restitution Act.

**The Elder Care Payment Restitution Act (35 P.S. §§ 10226.101—10226.107)**

The Elder Care Payment Restitution Act eliminated the requirements of Act 13 for which suspected abuse of individuals with mental retardation under the age of 60 was reported to the Area Agency on Aging and in some cases, to the Department of Aging. This act became effective February 9, 2003.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191)**

HIPAA and the applicable regulations at 45 CFR Parts 160 and 164 (Privacy Rule) established a set of National standards for the protection of personal health information. The Privacy Rule addresses the use and disclosure of individuals’ health information or “protected health information” by organizations subject to the Privacy Rule or “covered entities.” The Privacy Rule establishes standards for individuals’ rights to understand and control how their personal health information is used. The U. S. Department of Health and Human Services, Office of Civil Rights is responsible to implement and enforce the Privacy Rule.



**REPORTING MATRIX**

The following is provided as a guide to assist in identifying additional reporting. This does not fully define, nor is it intended to substitute for, the applicable statutes and regulations.

<i>Reportable Incident</i>	<i>Report to OMR</i>	<i>Report to County<sup>1</sup></i>	<i>Report to AAA<sup>2</sup> If 60 or older</i>	<i>Report to ChildLine if under 18</i>	<i>PA Department of Aging<sup>3</sup> If 60 or older</i>	<i>DOH</i>	<i>Local Law Enforcement</i>	<i>Acts 28/26<sup>4</sup></i>
			If suspicious	If suspicious	If suspicious	If ICF/MR	If suspicious	If the result of neglect
Death	X	X				X		
Disease Reportable to the Department of Health	X	X						
Emergency Closure	X	X				If ICF/MR		
Emergency Room Visit	X	X				If ICF/MR		
Fire	X	X				If ICF/MR		
Hospitalization	X	X				If ICF/MR		
Individual to Individual Abuse	X	X				If ICF/MR		
Injury requiring treatment beyond first aid	X	X				If ICF/MR		
Law Enforcement Activity	X	X				If ICF/MR		
Medication Error	X	X				If ICF/MR		
Missing Person	X	X				If ICF/MR	If person is at risk	
Misuse of Funds	X	X	If exploitation			If ICF/MR	If it appears that a crime has occurred	

<i>Reportable Incident</i>	<i>Report to OMR</i>	<i>Report to County<sup>1</sup></i>	<i>Report to AAA<sup>2</sup> If 60 or older</i>	<i>Report to ChildLine if under 18</i>	<i>PA Department of Aging<sup>3</sup> If 60 or older</i>	<i>DOH</i>	<i>Local Law Enforcement</i>	<i>Acts 28/26<sup>4</sup></i>
Neglect	X	X	X	X	If serious bodily injury or serious physical injury	If ICF/MR	If serious bodily injury or serious physical injury	If serious bodily injury
Physical Abuse	X	X	X	X	If serious bodily injury	If ICF/MR	If serious bodily injury or serious physical injury	
Psychiatric Hospitalization	X	X				If ICF/MR		
Psychological Abuse	X	X	X	X		If ICF/MR		
Restraint	X	X				If ICF/MR		If serious bodily injury
Rights Violation	X	X				If ICF/MR		
Sexual Abuse	X	X	X	X	X	If ICF/MR	X	
Suicide Attempt	X	X				If ICF/MR		
Verbal Abuse	X	X	X			If ICF/MR		

<sup>1</sup> If an individual is not funded by OMR or by County MR services a report should be made to the funding agent.  
<sup>2</sup> Allegations of abuse or neglect involving children under 18 who reside in a facility that primarily serves adults must be reported to Child Line.  
<sup>3</sup> Allegations of abuse or neglect involving children under 18 who reside in a facility that primarily serves adults must be reported to Child Line.  
<sup>4</sup> Reporting under Acts 28/26 is only mandated for Commonwealth employees.

**Source**

The provisions of this Appendix F adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234.

**Cross References**

This appendix cited in; and 55 Pa. Code § 6000.951 (relating to initial reporter).

