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STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Notice Public Meeting

Pursuant to T.C.A. § 33-1-309

In accordance with § 33-1-309 of the Tennessee Code Annotated a Public Meeting will be held to receive comments on the Department of Intellectual and Developmental Disabilities " Provider Manual Chapter 11 & 18, as well as the Community Transition and Death Reporting and Review Policies", a copy of which is attached hereto.

This Public Meeting will be held on Monday, March 19, 2012 from 1:30 to 3:00 p.m. in the Large Conference Room on the Ground Floor of One Cannon Drive, Clover Bottom Developmental Center Campus, One Cannon Drive, Nashville, Tennessee 37214.

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CHAPTER 11

HEALTH MANAGEMENT & OVERSIGHT

11.1. Introduction

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. World Health Organization, 1946

Maintaining optimal health is one of the most basic supports provided by DIDD and DIDD service providers. Achieving this outcome is dependent upon a number of factors including the following:

- Helping people to make person centered decisions about a healthy lifestyle and to participate, to the extent possible, in decisions about their health.
- Ensuring that people receive preventive health-related care and services, including recommended physical and dental exams.
- Ensuring that people receive assessment, treatment and follow up for acute and chronic health issues as recommended by treating practitioner(s).
- Medication management including proper administration, observation of medication effects and proper documentation as well as reporting any concerns to the proper professional(s).
- Maintaining accurate records to assure current information regarding health is available.

11.2. People are supported to have the best possible health

DIDD and DIDD providers have a shared responsibility to ensure that people maintain the best possible health. Best possible health is different for each person and depends on the individual's current overall health status and what can be done to provide preventative care, treat existing and acquired conditions or improve current health status.

11.2.a. Conceptual overview of Health Care Oversight:

It is important to note the ongoing expectation of DIDD that each person receives the level of health care oversight necessary to ensure that all his/her health care needs are met. Providers of residential, day, personal assistance, independent support coordination and clinical services are required to define in policy how they will manage and document the health care of persons served. Health management and oversight mechanisms applicable to all persons served must be incorporated into the provider's policies and procedures.

Health care oversight is an ongoing systematic monitoring and review to assure the person's health care needs are being addressed. It can be broad or limited. This includes activities such as oversight of the Medication Administration Record and medication variances. Providers are obligated to ensure that qualified staff performs appropriate health care oversight. Providers are responsible for obtaining a Professional Supports Services License from the Department of Health (DOH, reference TCA 1200-08-34) if health care supports includes the completion of tasks that can only be performed by licensed staff.

11.2.b. Health Care Management and Oversight Responsibilities of Residential, Day, Nursing and Personal Assistance Providers: Providers are expected to develop/maintain policies and implement practices that achieve the following outcomes related to health care management and oversight:

- 1) Appropriate consents are obtained prior to sharing health related information and prior to providing services and treatments that require informed consent;
- 2) Necessary medical, dental and other appointments are arranged and attended in a timely manner including routine appointments and any recommended follow-up appointments, exams or treatment;
- 3) Arranging and/or providing transportation for medical, dental and other appointments, timely arrival of service recipients to scheduled appointment, and preparation of the service recipient for any procedure scheduled;
- 4) Staff accompanying service recipients to medical, dental and other appointments are familiar with the person served and are able to provide necessary information such as current medications and behavior problems (e.g. aggression, anxiety, etc.) to practitioners;
- 5) The day and residential agency's process ensures that medical providers have information about the person's current medication as well as any pertinent historical information about any allergies or issues related to specific medications.
- 6) Staff assist the person and/or family in requesting clarifications as needed from practitioners in regard to information provided about health-related conditions or treatments;
- 7) Adequate information describing the outcome of the appointment and any further recommendations is incorporated into the person's record and appropriate internal and external staff (i.e. support coordinators, case managers) are informed of any orders, necessary follow up, or recommendations;
- 8) Orders, treatments and recommendations from medical and clinical practitioners are implemented as recommended;
- 9) Staff monitor for and identify basic medical signs and symptoms such as swelling, rashes, shortness of breath, bleeding, etc., and report these to a medical practitioner, when appropriate (e.g., nurse, primary care provider (PCP) or emergency services);

- 10) Staff knows how to respond to symptoms that may indicate serious health problems requiring immediate attention and are able to take the appropriate actions (e.g., choking);
- 11) Staff recognizes and communicates symptoms that are uncharacteristic or abnormal for a person so the appropriate medical, clinical, dental or mental health evaluations can be initiated;
- 12) Medications are administered as ordered;
- 13) Medication administration is completed and appropriately documented by licensed and unlicensed staff;
- 14) Medication variances are detected, reported and addressed immediately;
- 15) Medication changes and other significant changes in health status are communicated to all direct support professionals who provide services to the person, to conservators/legal representatives, to family members, to support coordinators/case managers and to any other professionals who provide direct services and need the information to ensure services are appropriate and adequate;
- 16) Health considerations such as eating a healthy diet, participating in regular exercise and getting adequate sleep are incorporated into daily routines in accordance with the recommendations of the person's treating health care practitioners (e.g., PCP or nutritionist) and preferences as specified in the support plan;
- 17) Food and nourishment are provided in accordance with nutritional needs, prescribed diets, mealtime instructions and physician's orders.

11.2.c. Responsibilities of Support Coordinators and Case Managers in supporting health and oversight: Support Coordinator and Case Manager responsibilities include:

- 1) Information is routinely provided about best health care choices to persons served, their families and/or legal representatives;
- 2) Information regarding how particular treatments and services such as physical therapy, occupational therapy, behavior services, and nutrition services may contribute to best possible health choices for the person served is routinely provided;
- 3) Necessary information and support is routinely provided to persons served and their family/legal representatives about addressing end of life issues.
- 4) Assistance with arranging and scheduling transportation to medical, dental, or other health care related appointments.

11.3. Primary Care Practitioner and Dental Services

Persons served shall have access to primary care services as needed. Regular contact with the Primary Care Provider (PCP) for physical examination,

appropriate medical screenings and medical care of acute and chronic conditions is essential to maintenance of best possible health.

Persons served shall have access to dental services as needed. Regular contact with the dentist is essential to maintenance of best possible health.

11.3.a. Frequency of Physician Contacts:

Each person served must receive a medical examination according to TennCare Rules. Table 11.5 describes TennCare, CMS, and DIDD minimum requirements for medical examination by the physician.

Table 11.5
Schedule for Medical Examinations per TennCare Rule

Age	Minimum Frequency
Up to age 21	In accordance with TennCare Early Periodic Screening, Diagnosis and Treatment (ESPDT) standards.
Age 21-64	Every one (1) to three (3) years as determined and documented by the PCP.
Age 65 and older	Annually

Note: TennCare rules indicate physical exams must be annual unless otherwise noted by exception by the attending primary care practitioner.

11.3.b. Provider Responsibility for Scheduling and Keeping Physician Appointments:

- In residential services, the provider is responsible for making, and supporting the person in keeping the appointment and ensuring the outcome of the appointment is documented in the person's record.
- In day services with no residential component, the provider is responsible for working with the person, family or legal representative to make appointments, supporting the person in keeping the appointment and ensuring the outcome of the appointment is properly documented in the person's record.
- If a person does not receive residential or day services, the person's Support Coordinator/Case Manager will assist the primary caregiver as needed to ensure appointments are made, kept and proper documentation is obtained.
- The Support Coordinator/Case Manager must take every available opportunity to ensure the person attends medical examinations as needed or required (e.g. periodic medical examinations). If the person does not obtain the medical examination as required, the support coordinator/case manager must document, in case notes, evidence of all supports given

and/or offered to the person and their family as well as update the person's risk assessment as to the refusal to obtain an annual examination.

11.3.c. Documentation of Primary Care Provider (PCP) and Other Physician Visits: It is not required that primary care provider's use any particular form to document the history, physical examinations and/or assessments. Documentation is required to demonstrate that an appropriate health review has been performed.

Documentation of all physician visits must be maintained. While not required, providers may wish to develop a standard form for use in assisting with the communication of all needed information. Documentation of periodic health reviews is required to demonstrate that these have been performed.

11.4. Management of Medication Administration

A statutory exemption (TCA 4-5-202 and 68-1-904) was established as a means to allow unlicensed staff to administer certain medications to people who receive DIDD services. As a result of this exemption, DOH promulgated rules which established a mechanism of training unlicensed staff to administer medications. The training curriculum, *Medication Administration for Unlicensed Personnel*, was developed by DIDD and is based on DOH rules.

11.4.a. Operating a Medication Administration Training Program: A provider must obtain approval from DIDD to offer a training program for unlicensed staff as specified in DOH rule 1200-20-12.02 (1).

11.4.b. Utilizing Unlicensed Staff to Administer Medications: Providers who employ unlicensed staff who administer medications must be able to manage medication administration in accordance with state rules.

- Providers are required to develop, maintain and implement written policies and procedures that meet DOH requirements pertaining to the administration of medication by unlicensed staff.
- Provider policies and procedures shall be reviewed and accepted by DIDD prior to any unlicensed staff administering medications.

11.4.c. The Medication Administration Record (MAR): A separate MAR must be maintained for each person receiving medications. MAR required elements are specified in DOH rules (1200-20-12-.06) and are also included in the training curriculum manual *Medication Administration for Unlicensed Personnel*.

11.5. Provider Responsibility for Administration of Medications

Responsibility for administration and management of all medications lies with the residential provider if residential services are received. If there is no residential provider, any providers employing staff who administer or assist with administration of medications are responsible for the administration and management of medications during the hours services are provided.

11.5.a. Provider Responsibilities for psychotropic medications: Psychotropic medications are appropriate as part of the treatment plan for psychiatric illness. The responsibilities of providers in relation to people with prescribed psychotropic medications include, but are not limited to:

- 1) Documenting the service recipient's response on the psychotropic medication in terms of side effects, frequency of targeted behaviors, recipient's quality of life, and recipient's compliance/ non-compliance with psychotropic medication treatment;
- 2) Ensuring that Tardive Dyskinesia screenings are completed by the prescribing physician or appropriately trained staff at least every six (6) months for people using psychotropic or other medications known to cause Tardive Dyskinesia;
- 3) Ensuring that there is a plan for "as needed" or PRN orders for psychotropic medications as ordered by the physician. The plan shall include a list of less restrictive measures to be taken or attempted to stabilize the situation should a crisis occur. Psychotropic medication may only be administered by a licensed nurse after a registered nurse or prescribing practitioner has determined that all other less restrictive measures have been taken.
- 4) Providing current information to clinicians regarding the medications taken by the person served, including any psychotropic medications; and
- 5) Ensuring training has been provided on recognizing Neuroleptic Malignant Syndrome, Serotonin Syndrome and other potentially life threatening side effects.

11.6. Managing Medication Variances

Providers who employ unlicensed and licensed staff to administer medications must manage medication variances. A medication variance occurs when a medication is given in a way that is not consistent with how it was ordered by the physician or other provider. Medication variances result when:

- medications are given to the wrong person,
- medications are omitted,
- medications are given at the wrong time,
- the wrong dose is given,
- the wrong medication is given,
- the medication is given by the wrong route (e.g., via injection when by mouth was ordered),

- medications are not prepared according to orders (e.g. given whole when ordered crushed or given in pill form when liquid form is ordered).

A description of medication variances and required responses to variances are provided in the *Medication Administration for Unlicensed Personnel Manual, October 2008* (Unit 6, Part 3, pages 139-140).

Providers are required to implement written policies that ensure:

- reporting requirements are met,
- medication variances are identified and tracked,
- medication variance trends are identified.

11.6.a. Provider Response to Medication Variance: Providers must take prompt actions to address any medication variance that occurs, per the category of the variance. The first priority is to determine how the medication variance has affected, or could affect, the person and ensure measures are taken to stabilize or prevent deterioration of health status. If the potential for harm is present, the person's prescribing primary care practitioner, pharmacist or a hospital emergency room should be contacted for consultation. Actions expected to occur following stabilization of the person's health status include, but are not limited to:

- 1) Contacting the health care practitioner who prescribed the medication.
- 2) Documenting the variance in the record.
- 3) Documenting instructions received from practitioner consulted and follow up actions taken by staff member.

Medication variance categories include Categories A - I. Categories D and above require primary care practitioner contact. See Medication Variance Form MR-0484 for further information.

11.6.b. Documenting and Reporting the Medication Variance: The provider is responsible for documenting medication variances in the person's record. The documentation should report what medication was given, what medication should have been given, and any intervention that resulted. The Medication Administration Record (MAR) should indicate the nature of the variance. For example, if the dose was administered incorrectly or omitted; if the wrong medication was administered; if medication was given by the wrong route and/or if medication was not prepared according to orders (e.g. given whole when ordered crushed or given in pill form when liquid is ordered). When any variance occurs, a DIDD approved medication variance form should also be completed. Not all medication variances are reportable incidents. Reportable incidents are defined in **Chapter 18 of this manual.**

11.7. Response to Medical Emergencies

All persons will have some form of identification that includes emergency contact information. Direct support staff should be trained to recognize symptoms indicative of medical emergency such as excessive bleeding, choking, loss of consciousness, expression of significant pain, obvious bone fracture, obvious break in skin integrity, etc. Staff should also be able to recognize any symptoms specific to the person that are indicative of a decline in medical status based on known medical conditions or past experiences. All staff should be able to provide emergency personnel with accurate and detailed information regarding the incident or circumstances which preceded the person's current medical condition, such as diagnosed medical conditions, allergies and current medications. Staff should be knowledgeable about advance medical directives for the person. Note that 'Do Not Resuscitate' orders do not apply to choking. The names of the physicians treating the person should be presented to emergency personnel as well.

Written policies and procedures and training that communicate to direct care staff actions expected to be taken in a medical emergency should include at a minimum:

- Instructions that 911 calls must not be delayed;
- Information regarding initiation of emergency first aid procedures;
- Instructions on how to help someone who is or appears to be choking;
- Requirements for provision of information to emergency medical personnel;
- Requirements for notification of designated provider supervisory staff; and
- Making information accessible in a timely manner.

11.8. Provision of Basic First Aid

Staff is to administer basic first aid. See Chapter 7 for specific training requirements.

11.8.a. First Aid Supplies/Kits: Stocked first aid kits must be accessible in residential settings and in any other site where services are routinely provided such as a home, day service site and vehicles used for transportation. First aid supplies will be kept in a secure container which includes items recommended by the American Red Cross. Contents shall include:

- 1) Assorted size of gauze pads and rolls of gauze;
- 2) Triangular bandage(s);
- 3) Assorted types of bandages;
- 4) Non-allergic tape;
- 5) Plastic waste bags;
- 6) Disposable gloves;
- 7) Hand cleaner such as antiseptic wipes or pads;

- 8) A small flashlight with extra batteries; and
- 9) Disposable scissors and tweezers.

11.9. Ensuring Continuity of Care During Hospitalization and Upon Discharge

11.9.a. Primary Provider Responsibilities: When in-patient hospitalization is necessary, communication, planning, collaboration and coordination between DIDD, provider staff and hospital staff is essential to continuity of care. Primary provider responsibilities include:

- 1) Ensuring a contact list is provided to hospital staff describing individuals to be called regarding medical issues and the circumstances under which such calls are to be made;
- 2) Ensuring that required items are taken to the hospital with the person, including personal items, medical information and copies of other relevant information including but not limited to a list of current medications and dosages;
- 3) Ensuring appropriate individuals are contacted, including family members, legal representatives, the support coordinator/case manager, medical providers and other DIDD providers.

11.9.b. Support Coordination/Case Management Responsibilities:

Be aware of changes to health status or needs of person in regards to long-term supports which may result from the hospitalization. If such changes occur, update the ISP within 14 calendar days from date of discharge to ensure the person's needs continue to be met.

- 1) Provide the hospital with contact numbers for the support coordinator/case manager, as well as information regarding how to make contact after hours.
- 2) Provide communication links between the person, family, legal representative, service provider and hospital staff.
- 3) Make hospital discharge planning staff aware of the role and assistance that the support coordinator/case manager is able to offer in identifying and obtaining the supports and services available to the person upon discharge.

11.9.c. Discharge Planning: Discharge planning should begin as soon as a person is admitted to an inpatient hospital. The support coordinator/case manager will collaborate with the family and/or the residential provider to ensure the person has adequate supports while receiving in-patient hospital care. The support coordinator/case manager will also coordinate any amendments to the ISP to include any anticipated additional services that may be needed post-discharge. Discharge planning should include:

- 1) Where the person is to go following discharge;

- 2) Identification of individuals and/or medical professionals to be contacted and informed when discharge is imminent;
- 3) Arrangements to resume or change previous professional services as appropriate and/or arrangements for providers of any new services and supports needed post-discharge;
- 4) Arrangements for any environmental modifications or new equipment needed post discharge;
- 5) Arrangements for transportation to alternative treatment facilities if necessary;
- 6) Providing instruction and/or training to new staff as needed to support the person served post-discharge;
- 7) Ensuring an adequate supply of medication needed in accordance with physician's orders post discharge; and
- 8) Making arrangements for follow-up appointments.

CHAPTER 18

PROTECTION FROM HARM

Introduction

Assuring the protection and safety of service recipients is a primary mission of the Department of Intellectual and Developmental Disabilities (DIDD) and all DIDD providers. This chapter identifies specific provider requirements intended to achieve the protection and safety of DIDD service recipients. Protection from harm is more than developing and implementing policies, plans and responses to incidents that have already occurred. Protection from harm is a legal and moral commitment to support, respect and value the dignity and worth of a person. It is an opportunity for all of us who have responsibility as partners in the service delivery system to strive toward achieving the goal of knowing that the people we support and serve feel safe enough to be able to enjoy their lives.

DIDD and provider agencies exist solely for the purpose of enhancing the quality of life of service recipients. Leadership at all levels of the system must foster an internal culture that supports individual respect. Respect for others is the first step in ensuring their safety and well-being. A combination of fostering respect for service recipients, planning to ensure safety and protection and responding to incidents appropriately, including careful analysis of the incidents that do occur will go far in achieving the mission of protection from harm.

Components of the Protection from Harm System

Complaint Resolution System	See Section 18.1.
Incident Management System	See Section 18.2.
Response to Abuse, Neglect and Exploitation	See Section 18.3.
Policy Requirements	See Section 18.4.

18.1 Complaint Resolution System

Complaint resolution is an integral component of a system that protects and prevents harm. Providers are expected to establish a complaint resolution system to which a service recipient, a family/guardian and/or a legal representative has knowledge of and easy access when seeking assistance and answers for concerns and questions about the care being provided. When the complaint cannot be rectified by the Provider agency, DIDD provides assistance to help resolve outstanding issues.

Providers must record complaints, take action to appropriately resolve the complaints presented and document complaint resolutions achieved.

All providers should establish a Complaint Resolution System which includes but is not limited to:

- 1) Designation of a staff member as the complaint contact person;
- 2) Maintenance of a complaint contact log; and
- 3) Documentation/trending of complaint activity.

Upon admission and periodically, providers should notify each service recipient, family/guardian and/or legal representative of their Complaint Resolution System, its purpose and the steps involved to access it. Providers should attempt to resolve all complaints in a timely manner within 30 days of the date that the complaint was filed.

In the event that service recipients, families/guardians and/or legal representatives do not agree with a provider's proposed solution to a complaint, they may contact the DIDD Regional Complaint Resolution Coordinator for assistance. The DIDD Regional Complaint Resolution Coordinator will subsequently contact the provider(s) and/or other party(ies) involved to discuss potential resolutions to the complaint. These could include formal mediation or intervention meetings. All efforts are made to reach a satisfactory result for the complainant.

The provider's Complaint Resolution System will be reviewed for appropriateness during the provider's DIDD Quality Assurance survey.

18.2 Incident Management System

In collaboration with providers, families/guardians, legal representatives and other stakeholders, DIDD has defined events and incidents that must be reported. All providers must develop and implement a system that provides for appropriate and timely reporting of reportable incidents, as well as appropriate and timely response to these incidents. Incident reporting provides both the provider agency and DIDD information to make adjustments and improvements in the services and care of service recipients.

18.2.a. Reportable Incidents: Defined incidents must be submitted to DIDD on the *DIDD Reportable Incident Form* (RIF). The following categories of incidents must be documented and submitted:

- 1) **Deaths of service recipients** regardless of the cause or the location where the death occurred;
- 2) **Allegations of abuse based on TCA §33-2-402 (1), neglect based on TCA §33-2-402 (9) and exploitation based on TCA §33-2-402 (8) (referred to as misappropriation of property in TCA)** in accordance with definitions below:
 - a) **Abuse:** the knowing infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

DIDD considers the three specific subcategories of abuse:

1) **Emotional/Psychological Abuse**: Actions including, but not limited to:

- humiliation,
- harassment,
- threats of punishment or deprivation,
- intimidation towards service recipients, or
- the use of oral, written, or gestured language either directed to the service recipient or within eyesight or audible range of the service recipient that is demeaning or derogatory to persons with intellectual disabilities.

Emotional/psychological abuse may cause the service recipient physical harm, pain, or mental anguish (To determine mental anguish the following question should be considered, “Would a member of the general public react negatively to the alleged incident of emotional/psychological abuse?”).

2) **Physical Abuse**: Actions including, but not limited to:

- any physical motion or action (e.g., hitting, slapping, punching, kicking, pinching,) by which physical harm, pain or mental anguish may occur to a service recipient;
- the use of corporal punishment;
- the use of any restrictive, intrusive procedure to control challenging behavior or for purposes of punishment; or takedowns or prone restraint of any duration.

3) **Sexual Abuse**: Any type of sexual activity between a service recipient and a staff person or anyone affiliated through DIDD as a contracted entity or volunteer is prohibited. Prohibited sexual activity includes, but is not limited to actions whereby a service recipient:

- is forced, tricked, threatened, or otherwise coerced into sexual activity;
- is exposed to sexually explicit material or language unless otherwise specified in a plan;
- has any contact with sexual intent.

Sexual abuse occurs whether or not a service recipient is able to give consent to such activities.

(TCA §39-13-527 (a)(3)(A): Sexual battery by an authority figure is unlawful sexual contact with a victim by the defendant or the defendant by a victim accompanied by the following circumstances: the defendant was at the time of the offense in a position of trust, or had supervisory or disciplinary power over the victim by virtue of the defendant’s legal, professional or occupational status and used the position of trust or power to accomplish the sexual contact. (b) Sexual battery by an authority figure is a Class C felony.

b) **Neglect**: Failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, which results in injury or probable risk of serious harm.

Neglect towards a service recipient includes being on duty while impaired or under the influence of illegal substances or prescription drugs without a valid current prescription for the drug. If a staff person has a valid current prescription for a drug and is impaired while on duty from the prescription drug, this too shall be considered neglect.

c) **Exploitation**: Actions including but not limited to the deliberate misplacement, misappropriation or wrongful, temporary or permanent use of belongings or money with or without the recipient's consent. DIDD also considers it exploitation to illegally or improperly use a person or person's resources for another's profit or advantage.

DIDD will investigate allegations of exploitation involving an amount of \$50 or more per incident, allegations of exploitation involving individual amounts totaling \$50 or more within a sixty (60) calendar day period of exploitation involving significant risk or serious adverse consequences to a service recipient. (See the Reportable Staff Misconduct definition for further clarification.)

The provider is required to reimburse the service recipient regardless of the amount of money involved.

3) **Serious Injury**: Physical harm to a service recipient:

- whether the injury is self-inflicted or inflicted by another person,
- whether the injury is accidental or not, and
- whether the cause of the injury is known or unknown, and
- requiring assessment and treatment (beyond basic first aid that could be administered by a lay person):
 - in a hospital,
 - in a hospital emergency room,
 - in an urgent care center, or
 - from a physician, nurse practitioner or physician's assistant.

Serious injury includes, but is not limited to, one or more of the following:

- Fracture,
- dislocation,
- traumatic brain injury (concussion),
- laceration requiring sutures (or Dermabond when used in place of sutures/staples),
- torn ligaments,
- second and third degree burns,
- loss of consciousness.

Other types of injuries such as bruises, abrasions, sprains and muscle strains can rise to the level of serious injury if they are diagnosed as serious or severe, or require treatment beyond first aid that could be administered by a lay person.

- 4) **Suspicious Injury:** Injury (whether minor or serious) to a service recipient possibly involving or resulting from abuse or neglect. This would also include an injury that does not coincide with the explanation given for the injury. Not knowing how an injury occurred is not reason enough to say the injury is suspicious. There must be further reason to believe the injury may have resulted from abuse or neglect.
- 5) **Reportable Behavioral Incident:** Any behavioral incident (physical aggression, self-injurious behavior, swallowing inedible substance, etc) resulting in one or more of the following:
- Serious injury to a service recipient or others;
 - Use of mechanical or manual restraint;
 - Takedowns or prone restraint of any duration for any reason are reportable and prohibited;
 - Administration of psychotropic medication as a response to the incident;
 - Property destruction over \$100;
 - Assessment or treatment by emergency medical technicians/paramedics or in a hospital emergency room;
 - In person involvement of law enforcement (police) or a Mental Health Mobile Crisis Team; or
 - Psychiatric hospital admission.
- 6) **Reportable Medical Incident:** Any medical incident (illness, accident, etc.) resulting in one or more of the following:
- medical illness that results in emergency medical interventions; i.e; cardiopulmonary resuscitation (CPR) x-ray to rule out a fracture or the Heimlich Maneuver/abdominal thrust;
 - assessment or treatment by emergency medical technicians or paramedics, or by personnel in a hospital emergency room;
 - medical hospital admission.
- 7) **Service recipients missing for longer than fifteen (15) minutes,** unless the Individual Support Plan (ISP) specifies that unsupervised periods of time longer than 15 minutes does not present a risk of harm to the service recipient or others;
- 8) **Acts of sexual aggression by a person receiving services toward another person supported, a staff person, or another community member;**
- 9) **Criminal Conduct or Probable Criminal Conduct** involving a service recipient including, but not limited to, arrest or incarceration of a service recipient;
- 10) **Reportable Staff Misconduct:** Actions or inactions contrary to sound judgment and/or training, related to the provision of services and/or the safeguarding of the service recipient's health, safety, general welfare and/or individual rights. Staff misconduct does not rise to the level of abuse, neglect or exploitation, in that there is no resulting injury or adverse effect, and the risk for harm is minimal.