**APPENDIX G  
VICTIM'S ASSISTANCE PROGRAMS**

When individuals are abused, neglected, injured or victims of crimes, there are resources to assist them physically, emotionally, financially and legally. Organizations have been developed based on the need to support victims through the criminal justice system, recognizing that victim's needs are oftentimes overlooked. Individuals with disabilities who fall victim to crimes, especially physical violence and sexual assaults, should be encouraged and assisted to access these resources. It is suggested that providers develop relationships with local entities and assist individuals in accessing such services when appropriate.

There are two main types of victim assistance programs: system and community-based organizations. System-based programs that generally operate out of a District Attorney's office provide notification to victims/witnesses of court proceedings. Community based programs are designed to provide support and assistance to victims. Usually, the programs fall under the categories of:

- Rape Crisis/Sexual Assault programs providing services to victims and their family/supporters. Domestic Violence programs provide counseling and temporary housing to victims, as needed.
- Crime Victim Services provide supports and assistance to victims of crimes excluding sexual assaults and domestic violence.

There are domestic violence centers, rape crisis centers and victim assistance offices throughout the Commonwealth. In order to locate the most appropriate resource for individuals, you may contact the following statewide organizations. Additional information regarding local resources is available through these organizations:

PA Commission on Crime and Delinquency (PCCD)  
(717) 787-2040

PA Coalition Against Rape (PCAR)  
(800) 692-7445  
(717) 728-9740

PA Coalition Against Domestic Violence (PCADV)  
(800) 932-4632

Office of Victim Advocate (crime victim compensation)  
(717) 783-7501

Pennsylvania Protection and Advocacy (PP&A)  
(800) 692-7443

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**Source**

The provisions of this Appendix G adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234.

**Cross References**

This appendix cited in 55 Pa. Code § 6000.921 (relating to categories of incidents).

**APPENDIX H  
ABBREVIATED INCIDENT REPORT****Medication Error**

The data entry screen is to include the following information:

- **DEMOGRAPHICS** (pre-populated from HCSIS demographics)

Name of the individual for whom the Medication Error is being reported.

Individual's Base Service Unit (BSU) number.<sup>1</sup>

- **CATEGORIZATION**

Secondary category of Medication Error.

Date and time when the incident was recognized/discovered.

- **MEDICATION ERROR INCIDENT INFORMATION**

Staff position of the person giving medication.

Name of medication(s).

Indication if the error occurred over multiple consecutive administrations.

The reason(s) why the Medication Error occurred.

The response(s) to the Medication Error.

The agency system response to prevent this type of error from occurring in the future.

Any additional comments.

Indication if another Incident Report was filed as a result of the Medication Error.

If another Incident Report was filed, the Incident ID number.

In addition to the required information, providers may choose to include optional information to further analyze their medication errors.

- **OPTIONAL MEDICATION ERROR INFORMATION**

The name or unique identifier of person making the Medication Error.

Indication if the person making the Medication Error was working longer than their regular work hours at the time of the Medication Error.

The length of time the staff person who made the Medication Error has been giving medications.

The number of medications supposed to be given to this person at the same time as the Medication Error was made including the medication when the Medication Error was made.

The number of medications this person receives on a daily basis.

The number of people that the staff person who made the Medication Error has to give medications to around the same time as the Medication Error occurred.

<sup>1</sup> If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.

**Source**

The provisions of this Appendix H adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234.

**Cross References**

This appendix cited in 55 Pa. Code § 6000.923 (relating to incidents to be reported within 72 hours); and 55 Pa. Code § 6000.924 (relating to incident management contingency plan).

**APPENDIX I  
ABBREVIATED INCIDENT REPORT****Restraint**

The data entry screen is to include the following information:

- DEMOGRAPHICS (prepopulated from HCSIS demographics)

Name of the individual for whom the Restraint was used.

Individual's Base Service Unit (BSU) number.<sup>1</sup>

- CATEGORIZATION

Secondary category of Restraint.

Date of the Restraint.

Time in Restraint.

Time out of Restraint.

- RESTRAINT INCIDENT INFORMATION

Restraint agent.

Antecedent to the Restraint.

Reason for the Restraint.

Indication if the Restraint was used on a planned or emergency basis.

Authorizing Staff.

Indication if Prone (face down) Restraint was used.

Indication if another Incident Report was filed as a result of the Restraint.

If another Incident Report was filed the Incident ID number.

**Source**

The provisions of this Appendix I adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234.

**Cross References**

This appendix cited in 55 Pa. Code § 6000.923 (relating to incidents to be reported within 72 hours).

**APPENDIX J  
INCIDENT MANAGEMENT CONTINGENCY PLAN**

In the event that a provider or county or entity is unable to report a 24-hour incident through the Home and Community Services Information System (HCSIS), faxed contingency reporting is to be utilized.

Incidents that are reported via fax are to be recorded on a copy of the attached Incident Management Contingency Form. This reporting method will satisfy regulatory requirements to report an incident. In the event of a serious incident

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<sup>1</sup> If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.

(such as abuse with injury, suspicious death), a provider should also call its OMR Regional Office and County MH/MR Program to alert OMR and the county of the incident.

Once complete, the Incident Management Contingency Form is to be faxed to the appropriate OMR Regional Office and to the County MH/MR Program. The form should have a fax cover sheet that identifies the fax as a reportable incident and states the reason that the report needed to be faxed. Faxing the Incident Management Contingency Form is a short-term solution for meeting regulatory requirements for reporting incidents; however, once access to HCSIS can be established, the incident must be entered into HCSIS.

**CONTACT INFORMATION:**

OMR Regional Office Fax Numbers:

- Northeast Region (570) 963-3177
- Southeast Region (215) 560-3043
- Central Region (717) 772-6483
- Western Region (412) 565-5479

OMR Regional Office Phone Numbers:

- Northeast Region (570) 963-4391
- Southeast Region (215) 560-2242
- Central Region (717) 772-6507
- Western Region (412) 565-5144

**INCIDENT MANAGEMENT  
CONTINGENCY FORM**

FOR USE ONLY WHEN HCSIS IS NOT  
AVAILABLE

DATE OF REPORT: <b>M M D D Y Y Y Y</b> - -	TIME:  AM/PM
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The Incident Report must be entered into HCSIS when access to HCSIS can be established.

NAME OF INDIVIDUAL (LAST, FIRST, M.I.)			PROVIDER NAME:		
ADDRESS:			ADDRESS:		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
PHONE:		COUNTY OF REGISTRATION:	PHONE:		
BASE SERVICE UNIT NUMBER:					
DATE OF BIRTH: <b>M M D D Y Y Y Y</b> - -		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED: <b>M M D D Y Y Y Y</b> - -		
CLASSIFICATION OF INCIDENT:			TIME THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED:  AM/PM		
DATE AND TIME OF DEATH (IF APPLICABLE):			PROVIDER LICENSE NUMBER (IF APPLICABLE):		
DESCRIBE THE TYPE OF INCIDENT AND THE ACTION(S) TAKEN TO ADDRESS THE INDIVIDUAL'S HEALTH AND SAFETY AND THE RESPONSE TO THE INCIDENT, WHAT HAPPENED, IF A MEDICAL REFERRAL WAS NECESSARY (PLEASE LIST) AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE INCIDENT: (ATTACH ADDITIONAL SHEETS IF NECESSARY)					
NAME OF RELATIVE OR GUARDIAN:		RELATIONSHIP:	NOTIFIED (YES/NO)		
NAME OF POINT PERSON:		TITLE:	PHONE:		

**Source**

The provisions of this Appendix J adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234.

**Cross References**

This appendix cited in 55 Pa. Code § 6000.924 (relating to incident management contingency plan).

6000-71

**APPENDIX K  
STANDARDIZED INCIDENT REPORT**

**FIRST SECTION (completed within 24 hours)**

The First Section is to include the following information:

- **DEMOGRAPHICS** (pre-populated from HCSIS demographics)

Name of the individual involved/affected by the incident.

Individual's Base Service Unit (BSU) number.<sup>1</sup>

County of Registration.

Gender.

Individual's date of birth.

MR Diagnosis.

Home address of the individual.

Living Arrangement of the individual.

Name and address of the reporting entity.

Location where the incident occurred.

Name of the point person.

- **CATEGORIZATION**

Date and time when the incident was recognized/discovered.

Primary and secondary category of the incident.

Determination if an investigation is required or desired.

Name of the Certified Investigator assigned, if the incident requires investigation.