Exploitation involving amounts lesser than \$50 per incident or less than \$50 total in 60 calendar days that are not indicative of serious risk or adverse consequences will be addressed by the provider as reportable staff misconduct. The provider is required to reimburse the service recipient regardless of the amount of money involved.

18.2.b. Time Frames Applicable to Reporting Incidents

Table 18.2. Provides a summary of DIDD reporting requirements, including the time frames for reporting and where the report is to be directed.

TYPE OF INCIDENT / EVENT	NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN <u>FOUR</u> HOURS	NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN <u>TWENTY-FOUR</u> HOURS	NEXT BUSINESS DAY
Death	Regional Office Administrator on Duty (AOD) for all deaths DIDD Investigations Hotline (If death is suspicious, (abuse or neglect involved), or if unexpected or unexplained)	Legal Representative (document all attempts)	RIF to DIDD Central Office Notice of Death Form and RIF to Regional Director RIF to ISC Agency/Support Coordinator
Alleged or suspected abuse, neglect, or exploitation	DIDD Investigations Hotline Department of Human Services (DHS) Adult Protective Services or Department of Children's Services (DCS) Child Protective Services If criminal activity: Law Enforcement	Legal Representative (document all attempts)	RIF to DIDD Central Office RIF to ISC Agency/Support Coordinator
Serious Injury of Known/Unknown Cause	If unknown, DIDD Investigations Hotline DHS Adult Protective Services or DCS Child Protective Services	Legal Representative (document all attempts)	RIF to DIDD Central Office RIF to ISC Agency/Support Coordinator
Suspicious Injury (i.e suspicious as caused by abuse or neglect)	DIDD Investigations Hotline DHS Adult Protective Services or DCS Child Protective Services	Legal Representative (document all attempts)	RIF to DIDD Central Office RIF to ISC Agency/Support

TYPE OF INCIDENT / EVENT	NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN <u>FOUR</u> HOURS	NOTIFY AS SOON AS POSSIBLE AND NO LATER THAN <u>TWENTY-FOUR</u> HOURS	NEXT BUSINESS DAY
Reportable Medical Incident	Regional AOD if: <ul style="list-style-type: none"> Unplanned Hospitalization 	As defined by Legal Representative	Coordinator RIF to DIDD Central Office RIF to ISC Agency/Support Coordinator
Reportable Behavioral Incident Missing Person Sexual Agression Criminal Conduct	Regional AOD for: <ul style="list-style-type: none"> Any hospitalization resulting from a behavior or psychiatric incident, or any behavioral incident with Law Enforcement or Mental Health Mobile Crisis Team involvement at the scene or in person Any incarceration 	As defined by Legal Representative	RIF to DIDD Central Office RIF to ISC Agency/Support Coordinator
Reportable Staff Misconduct Incident		As defined by Legal Representative	RIF to DIDD Central Office RIF to ISC Agency/Support Coordinator
Request for Emergency Service Approval outside of regular DIDD business hours	Regional AOD		

1. Submission of Reportable Incident Forms: The front page of the *DIDD Reportable Incident Form* must be reviewed by the agency Incident Management Coordinator and then securely submitted to the DIDD Central Office and the ISC Agency/Support Coordinator within one (1) business day of the time the incident occurred or was discovered.

- DIDD recognizes that on occasion two or more provider agencies may witness a Reportable Incident. The provider with primary responsibility for the person receiving

services at the time of the incident has the obligation to report. Provider policy should include a provision for obtaining written confirmation that the primary provider has filed an incident report with DIDD.

- When support coordinators/case managers or other non-primary providers are the initial reporter of an incident, a copy of the *DIDD Reportable Incident Form* is sent to the service recipient's primary provider as soon as possible and in all cases, within one (1) business day.

2. Immediate Notification Via the DIDD Investigation Hotline: Providers are required to notify immediately, via the DIDD Investigation Hotline all reports of alleged or suspected abuse, neglect, exploitation and serious injury of unknown cause. Service recipient deaths that are questionable or suspicious and appear to be a result of abuse or neglect need to be called into the hotline as well. "Immediate" means as soon as possible (ASAP) and in all cases, within four hours of the incident or its discovery. In instances when provider staff is uncertain if an incident qualifies for immediate notification to the DIDD Investigation Hotline, it is expected that the provider will contact the hotline in order to consult with an investigator.

3. Additional Notification Requirements: In addition to filing Reportable Incidents with DIDD, providers must ensure that:

- Service recipients' legal representatives must always be notified within twenty four hours once the decision is made to investigate an incident for alleged abuse, neglect, or exploitation;
- Service recipients' legal representatives are notified within 24 hours of all Reportable Incidents; notice is documented on the Reportable Incident Form, unless the legal representative indicates in writing that notification is to be provided only in limited circumstances;
- If, despite diligent efforts, legal representative notification is not achieved within twenty-four (24) hours, documentation reflects efforts made and the date/time of notification and method whereby notification was achieved;
- Service recipient support coordination providers/DIDD case managers receive copies of filed *DIDD Reportable Incident Forms* as soon as possible, and in all cases within one (1) business day;
- Law enforcement officials are notified as soon as possible, but in all cases within (4) four hours, of Reportable Incidents when there is reason to believe a crime may have been committed (if uncertain as to whether law enforcement officials should be notified, consultation with the DIDD Director of Investigations or designee may be initiated);
- Provider staff are considered mandated reporters, therefore, The Department of Children's Services (DCS), Division of Child Protective Services is notified as soon as possible, but no later than four (4) hours following the incident or discovery of the incident when service recipients under the age of eighteen (18) are alleged to have been the victim of abuse, neglect or exploitation (STCA 37-1-403 & 37-1-605); and
- Provider staff are considered mandated reporters, therefore, The Department of Human Services (DHS), Division of Adult Protective Services is notified as soon as possible, but no later than four (4) hours following the incident or discovery of the incident when

service recipients eighteen (18) years of age or older are alleged to have been the victim of abuse, neglect or exploitation (§TCA 71-6-103 (b) (1) & §TCA 71-6-103 (2) (c)).

It should be noted that the definitions of abuse, neglect or exploitation used by other state agencies and organizations, as well as timeframes for reporting, may be different from those used by DIDD.

18.2.c Incident Review and Corrective/Preventive Action Requirements

1. Designation of an Incident Management Coordinator: Providers must designate a management staff person to serve as the Incident Management Coordinator. The Incident Management Coordinator will have primary responsibility for ensuring provider compliance with this chapter. Specific responsibilities of the Incident Management Coordinator include:

- Reviewing incidents for timely and appropriate response;
- Ensuring that incidents have been reported or referred to the DIDD Investigation Hotline as required;
- Ensuring that Reportable Incident forms have been made legible (typed) and are complete and submitted to DIDD Central Office as required;
- Ensuring that documentation of the submission of Reportable incident forms is maintained;
- Ensuring that recommendations associated with Reportable Incidents and DIDD investigations are addressed;
- Serving as chair of the Incident Review Committee; and
- Completing or ensuring the completion of trend studies of Reportable Incidents.

2. Incident Review Committees: Residential, day and personal assistance providers must establish an Incident Review Committee with a defined membership and meeting schedule. The Incident Review Committee may be an independent committee or a sub-committee of another operational provider committee. Independent providers and very small providers, including microboards, may elect to share an Incident Review Committee with another provider(s) if appropriate steps are taken to maintain confidentiality, such as obtaining signed confidentiality agreements from each Committee member or redacting information provided to the committee.

3. Incident Review Committee Membership: DIDD requires inclusion of at least two (2) provider management personnel. DIDD also requires inclusion of supervisory and direct support staff. Beyond these requirements, the provider has discretion in determining the appropriate membership of the Incident Review Committee; however, larger provider agencies should consider members who are service recipients, service recipient family members or legal representatives and members who serve on the provider board of directors/advisory committee.

4. Incident Review Committee Functions: Incident Review Committee functions include:

- Monitoring to ensure appropriate reporting of incidents;

- Reviewing and providing recommendations as necessary regarding provider incident reports, DIDD completed investigation reports and provider incident reviews, including reportable staff misconduct incidents;
- Ensuring implementation of corrective actions and recommendations pertaining to Reportable Incidents;
- Identifying trends regarding reportable incidents;
- Identify individual risk issues for prevention of harm.

5. Incident Review Committee Meeting Schedule: The Incident Review Committee is expected to meet at least every other week. Meetings of the Incident Review Committee may be deferred in the event that there is no pending business before the Committee. Because recommendations are followed to closure, pending business is not limited to recently filed Reportable Incident Forms. Independent providers and very small providers may request to be exempted from the scheduled meeting requirement by requesting such exemption in writing to the Regional Director, who will forward the request to the Commissioner for consideration. This exemption must be approved annually. However, in all cases, regardless of any exemption, there should be evidence that all required incident review and follow-up activities are completed in a timely and appropriate manner.

6. Trend Analyses of Reportable Incidents: Provider Incident Review Committees are responsible for reviewing trends and patterns related to Reportable Incidents, including substantiated reports of abuse, neglect and exploitation. Providers must implement procedures for the completion of an annual written analysis of the trends and patterns related to Reportable Incidents, including substantiated reports of abuse, neglect, and exploitation. The written annual trend report must be available to DIDD staff who may request the report. This report must be sufficient in detail to provide a minimum of the following:

- Increasing and decreasing incidence rates of specific types of Reportable Incidents (including abuse, neglect and exploitation);
- Increasing and decreasing incidence rates of Reportable Incidents that resulted in serious injuries;
- Service recipients having higher than average numbers or multiple cases (of similar type allegations) of Reportable Incidents and/or substantiated reports of abuse, neglect and exploitation;
- Programs, and homes (as applicable) having higher than average numbers or multiple cases (of similar type allegations) of Reportable Incidents and/or substantiated reports of abuse, neglect and exploitation;
- Individual direct support staff and program/home supervisors (as applicable) having been involved in higher than average numbers or multiple cases (of similar type allegations) of Reportable Incidents and/or substantiated reports of abuse, neglect, and exploitation.

7. Incident Review Committee Minutes: Incident Review Committee meeting minutes describing committee discussion, recommendations, determinations and actions must be recorded and kept on file by the provider. Minutes must also reflect the date and time of the meeting, the meeting agenda and the members present. The provider agency has discretion regarding the format of Incident Review Committee minutes, but must ensure that the minutes

contain the required elements. Final determinations and actions taken regarding Reportable Incidents are to be documented on or as an addendum to the *DIDD Reportable Incident Form*.

18.3. Investigation of Abuse, Neglect and Exploitation Allegations

Incidents of alleged abuse, neglect and exploitation, as well as serious injuries of unknown cause and injuries or deaths suspicious of having been a result of abuse or neglect must be reported to DIDD per the timelines in Table 18.2.b "Time Frames Applicable in Reporting Incidents" in order to provide a means of safety and protection both to the alleged victim, as well as to other potential victims. All providers must develop and implement a system for timely reporting and responding to allegations of abuse, neglect and exploitation.

18.3.a. Responsibility for Conducting Investigations:

1. DIDD investigators are responsible for conducting investigations into allegations of abuse, neglect, and exploitation towards service recipients which involve DIDD employees, contracted employees, volunteers, or others affiliated with service recipients through DIDD. DIDD investigators also investigate serious injuries of unknown cause, suspicious injuries, and suspicious deaths (i.e. those possibly involving abuse, or neglect).
2. Incidents beyond DIDD jurisdiction shall be referred to the appropriate entity; i.e. Adult or Child Protective Services, Health Related Boards or local or state law enforcement.
3. DIDD may conduct investigations into failure to report incidents in a timely manner, as outlined in this chapter.
4. Except for the incidents described above, provider agency staff shall conduct all other reviews of reportable incidents; however, DIDD reserves the right to conduct an investigation into any incident.

18.3.b. Requirements for Investigation of Allegations Involving the Provider Executive Director/Chief Executive Officer or Other Provider Management Staff:

In cases when DIDD investigates the Executive Director/Chief Executive Officer or other Provider Management staff, the *DIDD Investigation Report* and *DIDD Summary of Investigation Report* will be sent to the Board Chair for not-for-profit providers and to the owner or corporate executive responsible for supervision of the local CEO of for-profit providers. The Board Chair or owner/corporate executive will be required to respond to final investigation reports that are substantiated.