- **HEALTH AND SAFETY ASSURANCE**

Description of the immediate and subsequent steps taken by the point person or other representatives of the provider to ensure the individual's health, safety and response to the incident, including date, time and by whom those steps were taken.

- **INCIDENT DESCRIPTION**

Narrative description of the incident completed by staff or other person(s) who were present when the incident occurred or who discovered that an incident had occurred.<sup>2</sup>

**FINAL SECTION (completed within 30 days)**

The reporting entity will complete the Final Section of the incident report within 30 days from the date of the incident or of the date the provider learns of the incident (unless an extension has been made). The Final Section will retain all of the preceding information from the First Section and will add:

Name of the initial reporter.

Name of the individual's supports coordinator (pre-populated).

Whether CPR was administered.

Whether the Heimlich was administered.

If 911 was called, the time, date and person who called.

<sup>1</sup> If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.

<sup>2</sup> Providers may summarize the narrative description, but the written statements of the person(s) directly involved are to be available for review, if needed.



If the incident involves an illness or injury, the name of the practitioner/facility by whom the individual was treated initially, the date and time of the initial contact with a health-care/medical practitioner, the nature/content of the initial treatment/evaluation, and the nature of, date of, time of, and practitioner involved in any subsequent treatments, evaluations.

In the event of a death, indication if the individual was in hospice care, had a diagnosis of terminal illness, if a “Do Not Resuscitate” order was in effect, if the coroner was contacted, if an autopsy has been or will be performed.

Identification of all persons to whom the incident notification has been (or will be) submitted (i.e., family, law enforcement agency), the date the notification has been made, and the person who has/will notify the necessary parties.

Update of incident description, as needed.

Specific description of any injury received by the individual.

Present status of the individual in reference to the incident.

Identification of other persons who may have witnessed or been directly involved in the incident.

Specific signs and symptoms of any illness (acute or chronic) which may be contributory to the incident.

Any relevant background information on the individual, including medical history and diagnoses.

Date on which the investigation began, if required.

Summary of the investigator’s findings and conclusions, if required.

If the incident involves an allegation of abuse or neglect, the conclusion reached on the basis of the investigation (i.e., the allegation is confirmed, not confirmed, inconclusive) and the status of the target.

Description of the steps taken by the provider in response to the conclusions reached as a result of the investigation.

If the incident involves an injury of unknown origin, confirmation of the cause (if one has been identified) and steps taken to prevent recurrence.

Description of any changes in the individual’s plan of support necessitated by or in response to the incident.

Verification by the provider that all necessary corrective actions have been identified.

If any corrective action cannot/has not been completed by the time the Final Section is submitted, the expected date of completion must be provided along with the identity of the person responsible for carrying the extended action through to completion.

If the nature of the incident requires contact with local law enforcement, the name and department/office of the person(s) contacted, the date of the contact, the name of the person who initiated the contact, and a description of any steps taken by law enforcement officials.

If the individual has been hospitalized, the date of admission, name of the hospital, the admitting diagnosis(es), indication if the admission was from the emergency room, what occurred during the hospitalization, change in voluntary/involuntary status, the date of discharge, the discharge diagnosis(es), an indication that the Hospital Discharge Instructions were provided, what changed after discharge, current status and any plans for subsequent medical follow-up.

If the individual is deceased, the Final Section is to be supplemented by a hard copy of the following:<sup>3</sup>

- Lifetime medical history.
- Copy of the Death Certificate.
- Autopsy Report, if one has been completed.
- Discharge Summary from the final hospitalization, if the individual died while hospitalized.
- Results of the most recent physical examination.
- Most recent Health and Medical assessments.

Name of the family member notified of the results of the investigation, if required.

The incident classification the provider believes is most appropriate.

The date and time the provider believes is most appropriate.

After final submission by the provider, the county and OMR will perform a management review and close the incident.

#### Source

The provisions of this Appendix K adopted February 27, 2004, effective February 21, 2004, 34 Pa.B. 1234.

#### Cross References

This appendix cited in 55 Pa. Code § 6000.961 (relating to standardized incident report).

[Next page is 6100-1.]

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<sup>3</sup> Documents, which are not immediately available, must be forwarded to the appropriate parties (county and/or OMR Regional Office) as they become available. If, after attempting to acquire the document, it is determined to be unobtainable, the expecting party will be notified.