18.3.c. Administrative Staffing Actions During Active Investigations: If there is an allegation of physical or sexual abuse, the provider is required to place any and all staff whose conduct may have contributed to the alleged abuse, on leave or assign such employees duties that do not involve direct care of service recipients, direct supervision of service recipients or supervision of other direct care staff, pending the completion of the DIDD investigation. If the provider believes that any involved staff should not be placed on leave, or reassigned, the provider agency may file

a written request for waiver of this requirement to the DIDD Central Office Director of Investigations or designee. Nevertheless, as stated above, if there is an allegation of physical or sexual abuse involved staff must be placed on leave or reassigned duties that do not involve direct care of service recipients until a decision on the waiver request is received from DIDD.

For allegations other than those described in the previous paragraph, the provider's policy will guide all administrative staffing actions during the investigative process. While the provider is not required to place the staff on administrative leave, the provider shall ensure that adequate steps are taken to assure the protection and safety of the alleged victim and other service recipients. For added assurance that people are protected, the provider's policy will be reviewed during the investigative process.

Regardless of the staff leave/reassignment, the provider should instruct all staff that the circumstances of the allegation are not to be discussed with anyone except the assigned DIDD investigator.

18.3.d. DIDD Distribution of Investigation Reports and Summary of Investigation Reports:

1. DIDD will send a final *DIDD Investigation Report*, as well as, a *DIDD Summary of Investigation Report* to the provider(s) responsible for the service recipient(s) involved.
2. The *DIDD Summary of Investigation Report* will be sent to the support coordination provider/DIDD case manager for all service recipients involved in the incident.
3. The provider will be expected to document reasonable attempts to notify alleged perpetrator(s) of the outcome of the investigation.
4. Within five (5) business days of receipt of the *DIDD Summary of Investigation Report*, the summary shall be discussed with the service recipient(s) involved to the extent possible (if a legal representative has been appointed, the legal representative shall be invited to participate), with such discussion conducted by a representative of the provider who supports the service recipient. The provider will document the date and time of this discussion.

18.3.e. Requesting a Review of DIDD Final Investigation Report: Providers (including support coordinators/case managers) and service recipients or legal representatives may request a review of the DIDD Final Investigation Report by:

- filing a written request for review with the DIDD Central Office Director of Investigations, or designee;
- filing within fifteen (15) business days of receipt of the DIDD Final Investigation Report (requests will not be considered outside this timeframe);
- filing on the *DIDD Review of Investigation Form* and include all referenced information; and
- filing by mail, fax or secure e-mail.

The review process is not an appeal; however, it is a process to review the accuracy of a Final Investigation Report when there is a disagreement with the conclusion or a question that the integrity of an investigation may have been compromised.

A disagreement with the conclusion or question of integrity must be based on new or additional evidence not addressed in the DIDD Final Investigation Report. A DIDD Final Investigation Report shall not be reviewed without evidence submitted to support the disagreement with the conclusion or evidence submitted to support the questioned integrity.

DIDD will respond in writing to requests to review investigations with a final decision within thirty (30) days of receipt of the request to review the investigation, unless it is determined that further investigation is warranted. If further investigation is warranted, an interim response will be issued, notifying the complainant or entity requesting review that further investigation is underway. A final decision will be issued upon completion of the additional investigation. In most cases this will occur within forty-five (45) days.

18.3.f. Provider Response to DIDD Final Investigation Reports: Regardless of any pending request for review of a DIDD investigation, the provider agency is required to respond to any DIDD Final Investigations where there is a substantiated allegation in writing (via mail or e-mail) within fourteen (14) days. Upon receipt of the substantiated DIDD Final Investigation Report, the provider will review the report and develop a plan of correction relevant to the incident(s) investigated and substantiated. The response to the investigated incidents shall include, but is not limited to:

- what has been done to safeguard the person;
- what procedures, if any, have been developed and implemented for protecting people from further abuse, neglect, or exploitation;
- if the incident was reported to DIDD in an untimely manner what has been done to address late reporting;
- copies of any staff disciplinary actions; and
- copies of the notifications of the outcome of the investigation sent to staff allegedly involved in the incident.

Provider response to a substantiated investigation will be reviewed and additional information may be requested of the provider if the follow-up is incomplete.

For unsubstantiated investigations: No plan of correction is required, but the agency is responsible for notifying staff allegedly involved in the incident of the outcome of the investigation and for addressing any additional incident information.

In the case of any investigation, DIDD staff will conduct follow-up to ensure that all appropriate actions have been taken.

18.3.g. Corrective/Preventive and Disciplinary Actions: Providers must ensure that appropriate actions are taken to achieve correction and/or prevention of issues identified as a result of Reportable Incidents, investigations and risk assessments, including questions, requests and recommendations from the Abuse/Neglect Prevention Committees (ANPC). Recommendations are to be acted upon and necessary corrective/preventive actions are to be taken in a timely manner. Provider documentation must be sufficient to describe any recommendations for corrective/preventive actions made by provider staff or committees and any actions taken to address recommendations provided by internal or external sources. Providers shall maintain and make available for DIDD review, evidence of response to all investigations including any follow-up on incidental information.

18.4. Provider Policy Requirements Pertaining to Protection from Harm

All providers are expected to develop Protection from Harm policies that address the various health, safety and welfare systems for the persons receiving services. Policies required include, but are not limited to:

1. Provider personnel policy must include a description of progressive disciplinary actions that will occur when substantiated reports of abuse, neglect and exploitation identify provider staff as perpetrators or when other types of staff misconduct occur (*DIDD Personnel Disciplinary Guidelines* are available to providers for use in developing appropriate disciplinary procedures and standards).

2. Requirements for Provider Reportable Incident and Abuse, Neglect and Exploitation Policy: Provider policy should ensure that when Reportable Incidents occur and involve service recipients, the agency has effective procedures for addressing the situation promptly and appropriately and for minimizing the future risk of a similar incident or event. Although policy for different providers may vary in certain respects, all such policies must be compliant with DIDD requirements in the eight basic areas listed below:

- Incidents that are defined as Reportable Incidents that must be reported to the DIDD Central Office;
- Reportable Incidents that must be reported immediately (within four hours) to the DIDD Investigation Hotline;
- Review, follow-up and closure of Reportable Incidents;
- Requirements for notification of entities external to the provider organization and DIDD of the occurrence of Reportable Incidents and of pending DIDD investigations;
- Timely response to Reportable Incidents and DIDD investigations;
- Trend studies of Reportable Incidents and substantiated reports of abuse, neglect, and exploitation;
- Risk assessments/reviews of service recipients, community homes/programs or other situations/circumstances which trend studies identify as presenting high protection and safety risks; and
- Immediate Response to Safety and Health Risks Associated with Reportable Incidents: Providers must implement policy to ensure immediate response to the safety and health

risks of service recipients, staff and others associated with each reportable incident. Such actions may include, but are not limited to:

1. Obtaining needed medical attention for service recipients, staff or others who are or could be injured or harmed
2. Immediately correcting any physical hazard that may have contributed to the incident;
3. Immediately attending to staff conduct that may have contributed to the incident;
4. Notifying the service recipient's support coordinator/case manager of the incident, including the need to obtain approval for additional services or supports or the need for funding to complete physical plant or adaptive equipment repairs, adaptations or replacement, as warranted; and
5. Consulting with the support coordinator/case manager regarding initiating planning to arrange for any counseling or psychiatric care that may be needed by the service recipient due to the trauma of being the victim of an incident (e.g., rape counseling).

3. Provider policy may require direct support staff to contact a supervisor prior to contacting the DIDD Investigation Hotline. If initial supervisory contact is required, the policy must also specify that no staff will suffer any adverse consequence if he/she chooses to report directly to the DIDD Investigation Hotline. It should also be noted that providers will be held accountable for any delays in filing reports to the DIDD Investigation Hotline that result from provider internal procedures.

4. Provider policy should specify the responsibilities of all staff in regard to reporting incidents timely and accurately, cooperating with DIDD investigators, including providing requested information timely, ensuring accurate documentation of Reportable Incidents and investigations and documenting corrective/preventive actions.

5. Provider policy must specify that the falsification of incident reports and/or related documentation, the filing of false allegations, the provision of false or misleading information during an investigation or the withholding of information during an investigation by any staff person may be cause for severe disciplinary actions, including legal or other administrative measures as appropriate.

6. Provider policy must specifically state that: "Any person subject to this policy who retaliates against another person for his or her involvement as a reporter, witness or in any other capacity related to incident management and/or investigations of abuse, neglect and exploitation shall be subject to disciplinary action, including possible termination. Such actions may also result in legal or other administrative measures as appropriate."

7. Provider Policy: All providers are required to develop **and implement** an internal written policy that addresses how administrative staffing actions are handled with regard to investigations. This includes alleged perpetrators identified initially as well as those identified at any point during the investigative process.

Staff alleged to have committed physical or sexual abuse are required to be placed on leave or be assigned duties that do not involve direct care of persons served, direct supervision of persons served or supervision of other direct care staff pending the outcome of the investigation.

For all other allegations of abuse, neglect and exploitation, the provider policy must outline specific provider actions to be taken to ensure the protection and safety of **the alleged victim and** all people receiving services who may come in contact with the alleged perpetrator.

8. Providers policy must ensure the confidentiality of the following:

- *DIDD Reportable Incident Form*;
- incident follow-up and review documentation; and
- DIDD investigation reports.

Confidentiality of this information must be ensured through secure storage of documents and reports in a location separate from service recipient records.

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	POLICIES AND PROCEDURES State of Tennessee Department of Intellectual and Developmental Disabilities	Policy #:	Page 1 of 8
Policy Type: Community	Effective Date:		
Approved by: <hr/> Commissioner	Supersedes: N/A Last Review or Revision: N/A		
Subject: COMMUNITY TRANSITION POLICY			

- I. **AUTHORITY:** Tennessee Code Annotated, Section 4-3-2701; Tennessee Code Annotated, Section 4-3-2708; Tennessee Code Annotated, Section 33-1-201; Tennessee Code Annotated, Section 33-3-103.
- II. **PURPOSE:** The purpose of this policy is to clarify the process to transition from one service provider to another or from one residential site to another for people enrolled in any Department of Intellectual and Developmental Disabilities (DIDD) services. This policy will also clarify the responsibilities of all contracted providers concerning community transitions and the ethics of recruiting waiver enrollees.
- III. **APPLICATION:** This policy applies to all DIDD staff, support coordination agencies, and contracted providers who may be involved in any service transition for people enrolled in DIDD services.
- IV. **DEFINITIONS:**
 - A. **Circle of Support (COS)** shall mean a group of people who meet together on a regular basis to help a person supported plan for and accomplish his/her personal outcomes and actions. The person supported is the focus or the center of the COS. At a minimum, this includes the person supported, his/her family member(s) and/or conservator(s), Case Manager, and the providers of any supports and services that the person receives. Friends, advocates, and other non-paid supports are included at the invitation of the person.
 - B. **Community Transitions** shall mean the movement of a person supported from one community service provider to another community service provider, from one residential setting to another residential setting, or from one grand region to another grand region.
 - C. **Community Transition Coordinator (CTC)** shall mean the Regional Office staff person who oversees the community transition process and ensures that transitions are implemented consistently and according to this policy.
 - D. **Home and Community Based Services (HCBS) Waiver or Waiver** shall mean a waiver program approved for Tennessee by the Centers of Medicare and Medicaid Services to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability (e.g. mental retardation) and who meet criteria of Medicaid reimbursement of care in an Intermediate Care Facility for the Intellectually Disabled. The

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Tennessee HCBS waivers operated by the Department of Intellectual and Developmental Disabilities (DIDD) include:

1. Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (#0128.R04.01) and any amendments thereto;
2. Home and Community-Based Services Waiver for Persons with Mental Retardation (#0357.R02.01) and any amendments thereto; and
3. Self-Determination Waiver (#0427.R01.03) and any amendments thereto.

E. **Exploitation** shall mean actions included but not limited to deliberate misplacement, misappropriation or wrongful temporary or permanent use of a person's belongings or money with or without consent. DIDD also considers it exploitation to illegally or improperly use a person or a person's resources for another's profit or advantage.

F. **Individual Support Plan (ISP)** shall mean Tennessee's format for the federally required plan of care. The ISP is a person-centered document that provides an individualized, comprehensive description of the person as well as guidance for achieving outcomes that are important to the person in achieving a good quality of life in the setting in which they reside. The ISP clearly describes the needs of the person and the services and supports required to meet those needs. The ISP also serves as the vehicle for justifying the person's need for services so that services can be authorized by the DIDD Regional Offices.

G. **Person Centered Planning** shall mean the process which focuses on a person in terms of who they are, what they want in life, and how their desired outcomes may be accomplished. Based on the values of human rights, inter-dependence, social inclusion, and responsible choice, this process discovers the person's gifts, skills and capacities while balancing what is important to and important for the person now and in the future.

V. **POLICY:** This policy outlines a person-centered planning process for transitions of people supported from one DIDD service provider to another, from one residential home to another or from one grand region to another. This process requires the wishes and desires of the person supported be considered by the COS and incorporated into the planning process. The COS in conjunction with the person shall determine if the proposed transition is in the person's best interests and if not, provide justification for pursuing the transition over objections.

VI. **PROCEDURES:**

A. **General Guidelines:** Transition from any service provider initiated by the Person, Circle of Support (COS) or Conservator:

1. Any person enrolled in DIDD services has the right to choose service provision from all available and qualified providers in the DIDD provider network.
2. The person supported Independent Support Coordinator (ISC) is responsible for facilitating the transition, completing the transition form, compiling documents to be included in the transition packet, and forwarding the entire packet to the respective DIDD Regional Office CTC.

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3. Any change in provider initiated by the COS must:
 - a. Be in the best interest of the person.
 - b. Have the agreement of the person supported or document the reason the transition is being pursued without such agreement.
4. If a person in services wishes to transition from one provider to another, and makes this desire known, regardless of reason the COS has the responsibility to pursue this request.
5. A member of the COS shall inform the person of the outcome of that request. If the person is not able to transition to the chosen provider, alternatives need to be offered.
6. If possible, the current situation shall be resolved to the person's satisfaction. However, if there is no resolution to the satisfaction of the person, the COS shall continue to investigate alternatives or modifications of current supports to address the person's concerns.
7. The person supported must be included in and informed of any decision concerning where or with whom he/she lives and what services are received. This choice is to be provided even if the person has a legal conservator that typically makes those decisions.
 - a. If the person expresses disagreement with a proposed transition, the transition plan must state the reasons for the disagreement and the reason the transition is being pursued without that agreement.
 - b. Conservatorship papers may be requested and reviewed by the Regional Office Community Transition Coordinator (CTC). This review is to ensure that the conservator has the legal authority to pursue the transition regardless of the person's wishes.
 - c. If there is disagreement among the COS members about the appropriateness of a proposed transition, any member of the COS may contact the DIDD Regional Director or Complaints Coordinator for conflict resolution or mediation.
8. Recruitment of individuals for providers benefit is **not acceptable**. If recruitment is suspected, any member of the COS is encouraged to contact the DIDD Regional Office or Complaints Coordinators prior to the transition meetings for assessment and intervention as needed.
 - a. A meeting shall be held with the person, family, conservator and the current service provider to discuss and attempt to resolve any concerns regarding current services. If these concerns cannot be resolved, the reasons must be thoroughly documented and submitted to the Regional Office as part of the transition packet.
 - b. If the Regional Office determines the transition does not clearly increase the benefit of services for the person, the transition plan will be denied.

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- c. In addition to the possible denial of the transition, the situation may be referred to the DIDD Investigation Unit to determine if exploitation of a person has occurred.

B. Inter-agency transitions initiated by person supported, conservator or COS:

1. Both the sending and receiving agency shall be involved in all transition planning and have representatives present at all transition meetings.
2. The Transition Planning Form shall document how this transition will better meet the needs of the person supported.
3. The transition packet shall be submitted to the Regional Office at least fourteen (14) calendar days in advance of the projected transition date and shall include at a minimum:
 - a. An amended ISP, including the amended Section C with the name of the service providers, and the amount, frequency and duration of services.
 - b. Transition Planning Form
 - c. Recommended staff cross training, if applicable.
4. Regional Office staff shall review the ISP in accordance with DIDD service authorization protocols and shall follow established procedures for approval or denial of service requests as well as issue written notice of the decision.
5. A copy of the person's complete comprehensive record (including applicable releases of information) must be transferred to the receiving agency no later than the date of the transition in accordance with Section A.19 of the Provider Agreement.

C. Changes initiated by the current service provider: If a service provider has determined that services will be discontinued for a person supported, the provider shall comply with Section A. 19 of the Provider Agreement between the State of Tennessee Department of Intellectual and Developmental Disabilities and the Bureau of TennCare (Provider Agreement) and an official notice of discontinuation of services must be issued.

1. The ISC, Regional Office and legally responsible person shall work together to locate an alternative service provider for the person within sixty (60) calendar days of the issuance of the written notice.
2. Timeframes for completion of the transition must be developed as part of the plan and the Regional Office must be notified as soon as there is recognition that the transition cannot be accomplished by the original target date.
3. If this transition cannot be accomplished within that sixty (60) calendar day timeframe, the COS shall meet as soon as possible prior to expiration of the sixty (60) day timeframe to identify and address barriers to the transition. This meeting shall include a representative from the Regional Office.

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4. The COS and the Regional Office are responsible to ensure that the transition occurs as soon as possible while simultaneously ensuring the person's health and welfare.

D. **Transition of Residence or Residential services:** If a person receiving residential services is transitioning from one residential service provider to another but staying in the current home; moving to a different residential home with the same provider; or to a different residential home with a different provider, the following procedures shall apply:

1. The COS shall ensure that the person is aware of and agrees with the transition even if the person has a conservator
 - a. If the transition has been precipitated by a dispute between the provider and the contracted agency, the ISC shall inform the DIDD complaint coordinator or Regional Office.
 - b. A meeting shall be held with the person, family, conservator and the current service provider to discuss and attempt to resolve any concerns regarding current services. This meeting shall include a representative from the regional office.
 - c. If these concerns cannot be resolved, the reasons must be thoroughly documented and submitted to the Regional Office as part of the transition packet.
2. The Transition Planning Form shall be completed.
3. Requirements regarding a change in providers as written in Policy P-008-B Personal Funds Management Policy Section E.3. (h) shall be completed, as applicable. A personal budget shall be submitted indicating that the person supported can afford the on-going expenses associated with daily living in the new home. The COS shall determine how moving expenses will be funded. This shall be documented on the Transition Planning Form.
4. All necessary equipment and medication shall be present and ready for use at the new location on the day of the move.
5. An assessment of the person's mobility shall be performed in order to determine the need for environmental modifications to the home. If environmental modifications are needed in order to safely support the person in the home, a site assessment of the home shall be performed. If the COS has questions concerning the need for a site assessment, the COS and or residential provider may contact the regional therapeutic services team, or a DIDD contracted physical therapist (PT) or occupational therapist (OT) for consultation.
6. All environmental modifications determined to be necessary for the person to be supported safely shall be in place, functional and inspected by the evaluating clinician (e.g. OT or PT) prior to the move unless otherwise indicated in writing by that clinician.
7. If environmental modifications cannot be completed prior to the actual move, a plan with timeframes for completion and for ensuring the person receives needed

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services and care shall be submitted to the Regional Office CTC as part of the transition packet. The plan must include a target date for completion of the modifications. The ISC shall notify the Regional Office CTC when the modifications are completed.

8. Any residence that will be occupied by a person supported must meet all applicable occupancy requirements (e.g. licensure, fire safety, etc.) in accordance with DIDD Provider Manual Chapter 19 Residential Services prior to transition to the new residence.
9. A person supported shall remain in a rented or leased residence until the terms of rental agreement or lease have been met. This requirement may be waived when:
 - a. The provider agency initiating the transition is willing to accept responsibility for the payment of the remainder of the lease.
 - b. The person supported has made arrangements for the payment of the remainder of the lease. If this arrangement involves an advance from a provider, there must be an approved agreement in place as required in P-008-B Personal Funds Management Policy.
 - c. The person supported has received a notice of eviction.
 - d. The lessor (e.g. landlord) is in default of the lease or rental agreement per Tenn. Code Ann. 47-2A-508.
10. The sending and receiving service providers shall complete the applicable section of the *Day of Move Notification of Community Transition* form and submit it to the Regional Office CTC by the first business day after the move.
11. If there is a change in residence, the ISC will ensure the next monthly visit occurs in the person's new home.

E. Transition of Independent Support Coordination Agencies:

1. A person in services or the person's guardian/conservator may request a change in support coordination providers through the current ISC or by contacting the DIDD Regional Office.
2. A list of all support coordination providers shall be made available to the person and/or the guardian/conservator.
3. The DIDD Regional Office staff will work with the person supported and/or conservator to select a new ISC provider.
4. Before the transition is approved, the Regional Office shall receive documentation that the change is in the best interests of the person supported. No transition will be approved without such documentation.
5. The DIDD Regional Office shall notify the current as well as the new support coordination provider within seven (7) business days of approving the transition.

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6. The transition shall be effective on the first day of the calendar month following approval of the transition.
7. The new ISC provider shall amend the ISP including Section C to reflect the new provider of support coordination services.
8. The transferring support coordination provider shall provide copies of the person's records to the new support coordination provider in accordance with Section A. 19 (a)(iv) of the provider agreement.

F. Change in Personal Assistance or Day Providers:

1. The ISC shall complete the transition packet and submit it to the Regional Office CTC.
2. Before any change is approved, the Regional Office must have documentation that the change is in the best interests of the person. No change shall be approved without such documentation.
3. Prior to initiation of personal assistance services rendered in a private home, the DIDD contracted provider shall conduct an inspection of the home to ensure the person's health, safety and welfare can be maintained while receiving services within the designated environment.
4. If the provider determines that the person supported cannot be safely supported in the designated home, then the provider shall notify the Regional Office CTC and the ISC within one (1) business day. The ISC and CTC will assist the person supported with identifying alternate service options.

G. Inter-region Transitions:

1. When a person is transitioning from one grand region to another, the current ISC shall notify the current region's CTC as soon as possible of the intended move.
2. The current CTC shall work with the CTC in the region of the anticipated move, the person supported, current ISC and COS to ensure an effective, efficient and person-centered planning process for the transition.
3. The current ISC shall submit a transition plan for approval to the current CTC in accordance with this policy.
4. The current CTC shall review the transition plan and shall approve services according to service and rate approval protocols. The CTC shall ensure that all requirements in P-008-B Personal Funds Management Policy Section E.2.h have been met.
5. The person supported may choose to remain with the current ISC agency or if the current ISC agency is not operating in the region of the anticipated move, the person may choose a new ISC agency.

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6. If an ISC agency in the region of the anticipated move has not been chosen, the current CTC shall work with the person and legal representative to select a new ISC agency.
7. The new ISC will work with the person and legal representative to identify service providers in the region of the anticipated move.
8. The current CTC and the current ISC are responsible for ensuring that copies of the person's records including cost plan information, ISP and other documents are forwarded to the CTC in the region of the anticipated move in accordance with Section A. 19 of the Provider Agreement.
9. The CTC of the current region is responsible for ending services in that region upon completion of the transition.

VII. **ATTACHMENTS:**

- A. Transition Planning Form
- B. Day of the Move Notice

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

TRANSITION PLANNING FORM

(Person's Name)	(Meeting Date)

- FOR Change in Home Only
- FOR Change in Residential Provider
- FOR Change in Home and Provider

ISC Agency:
Current Provider:
New Provider:
Target Transition Date:
New address:

To Be submitted electronically

TRANSITION PLANNING ACTIVITIES:

(Instruction: All of the activities listed below must be addressed in reviewing and preparing for an upcoming transition. For any activity not completed, explain why and the steps to be taken to address the activity in the comments section.)

1. Reason for the transition: *What is the specific reason for the transition? What is the benefit to the person? If the transition is the result of dissatisfaction with the current service provider, was the complaint /concern discussed with the agency's or DIDD complaints resolution staff? If no, why not? What choices or options (including this transition) were discussed with the person and COS? Is the person and / or conservator in agreement with this move? If there is disagreement about the appropriateness of the move, list the reason for the disagreement and the reason the transition is being pursued without that agreement.*

2. Describe how the characteristics of the new home (i.e. home styles, no stairs, accessibility, location, terrain, storage needs, will the landlord allow these modifications) meet the person's needs. (N/A if there will be no change in home.)
N/A

3. Describe how the characteristics of the new housemate(s) make them a good match for the person. (N/A if there will be no change in housemates)
N/A

4. Budget Information:
 - a. The current residential provider has developed a personal budget.
Yes No
 - b. The person can afford moving expenses.
Yes No
 - c. The person will be able to live within their means.
Yes No
If No, explain how these issues will be resolved:
 - d. Will there be any additional monthly expenses with this transition?
Yes No
If yes, explain:

5. What cross training is needed to ensure a smooth transition for the person? (i.e. staff instructions, BSP, ISP, shadowing, etc.) NA if there will be no change in staff.
N/A

6. Mobility – If the answer to either question below is yes, contact the person's OT or PT OR the appropriate Regional Therapeutic Services staff to determine if a therapeutic site assessment is needed. (If modifications are found to be needed, ISC will follow up with the appropriate therapist to request documentation that the modifications have been completed prior to the move.)

Does the person use mobility devices?
Yes No

Does the person have a history of falls?
Yes No

If modifications are found to be needed, what is the estimated date of completion?
If unable to complete modifications prior to the move, what is the plan to make sure the person's needs are met?

**DEPARTMENT OF INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES**

**TRANSITION PLANNING
FORM**

(Person's Name)

(Meeting Date)

7. List COS members and others who were involved in developing this transition plan:

COMMENTS & NOTES:

--

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

**DAY OF MOVE
NOTIFICATION OF COMMUNITY TRANSITION**

Person's Name	Move Date(Today's Date)

- For change in residential only
- For change in provider
- For change in residential and provider

ISC Agency:
Previous Provider:
New Provider:

To be submitted electronically

ON THE DAY A PERSON TRANSITIONS, SEND THIS FORM TO THE COMMUNITY TRANSITION COORDINATOR AT THE DIDD TENNESSEE REGIONAL OFFICE

PLEASE SEND A COPY TO THE ISC AGENCY.

Provider agency representative(s):

- Please complete the entire form when a person changes residences, but continues to be supported by your agency.
- If a transition between agencies, outgoing provider agency completes section 1.
- If a transition between agencies, receiving provider agency completes section 2.

Section 1:

Previous Address:
Will anyone continue to reside in this home? Yes <input type="checkbox"/> No <input type="checkbox"/>
If No, do you want to discontinue site code? Yes <input type="checkbox"/> No <input type="checkbox"/> Effective Date:

Section 2:

Current/New Address:
Current/New Phone number:
Address notices and change of representative payee notices, as applicable, for all benefits, such as Foodstamps, SSI, STRAP, Form 2350, and checking account are complete. Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Explain:
Comprehensive record and all personal documents, including TennCare and Soc. Sec. Cards, legal papers, birth certificate, etc. are moved with the person. Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Explain:
All necessary equipment and medication is present. Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Explain:
Cross Training has been completed. Yes <input type="checkbox"/> No <input type="checkbox"/> If No, Explain:
Amount of money transferred with the person (mark N/A if no change in provider):

 <p style="text-align: center;">POLICIES AND PROCEDURES</p> <p style="text-align: center;">State of Tennessee Department of Intellectual and Developmental Disabilities</p>	Page 1 of 13
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Policy Type: Community, ICF/ID	Effective Date:
Approved by:	Supersedes: Policy #: 015
Commissioner	Last Review or Revision:
Subject: Death Reporting and Review Policy	

- I. **AUTHORITY:** Tennessee Code Annotated (TCA) 4-3-2708, TCA 33-3-101; TCA 33-2-402; TCA 39-13-527; TCA 68-11-1001; TCA 63-6-219; Code of Federal Regulations (CFR) 42 § 483.420 (a); Section 1150B of the Social Security Act, Patient Protection and Affordable Care Act (PPACA) Sec. 6703 (b)(3).
- II. **PURPOSE:** The purpose of this policy is to establish a process for conducting systematic reviews of deaths of persons with intellectual or developmental disabilities for whom the Department of Intellectual and Developmental Disabilities (DIDD) and private ICFs/ID provide services in Tennessee; to identify factors which may have contributed to the death; to recommend necessary preventive measures; and, to improve supports and services for all persons in the system.
- III. **APPLICATION:** This policy applies to all DIDD staff, service providers, and individuals who are responsible for reporting deaths or participating in the systematic review of the death. Deaths of individuals participating in all programs operated by DIDD which are funded by the State of Tennessee or by the Title XIX Medicaid Program are covered by this policy.
- IV. **DEFINITIONS:**
 - A. **Class Member** shall mean an individual meeting the requirements in the definition of the class specified in the People First of Tennessee, et al vs. the Clover Bottom Developmental Center, or The United States of America vs. State of Tennessee, et. al. (Arlington Developmental Center).
 - B. **Clinical Death Summary** shall mean a written report by a qualified registered nurse regarding the circumstances surrounding an individual's death that includes information such as services received or omitted, significant events, healthcare and medication histories, cause of death and autopsy findings (if available), and other information relevant to the death.
 - C. **DIDD Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)** shall mean Department of Intellectual and Developmental Disabilities (DIDD) state owned and operated facilities for persons with intellectual disabilities.
 - D. **Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule** establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule

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requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

- E. **Home and Community-Based Services Waiver or Waiver** shall mean a Home and Community Based Services waiver for persons with intellectual disabilities that includes the following:
1. Home and Community-Based Services Waiver for the Mentally Retarded (now referred to as Intellectual Disabilities) and Developmentally Disabled (0128.R04) and any amendments thereto;
 2. Home and Community-Based Services Waiver for Persons with Mental Retardation (referred to as Intellectual Disabilities) (0357.R02) and any amendments thereto; and
 3. Tennessee Self-Determination Waiver Program (0427.R01) and any amendments thereto.
- F. **Independent Review by a Qualified Physician** shall mean a medical review of a death covered under this policy through which a qualified physician unaffiliated with treatment of deceased individual will conduct a detailed medical review of the records to render evidenced based, objective determinations as to the cause of death and associated contributing factors.
- G. **Preliminary Death Review Team** shall mean a designated group of persons in the DIDD Regional Office that includes the Regional Office Director of Nursing or designee, Regional Office Director or designee, and the Regional Office Compliance Director or designee who review initial information about a death to determine if it meets criteria for a death review.
- H. **Private Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)** shall mean intermediate care facilities for persons with intellectual disabilities that are owned and operated by entities other than the state.
- I. **Suspicious Death** shall mean any death that possibly involves or results from abuse or neglect.
- J. **Unexpected or Unexplained Death** shall mean any death that did not result from the normal progression of a known medical condition or disease, including but not limited to healthcare or emergency intervention that is inappropriate, untimely, or inconsistent with physicians' orders, advance directives, or applicable policies or standards governing withholding of medical treatment.
- V. **POLICY:** Entities serving persons with intellectual and developmental disabilities who are supported by HCBS waiver or other community programs funded through DIDD, by DIDD ICFs/ID and by private ICFs/ID are responsible for reporting the death of such supported persons to DIDD and for complying with the DIDD Death Review process.

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VI. PROCEDURES:

A. Reporting a Death

1. Death incidents shall be reported in accordance with the following:
 - a. Deaths in HCBS waiver programs or other DIDD community programs and private ICF/IDs are reported in accordance with the DIDD Provider Manual Chapter 18 Protection from Harm. Notifications include:
 - 1) Within four hours of awareness of the death:
 - a) For private ICFs/ID: Notice to the private ICF/ID Director or designee and Regional Office Administrator of the Day;
 - b) HCBS Waiver programs/community programs: Notice to the Regional Office Administrator of the Day;
 - c) If the death is suspicious (alleged abuse or neglect involved), unexpected or unexplained, notice to the DIDD Investigations Hotline;
 - d) Notice to the person's family, next of kin, and/or legal representative as soon as possible but no later than within 24 hours.
 - b. Deaths in DIDD ICFs/ID are reported in accordance with the **Policy #-200 Protection from Harm in Public Intermediate Care Facilities for Persons with Intellectual Disabilities Policy**. Notifications include:
 - 1) Within one hour of awareness of the death:
 - a) For DIDD ICFs/ID: Notice to the DIDD ICF/ID Director or Chief Officer or designee or Administrator of the Day;
 - b) If the death is suspicious (alleged abuse or neglect involved), unexpected or unexplained, notice to the DIDD Investigations Hotline;
 - c) Notice to the person's family, next of kin, and/or legal representative as soon as possible but no later than within 24 hours.
 - 2) By the next business day:
 - a) Reportable Incident Form to the DIDD Central Office, Regional Office Director and the person's Independent Support Coordinator Agency or Support Coordinator;
 - b) Notice of Death Form to the Regional Office Director; and

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c) Commissioner.

3) If the death is the result of a suspected crime, the DIDD ICF/ID Director or Chief Officer shall contact local law enforcement and the Department of Health within one hour of awareness of the death.

2. Where the deceased individual had more than one provider, the priority order for determining the agency responsible for reporting the death, from highest to lowest, would be as follows, if applicable:

- a. The provider of Residential Services;
- b. The provider of Day Services;
- c. The provider of Personal Assistance services;
- d. The Independent Support Coordinator; or
- e. The DIDD Regional Office.

3. Notification of law enforcement or the medical examiner: Regardless of setting, the designated staff at the DIDD Regional Office or private ICF/ID shall notify law enforcement or the medical examiner immediately if the death occurred suddenly when the person was in apparent good health, if the death occurred in a suspicious, unexpected, or unexplained manner or if the death is the result of a suspected crime.

B. Preliminary Death Review

1. If the decedent is a class member and residing at Clover Bottom Developmental Center or Green Valley Developmental Center at the time of death, a Death Review will be conducted by developmental center staff. Therefore, a Preliminary Death Review is not applicable.

2. Within five (5) business days of receipt of a Notice of Death, the Preliminary Death Review Team shall conduct a Preliminary Death Review to determine if the death meets criteria for Unexpected or Unexplained under the following circumstances:

- a. The Death was of a Class Member in a DIDD ICF/ID (e.g. 4, 6, or 8-person home), and
- b. The Death was of a person receiving services through a Home and Community-Based Services (HCBS) waiver program, other community program administered by DIDD or was residing in a private ICF/ID.

3. A Clinical Death Summary by a DIDD or contract registered nurse and a DIDD Death Review by the Death Review Committee shall be completed for any death determined to be unexpected or unexplained. Once the process of preparing a Clinical Death Summary and initiating a Death Review has begun, the

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Preliminary Death Review Team has completed its responsibilities and shall not consider any additional information.

C. Clinical Death Summaries

1. A Clinical Death Summary shall be completed for the following deaths:
 - a. Any death of a Class Member
 - b. Any Unexpected or Unexplained death as determined by the Preliminary Death Review Team.
2. The Clinical Death Summary shall be completed within thirty (30) calendar days of the death by the DIDD Regional Nurse (registered) or a qualified, independent registered nurse. The DIDD Central Office (CO) Director of Nursing is responsible for making arrangements with the independent registered nurse, when applicable.
3. Clinical Death Summaries shall be distributed immediately upon completion to the following:
 - a. The DIDD Central Office Nursing Director
 - b. The DIDD Regional Office Director
 - c. The Executive Director of the provider agency primarily responsible for serving the individual
 - d. The Chief Administrator / Chief Officer of the DIDD ICF/ID
 - e. The Chief Administrator of the private ICF/ID
 - f. The DIDD Regional Compliance Director

D. Initial Agency Death Review: The purpose of the Initial Agency Death Review conducted by the agency is to identify any preventable and systemic conditions or practices that may have contributed to the death of a person that requires immediate intervention in order to protect other individuals from similar untoward events. The review must include a review of events surrounding the death, identification of known or likely contributing factors, and review of any other required information. Examples of such conditions or practices might include environmental hazards, a delay in emergency response or in seeking medical intervention, or abusive or neglectful conduct on the part of staff or others. The Initial Agency Death Review conducted by the agency is not expected to resolve all outstanding issues but may be used to identify questions or concerns to be addressed in subsequent investigations and proceedings.

1. When the death involves an individual receiving a residential service, the residential provider agency shall immediately initiate an Initial Agency Death Review.

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2. The Initial Agency Death Review shall be completed within five (5) business days of the individual's death. The Initial Agency Death Review Form shall be submitted electronically to the appropriate DIDD Regional Director.
3. The DIDD Regional Director or designee shall review the form for completeness and transmit it to the DIDD Commissioner or designee.
4. The Commissioner or designee shall review the Notice of Death Forms, the Reportable Incident Forms, and the Initial Agency Death Review Forms upon receipt and shall determine whether immediate intervention is necessary to protect other individuals who are receiving services.
5. When the death involves a resident of a DIDD ICF/ID, an independent review by a qualified physician of the death may be conducted either as part of the Initial Agency Death Review or at any time thereafter.

E. DIDD Death Reviews: The purpose of a DIDD Death Review is to conduct a comprehensive analysis of the relevant facts and circumstances, including the healthcare provided, to identify practices or conditions which may have contributed to the death and to make recommendations to prevent similar occurrences. It is not intended to be an investigative, fault finding process.

1. Death Reviews shall be performed by the Regional Death Review Committee.

a. Death Review Committee:

- 1) The chair of the Death Review Committee shall be the Regional Office Compliance Director or designee.
- 2) The Death Review Committee must include the following members:
 - a) A qualified physician unaffiliated with treatment of deceased individual and who was not associated with the provider agency, DIDD developmental centers, DIDD ICF/ID, or private ICF/ID, as applicable, within a year of the individual's death. However, a DIDD physician shall, upon request of the Chairperson, serve as the physician on the Death Review Committee.

For deaths occurring in community settings, a developmental center physician meeting the above requirements may serve as the independent physician member of the committee.

- b) The registered nurse who completed the Clinical Death Summary.
- c) The Executive Director or designee of the provider agency primarily responsible for serving the individual through an HCBS waiver program or other DIDD

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community program, the administrator of the DIDD ICF/ID or designee or the administrator of the private ICF/ID or designee, as applicable.

- d) At least one program staff person from the provider agency, the DIDD ICF/ID, or the private ICF/ID, who is familiar with the individual's health status and history and the course of events prior to death.
 - e) The Independent Support Coordinator or equivalent, assigned to the individual.
- 3) The Death Review Committee may also include the following members by invitation of the Chair:
- a) The primary care physician, nurse practitioner, or physician assistant who coordinated or provided health care to the individual.
 - b) The Agency Director of Nursing or the nurse who provided care to the individual while receiving services through an HCBS waiver program or other DIDD community program in a DIDD ICF/ID, or in a private ICF/ID.
 - c) One or more health specialists (e.g., psychiatrist, neurologist, occupational therapist, physical therapist or other specialists as needed) as determined by the Central Office Director of Nursing in consultation with the DIDD Commissioner
 - d) The parent of a person with a disability unrelated to the deceased individual.
2. **Timeline for Conducting a Death Review:** Death Reviews shall be conducted within 45 business days of the individual's death; however, this time period may be extended by the DIDD Commissioner for good cause.
3. **Death Review Committee Chair Responsibilities:**
- a. The Regional Office Compliance Director or designee shall be responsible for arranging the Death Review Committee meeting, selecting a time and location that takes into consideration the participants' schedules, and notifying the Death Review Committee members and the DIDD Central Office Nursing Director in writing of the meeting. The Regional Office Compliance Director or designee shall determine who, in addition to standing Committee members, can be included on the Committee for the particular Death Review.
 - b. Requests by additional persons (e.g. non-committee members) to attend the Death Review must be submitted in writing in advance of the meeting

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to the Death Review Committee chair and Central Office Director of Nursing. The chair will be responsible for notification that the request has or has not been granted.

- c. Preparing Death Review Packets for all Death Review Committee members.
 - 1) Death Review Packets for all Death Review Committee members must include:
 - a) Notice of Death form
 - b) Reportable Incident Report
 - c) Initial Agency Death Review Form
 - d) Current and recent medication history
 - f) DIDD Investigation Report (if applicable)
 - g) Autopsy Report (or preliminary report if applicable)
 - h) Death Certificate, if available
 - i) Clinical Death Summary
 - j) Individual Support Plan
 - 2) Death Review Packets for the DIDD Central Office Nursing Director, independent physician and other specialists, as applicable, on the Committee must also include:
 - a) Hospital and other discharge summaries
 - b) Medication histories and other relevant health care information
 - c) Any emergency services or 911 records
 - d) Any relevant psychosocial or other information relating to the deceased individual
 - d. At least five (5) calendar days prior to the Death Review meeting, distribute the appropriate Death Review Packet to each Death Review Committee member.
4. Death Review Committee Responsibilities
- a. Committee members shall review Death Review Packets prior to the meeting.

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- b. The Committee may make recommendations for improvement by the appropriate community agency, DIDD ICF/ID or private ICF/ID as follows:
 - 1) Recommendations will be made by members present at the meeting and will be agreed upon by the committee.
 - 2) The recommendation must be realistic and achievable.
 - 3) The recommendation must be measurable.
 - 4) There must be written rationale for the recommendation.
 - c. In instances when an autopsy is conducted but the final report is not available at the time of the Death Review Committee meeting, the registered nurse who wrote the Clinical Death Summary shall be responsible for attempting to obtain a preliminary oral or written autopsy report for discussion at the Death Review Committee meeting.
 - d. The Death Review Committee may reconvene to consider additional information that is pertinent to the death (e.g. autopsy, death certificate or investigation report) that is submitted subsequent to the initial Death Review Committee meeting.
 - e. The Death Review Committee, in consultation with the DIDD Central Office Nursing Director, shall determine from a review of the minutes whether any aspect of the death should be referred to any licensing or regulatory agency or to law enforcement officials, if referrals have not already been made.
5. Records of Death Review Committee Meetings
- a. Confidentiality: Records of Death Review Committee meetings are confidential.
 - 1) A Death Review Meeting Attendance Form containing a statement of confidentiality must be signed by all participants at the beginning of each meeting.
 - 2) The proceedings of the Death Review Committee, including discussions among the members and any documents reviewed, shall be treated as confidential.
 - b. Minutes: Formal minutes shall be maintained for each Death Review Committee meeting.
 - 1) Draft minutes shall be prepared by the Chair and made available to all Committee members for comment within eight (8) business days after the meeting.

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- 2) Committee members shall have four (4) business days to review the draft minutes and submit corrections and comments to the Chair.
- 3) Following the comment period, the Chair of the Committee shall finalize the minutes within three (3) business days.
- 4) These timeframes may be extended by the DIDD Commissioner or designee for good cause.
- 5) The minutes shall include:
 - a) Date of the meeting
 - b) List of names and titles of committee members in attendance
 - c) Name of the deceased
 - d) Age of the deceased at the time of death
 - e) Place of residence of the deceased at the time of death
 - f) Date, time, and place of death
 - g) Cause of death
 - h) Brief summary of the circumstances surrounding the death
 - i) Full summary of issues discussed by the committee
 - j) The Committee's specific findings with regard to the care and treatment provided to the individual
 - k) Identification of any factors which may have contributed to the death in question
 - l) Any recommendations for improvement agreed to by the committee. The minutes must clearly indicate the basis for all such recommendations.
- 6) Distribution and maintenance of Death Review Committee minutes.
 - a) Copies of the final minutes shall be distributed to the following:
 - (1) DIDD Commissioner or designee
 - (2) DIDD Central Office Nursing Director

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- (3) DIDD Regional Office Director
- (4) The administrator / Chief Officer of the DIDD ICF/ID, if applicable
- (5) The director of the private ICF/ID, if applicable
- (6) The executive director of the provider agency primarily responsible for serving the individual, if the death involved an individual receiving services through an HCBS/waiver or other community program; and
- (7) Other entities, as needed and determined by the Chair.

- b) Individuals authorized to receive the minutes shall maintain their copies in a secure location in accordance with state and federal confidential privacy statutes, rules and regulations.
- c) DIDD Regional Compliance Director or designee shall be responsible for maintaining a complete file of all relevant documents (including those reviewed by or made available to the Death Review Committee) in a secure location for at least ten years, in accordance with Tennessee Code Annotated 33-3-101. Records of Class Members shall be maintained until the lawsuit is dismissed, which, for some, may extend beyond the ten year requirement.
- d) The DIDD Commissioner, in consultation with the DIDD Central Office Nursing Director, shall determine whether the death review findings should be disseminated more widely.

F. Follow-up of Death Review Committee recommendations:

- 1. Response to Death Review Committee recommendations: The Executive Director or designee of the community provider agency, the Director / Chief Officer of DIDD ICF/ID or designee, or the administrator of the private ICF/ID or designee, as appropriate for the particular death, shall provide a written response to any Death Review Committee recommendations within thirty (30) calendar days of the receipt of the recommendations. The response shall include a complete plan with time frames for implementing each recommendation or an explanation of proposed alternative actions that will be taken to address the problem(s) identified. The response shall be submitted to the DIDD Regional Compliance Director who shall submit the response to the DIDD Regional Director for review.

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2. The DIDD Regional Office Director or designee shall be responsible for tracking and monitoring the provider's implementation of the Death Review Committee recommendations. Monitoring may include on-site review of records and the provider's practices.
3. The DIDD Regional Compliance Director or designee shall submit implementation status reports to the DIDD Central Office Nursing Director on a quarterly basis.

G. Additional quality improvement activities

1. Annual review of death data: At least annually, the Central Office Director of Nursing or designee shall review and analyze death data to determine possible patterns or risk factors in areas such as:
 - a. The demographic, medical, mental health and service provision profile of the deceased individuals.
 - b. The immediate and root causes of death.
 - c. The issues, problems, and deficient practices or procedures identified in death reviews.
 - d. The implementation of recommendations issued as a result of the death reviews.
2. Quality Reviews
 - a. The Central Office Nursing Director will facilitate an annual quality review of Death Reviews.
 - b. A standard review instrument will be used to review required components of the Death Review records:
 - 1) Clinical Death Summary
 - 2) Death Review Minutes
 - 3) Death Review Packets
 - c. The random record sample for the Review shall include 10 percent of death reviews conducted in each region.
 - d. The instruments used for scoring will be retained by the Central Office Nursing Director or designee who will prepare a Quality Review report. The Central Office Director of Nursing shall submit the Quality Review to the Director of Health Services for review and distribution it to Regional Office Directors, Regional Compliance Directors and Regional Nursing Directors.

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- e. The Director of Health Services or designee will work with appropriate Regional Office Compliance Directors to address the findings in the Quality Review.
- 1) For indicators scoring 85% or below, the responsible entity or entities shall develop an improvement plan and submit it to the Director of Health Services or designee for approval.
 - 2) The Director of Health Services or designee may propose recommendations for improving consistency and quality of Death Reviews based on results of the Quality Review.

VII. ATTACHMENTS:

- A. Reportable Incident Form
- B. Initial Agency Death Review Form
- C. Death Review Attendance Form
- D. Notice of Death Form

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DEATH REVIEW COMMITTEE ATTENDANCE FORM

Date: _____ Time: _____ Location: _____

Decedent Name: _____ SSN: ____ / ____ / ____ DOB: _____

The undersigned agree to hold the death review process in strict confidence. This agreement pertains to *all* activities and proceedings relating to the death review process and includes, but is not limited to, informal and formal discussions, decedent records, notes, reports, findings and recommendations.

PARTICIPANT SIGNATURE	PRINTED NAME	TITLE
1. _____	_____	_____, Chairperson
2. _____	_____	_____, Recording Sec.
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

Attach to DRC Final Report

CONFIDENTIAL



REPORTABLE INCIDENT

Department of Intellectual and Developmental Disabilities

Name of Service Recipient _____ SSN _____ Date of Incident ____/____/____

Please Type _____ Last, First, MI _____ Time of Incident ____: ____ AM PM

Region _____ Provider Responsible _____ Provider Code _____ Provider Reporting (if different) _____

DIDD Investigator must be notified within 4 hours (1 hour for Public ICF/MR) for alleged abuse, neglect, exploitation, serious injury of unknown cause, for any unexpected, unexplained, or suspicious Death, and for any injury that raises the suspicion of abuse or neglect.

This incident was Witnessed by Select One or Discovered

> Where incident occurred Address / Site of Incident
[Check one] Home - Inside Home - Outside Vehicle Day Program/Work/School
 Community-Supervised Community-Unsupervised Unknown

> This incident required Check all that apply
 Hospital Emergency Room Manual Restraint MH Mobile Crisis Team Police 911 Call
 X-ray (to rule out fracture) Mechanical Restraint Emergency Psychotropic Medication Incarceration
 Hospitalization - Medical Protective Equipment Hospitalization - Psychiatric Abdominal Thrust (Heimlich) CPR

> Description of Incident - (what/where/when/who)

> Description of Injury to Service Recipient: If applicable. Describe type, size, color, location on body; location of treatment; etc.

> Notified Legal Representative ISC Provider APS 888-277-8366 DCS 877-237-0004 Regional Office AOD (Death) 1-866-925-4204
Date & Time ____/____/____ : ____ AM PM

> Notified Chief Officer / AOD (Public ICF/MR) DIDD Investigator Investigator Name 1-888-632-4490
Date & Time ____/____/____ : ____ AM PM

> Person Writing This Report Print Name/Title: _____
Date /Time completed: ____/____/____ @ ____: ____ AM PM Signature: _____

> Incident Management Coordinator Review Reviewed by (Name/Title): _____
(If applicable, describe staffing or supervision issues below.)

> Type of incident ALL BOLDED TYPES MUST BE IMMEDIATELY REPORTED TO DIDD INVESTIGATIONS
 Alleged Abuse Alleged Neglect Alleged Exploitation
 Serious Injury - Unknown Cause Suspicious Injury (abuse or neglect suspected) Death
 Reportable Behavioral/Psychiatric Incident Sexual Aggression Missing Person (> 15 minutes)
 Reportable Medical Incident Criminal Conduct Other Type of Incident, specify _____
 Reportable Staff Misconduct - No injury and risk is minimal because... (describe below): _____
Additional Information: _____

No Apparent Injury Serious Injury - Fracture, dislocation, traumatic brain injury (concussion), laceration requiring sutures or staples (or Dermabond used in place of sutures), torn ligaments, 2nd and 3rd degree burns, loss of consciousness, sprain or strain (if moderate or severe). Other injuries may also be considered to be serious based on severity, location on the body, etc.
 Minor Injury

CONFIDENTIAL



REPORTABLE INCIDENT

Department of Intellectual and Developmental Disabilities

Name of Service Recipient _____ SSN _____ Date of Incident ____/____/____
Please Type Last, First, MI Time of Incident ____: ____ AM PM

Region _____ Provider Responsible _____ Provider Code _____ Provider Reporting (if different) _____
E

DIDD Investigator must be notified within 4 hours (1 hour for Public ICF/MR) for alleged abuse, neglect, exploitation, serious injury of unknown cause, for any unexpected, unexplained, or suspicious Death, and for any injury that raises the suspicion of abuse or neglect.

This incident was Witnessed by Select One or Discovered

> Where incident occurred Address / Site of Incident
[Check one] Home -- Inside Home - Outside Vehicle Day Program/Work/School
 Community-Supervised Community-Unsupervised Unknown

> This incident required Check all that apply
 Hospital Emergency Room Manual Restraint MH Mobile Crisis Team Police 911 Call
 X-ray (to rule out fracture) Mechanical Restraint Emergency Psychotropic Medication Incarceration
 Hospitalization - Medical Protective Equipment Hospitalization - Psychiatric Abdominal Thrust (Heimlich) CPR

> Description of Incident - (what/where/when/who)

> Description of Injury to Service Recipient: If applicable. Describe type, size, color, location on body; location of treatment; etc.

> Notified Legal Representative ISC Provider APS 888-277-8366 DCS 877-237-0004 Regional Office AOD (Death) 1-800-225-9302
Date & Time ____/____/____ : ____ AM PM

> Notified Chief Officer / AOD (Public ICF/MR) DIDD Investigator Investigator Name 1-800-579-0023
Date & Time ____/____/____ : ____ AM PM

> Person Writing This Report Print Name/Title: _____
Date /Time completed: ____/____/____ @ ____: ____ AM PM Signature: _____

> Incident Management Coordinator Review Reviewed by (Name/Title): _____
(If applicable, describe staffing or supervision issues below.)

> Type of incident ALL BOLDED TYPES MUST BE IMMEDIATELY REPORTED TO DIDD INVESTIGATIONS

Alleged Abuse Alleged Neglect Alleged Exploitation
 Serious Injury -- Unknown Cause Suspicious Injury (abuse or neglect suspected) Death
 Reportable Behavioral/Psychiatric Incident Sexual Aggression Missing Person (> 15 minutes)
 Reportable Medical Incident Criminal Conduct Other Type of Incident, specify _____
 Reportable Staff Misconduct -- No injury and risk is minimal because... (describe below): _____

Additional Information: _____

No Apparent Injury Serious Injury - Fracture, dislocation, traumatic brain injury (concussion), laceration requiring sutures or staples (or Dermabond used in place of sutures), torn ligaments, 2nd and 3rd degree burns, loss of consciousness, sprain or strain (if moderate or severe). Other injuries may also be considered to be serious based on severity, location on the body, etc.
 Minor Injury

CONFIDENTIAL



REPORTABLE INCIDENT

Department of Intellectual and Developmental Disabilities

Name of Service Recipient _____ SSN _____ Date of Incident ____ / ____ / ____
Please Type Last, First, MI Time of Incident ____ : ____ AM ____ PM ____

Region _____ Provider Responsible _____ Provider Code _____ Provider Reporting (if different) _____
M

DIDD Investigator must be notified within 4 hours (1 hour for Public ICF/MR) for alleged abuse, neglect, exploitation, serious injury of unknown cause, for any unexpected, unexplained, or suspicious Death, and for any injury that raises the suspicion of abuse or neglect.

This incident was [] Witnessed by Select One or [] Discovered

> Where incident occurred Address / Site of Incident
[Check one] [] Home - Inside [] Home - Outside [] Vehicle [] Day Program/Work/School
[] Community-Supervised [] Community-Unsupervised [] Unknown

> This incident required [] Check all that apply
[] Hospital Emergency Room [] Manual Restraint [] MH Mobile Crisis Team [] Police [] 911 Call
[] X-ray (to rule out fracture) [] Mechanical Restraint [] Emergency Psychotropic Medication [] Incarceration
[] Hospitalization - Medical [] Protective Equipment [] Hospitalization - Psychiatric [] Abdominal Thrust (Heimlich) [] CPR

> Description of Incident - (what/where/when/who)

> Description of Injury to Service Recipient: If applicable. Describe type, size, color, location on body; location of treatment; etc.

> Notified [] Legal Representative [] ISC Provider [] APS 888-277-8366 DCS 877-237-0004 [] Regional Office AOD (Death) (615) 218-0784
Date & Time : ____ / ____ / ____ : ____ AM ____ PM ____

> Notified [] Chief Officer / AOD (Public ICF/MR) [] DIDD Investigator Investigator Name 1-888-633-1313
Date & Time : ____ / ____ / ____ : ____ AM ____ PM ____

> Person Writing This Report Print Name/Title: _____
Date /Time completed: ____ / ____ / ____ @ : ____ AM ____ PM ____ Signature: _____

> Incident Management Coordinator Review Reviewed by (Name/Title): _____
(If applicable, describe staffing or supervision issues below.)

> Type of incident ALL BOLDDED TYPES MUST BE IMMEDIATELY REPORTED TO DIDD INVESTIGATIONS
[] Alleged Abuse [] Alleged Neglect [] Alleged Exploitation [] Death
[] Serious Injury - Unknown Cause [] Suspicious Injury (abuse or neglect suspected)
[] Reportable Behavioral/Psychiatric Incident [] Sexual Aggression [] Missing Person (> 15 minutes)
[] Reportable Medical Incident [] Criminal Conduct [] Other Type of Incident, specify _____
[] Reportable Staff Misconduct - No injury and risk is minimal because... (describe below): _____
Additional Information: _____

[] No Apparent Injury [] Serious Injury - Fracture, dislocation, traumatic brain injury (concussion), laceration requiring sutures or staples (or Dermabond used in place of sutures), torn ligaments, 2nd and 3rd degree burns, loss of consciousness, sprain or strain (if moderate or severe). Other injuries may also be considered to be serious based on severity, location on the body, etc.
[] Minor Injury

CONFIDENTIAL



REPORTABLE INCIDENT

Department of Intellectual and Developmental Disabilities

Name of Service Recipient _____ SSN _____
Please Type Last, First, MI

Date of Incident . / /
Time of Incident : AM PM

E-mail - Mr.Incidentmg@tn.gov

Sent Page 1 to: DIDD (Fax - 877-551-5591 or 615-253-4921) Date/Time: / / @ : AM PM

> Incident Review Committee summary Date: / /

Discussion Issues (Include review of staff actions in response, current status of person served, possible corrective/preventive actions)

Management Actions

Action Taken	Person Responsible	Expected Completion Date	Follow-up
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
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		/ /	
		/ /	

Incident Management Coordinator

PRINT NAME/TITLE _____

SIGNATURE _____

DATE/TIME / / @ : AM PM



INITIAL AGENCY DEATH REVIEW FORM

An Initial Agency Death Review shall be completed within five (5) business days of the death of a service recipient who is

1. Receiving a residential service through an HCBS waiver program or other DIDD community program;
2. A resident of a DIDD ICF/ID; or
3. A resident of a private ICF/ID when such residence is state-funded or funded by TennCare/Medicaid.

Providers and private ICFs/ID shall submit the form to the DIDD Regional Director. DIDD ICF/ID shall submit the form to the DIDD Commissioner or designee.

SERVICE RECIPIENT INFORMATION

Name (last, first, middle) _____ SSN _____

Home Address _____

Date of Birth ____/____/____ Date of Death ____/____/____ Age at Death ____

Name of Service Provider _____

Name of Director of Provider Agency, Administrator of Private ICF/ID, or Director of DIDD ICF/ID or Chief Officer: _____

Name(s) of Next of Kin and/or Legal Representative: _____

1. Please circle "Yes" or "No".

- a. YES NO Service recipient was discharged from a developmental center within the past 12 months.
- b. YES NO Service recipient resided in the current community placement less than 12 months.
- c. YES NO Service recipient's family or conservator was involved in care/treatment and visited often.

2. Briefly describe the service recipient's functional independence in daily living.

3. Briefly describe the service recipient's need for special custodial care and supervision.

4. Briefly describe the service recipient's physical limitations.

5. List the service recipient's medical diagnoses or conditions.

6. Please indicate whether "End of Life" issues were discussed at the most recent annual Individual Support Plan Meeting, and describe any "End of Life" plans.

CIRCUMSTANCES SURROUNDING THE DEATH

1. Briefly describe the situation or circumstances surrounding the service recipient's death:

2. Specify the location where service recipient died or was found dead: _____

3. Please circle "Yes" or "No".

a. YES NO Service recipient's cause of death was known.

b. YES NO Service recipient died in a hospital. If "Yes", specify hospital and date of admission:

c. YES NO An autopsy was done.

d. YES NO Family or conservator guardian declined to have an autopsy done.

e. **YES** **NO** Service recipient received emergency medical procedures (e.g., CPR, Heimlich) immediately prior to death. If "Yes", specify types: _____

f. **YES** **NO** Service recipient's death was unexpected. If Yes, specify why: _____

CIRCUMSTANCES ASSOCIATED IN TIME WITH THE DEATH: "Associated" as used here does not imply that the circumstance "caused" the death, but rather that the circumstance was associated in time with the death. Please circle "Yes" or "No". For any "Yes" response, provide an explanation in the space provided.

- 1. **YES** **NO** An actual or suspected seizure
- 2. **YES** **NO** A choking incident or aspiration of food/liquids, vomit, or foreign bodies
- 3. **YES** **NO** A fall
- 4. **YES** **NO** An environmental problem or hazard
- 5. **YES** **NO** Self-injurious behavior (e.g., PICA, suicidal behavior)
- 6. **YES** **NO** A behavioral incident involving the service recipient
- 7. **YES** **NO** A lapse in staff supervision
- 8. **YES** **NO** A violent act by a staff person
- 9. **YES** **NO** A violent act by any other individual
- 10. **YES** **NO** A "Do Not Resuscitate" order and/or *Physician Scope of Treatment* (POST FORM)

Provide a brief explanation for any "Yes" response to Items #1 to 10 above, attaching additional sheets if needed:

FOLLOW-UP

1. Please describe any issues requiring further review or follow-up: _____

_____	_____
Print Name of Person Completing This Form	Title
_____	_____
Signature	Date



NOTICE OF DEATH FORM

Within 4 hours of the discovery of a death that is or may be a Suspicious, Unexpected, or Unexplained Death, the entity responsible for reporting the death shall report it to the DIDD Investigator. Also, within 4 hours of the discovery of any death, the primary provider must notify the DIDD Regional Director or, if applicable, the DIDD Commissioner or designee by telephone. A completed Notice of Death Form must be sent within 1 business day after discovery of the death. If a waiver provider or private ICF/ID, send it to the DIDD Regional Director. If a ICF/ID, send it to the DIDD Commissioner or designee.

East DIDD Regional Director	Middle DIDD Regional Director	West DIDD Regional Director
Phone # (865) 588-0508	Phone # (615) 231-5436	Phone # (901) 745-7361
Fax # (865) 594-5180	Fax # (615) 231-5150	Fax # (901) 745-7379
Crisis Pager 1-800-225-9302	Crisis Pager (615) 963-1700	Crisis Pager 1-866-925-4204

SERVICE RECIPIENT INFORMATION

DIDD REGION East Middle West

NAME _____ **DATE OF BIRTH** _____

SOCIAL SECURITY NO. _____ **AGE AT DEATH** _____

RACE White Black Hispanic Other _____ **SEX** Male Female

CLASS MEMBER STATUS Settlement Agreement Remedial Order Not applicable

FUNDING STATUS "Statewide" Waiver "Self-Determination" Waiver Private ICF/MR
 "Arlington" Waiver State-Funded Developmental Center

RESIDENCE Lived with family Supportive Living Private ICF/MR
 Lived in Own Home with Support Residential Habilitation Developmental Center
 Lived Independently Medical Residential Services Nursing Facility
 Family Model Residential Services Other (explain) _____

DID THE SERVICE RECIPIENT MOVE IN THE PAST 6 MONTHS? No Yes (specify date: _____)

DATE OF DEATH _____ **DATE REPORTED** _____ **TIME REPORTED** _____ AM / PM

PLACE OF DEATH Home Psychiatric Facility
 Hospital Other _____

DETAILS OF DEATH _____

- 1. **AUTOPSY REQUESTED?** No Yes If so, by whom _____
- 2. **MEDICAL EXAMINER CONTACTED?** No Yes If so, by whom _____
- 3. **CORONER CONTACTED?** No Yes If so, by whom _____
- 4. **INCIDENT FORM SUBMITTED?** No Yes

INDICATE WHO HAS BEEN NOTIFIED ISC/Case Manager Legal Representative Family
 DIDD Investigator Police

NAME OF PRIMARY CARE PROVIDER _____ **PHONE NO.** _____

TYPE OF CASE MANAGER ISC State Case Manager QMRP

NAME OF CASE MANAGER _____ **PHONE NO.** _____

NAME OF ISC AGENCY (if applicable) _____ **PHONE NO.** _____

NAME(S) OF NEXT OF KIN and/or LEGAL REPRESENTATIVE _____

GENERAL HEALTHCARE INFORMATION

NAME OF SERVICE RECIPIENT _____

AMBULATION: Ambulatory
 Non-ambulatory

COMMUNICATION Verbal
 Non-verbal

NUTRITION Eats independently
 Eats with assistance
 Tube-fed

WEIGHT IS Normal Weight
 Overweight
 Underweight

WEIGHT _____
HEIGHT _____

PHYSICAL STATUS REVIEW (if applicable) DATE OF LAST PSR _____ PSR LEVEL _____

MEDICATIONS

ID LEVEL Mild Moderate Severe Profound Unknown/Unspecified
 Etiology (if known) _____

BEHAVIORAL/PSYCHIATRIC DIAGNOSES

GENERAL MEDICAL DIAGNOSES

HOSPITALIZATIONS AND PROCEDURES IN PAST 12 MONTHS

<u>Reason for Hospitalization or Procedure</u>	<u>Treatment Location</u>	<u>Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Provider, Private ICF/ID, or DIDD ICF/ID	Phone Number
Print Name of Person Completing This Form	Title
Signature	Date