Appendix
Table of Contents

Animal Facility Rules

No sitting or climbing on fences

Never sit or kneel beside, in front of, or behind horses

No running in barn or around horses/animals

Use calm voice tone around animals at all times

Only staff may feed the animals.

No outside animals or pets may be brought onto property.

No food is allowed at the animal facility; all garbage must be thrown away.

There is no smoking allowed at the animal facility.

Residents and staff should wash their hands upon arrival and prior to departure from the equine facilities

No inhumane treatment of animals will be tolerated.

Lead ropes must be used in any activity involving the horses.

At least 2 staff members to be present when residents are at the stable.

Residents are not allowed in stalls while animals are present.

Residents are not allowed in pastures without staff members in immediate proximity (20 feet) and same side of fence.

Residents and staff may interact with animals designated and owned by RHG.

Annual Budget Planning Worksheet

Fiscal Year: _____

Person Completing this Worksheet: _____

Title of Person Completing this Worksheet: _____

Do you anticipate any significant changes in staffing or personnel in your department or area? Y/N

If Yes, please describe: _____

_____

_____

Do you anticipate any significant changes in the operational needs, support needs, or supplies required to enhance your department or area? Y/N

If Yes, please describe: _____

_____

_____

Do you anticipate the need for any capital expenditures, including furniture, fixtures, equipment or vehicles, that may be required to enhance or support your area or department? Y/N

If Yes, please describe: _____

_____

_____

Other input or feedback that should be taken into account during the Budget process: _____

_____

_____

_____ _____

Staff Signature Date

ANNUAL REVIEW OF THE ENVIRONMENT OF CARE
Florida
2015

Overview

In order to preserve and protect the safety of residents, staff, visitors, equipment and facilities, Renaissance Healthcare Group, LLC shall implement a comprehensive Environment of care program.

Management Team

The Executive Director shall appoint, on an annual basis, a Safety Officer and Risk Manager. These individuals will meet with the department managers and Compliance Officer on a monthly basis to review incidents, reports and concerns.

The Management team shall review compliance issues, infection control issues, safety issues, trainings, drills, external inspections, and resident complaints. In addition, the Risk Manager will produce quarterly Risk Management Reports including data collected and analyzed from Incident Reports.

The Management team may take any necessary action to ensure safety when conditions exist that pose an immediate threat to life or health, or pose a threat to equipment or facilities.

Policies, procedures, protocols, safety and risk management data will be reviewed annually by the Management team to evaluation program effectiveness and make performance improvements.

Management Team minutes will be disseminated to all managers and presented to the Governing Board.

Data Collection and Monitoring

The Safety Officer has many venues at his/her disposal to receive information and data about safety issues. The most common method is the reporting of safety related issues on the Incident Report, which is forwarded to the Risk Manager. When the Risk Manager identifies a safety related issue, the Safety Officer is contacted for consultation and coordination. The Safety Officer reviews quarterly reports by the Risk Manager for trends and patterns that may suggest a need for improvement.

Staff may also bring concerns, ideas or suggestions to the direct attention of the Safety Officer, without an incident report being initiated. The communication may be informal, may come through the weekly staff meeting, or may be a formal letter of suggestion.

Lastly, the Safety Officer, through ongoing monitoring, facility walk through and evaluation, will identify areas of concern and opportunities for improvement.

Key Functions

Within the Environment of Care are seven key functions that require specific policies, procedures, attention, monitoring, and reporting. These key functions are:

- Fire Plan
  Policy: EC-04
- Shelter in Place Plan
  Policy: EC-05
- Evacuation Plan
  Policy: EC-06
- Security
  Policy: EC-08
- Utilities Management Plan
  Policy: EC-09
- Management & Disposal of Bio-Hazardous Waste
  Policy: EC-12
- Infection Control
  Policies: IC-01 through IC-09

Evaluation

Fire Plan: The fire plan was updated in 2015 to reflect additional CRH homes being licensed; La Salle and North Shore to identify designated safe yards for evacuation. All fire safety inspections were completed by external agencies. Internal, monthly inspections of smoke detectors, fire extinguishers and egress lighting began in April 2013, per JCHAO standards. Improved documentation of inspections and tests also began in April 2013. The fire drill report was improved. Drills were happening at the same time of day; this was moved to one on each shift and 50% unannounced in 2014 with at least 50% completed in two minutes or less. We met this goal consistently in 2014.

Shelter in Place Plan: (Formerly Evacuation Plan) This plan was edited when we began to pursue the Joint Commission Accreditation. A HVA was conducted and hurricanes/thunderstorms were identified as the prioritized risk. This will continue to be completed annually. We did an inventory of internal and external resources/assets as well as an audit of expiration dates, battery replacements and availability of resources/assets. The shelter in place plan was reviewed at the Management Team meeting in June 2014 and distributed to staff. Additional staff training was identified when a tornado warning was initiated in the area the same month. All managers and night staff were trained in the use of the hurricane shutters and emergency utility shut off as a result.

Evacuation Plan: This plan was updated for 2015. Contact was made with the administrator at Lakewood Center to continue the relationship with this facility for local evacuation. Directions to the Lakewood Center were placed in facility vehicles. The evacuation plan was reviewed at the June 2014 Management Team meeting. An evacuation drill was completed during the July 2014 Management Team meeting; including driving to Lakewood Center. This will be completed annually.

Security: Documents in the medical record and financial files continue to move to electronic forms and storage. Best Notes added the option of an electronic pin that allows residents to sign documents with a unique pin. This function was expanded to admissions and consents documents with the exception of the Authorization to Release Confidential Information.

Additional cameras were added to entrances and main resident areas (not resident bedrooms) in May 2013.

Added additional monitoring cameras on the east side of the Villa in February 2015.

The building access codes continued to be changed on a regular basis for security.

Utilities Management Plan: This is a new policy that encompasses the management of utilities systems. Management Team reviewed this plan in June 2014 Management Team meeting. Department Managers and night staff were trained on the operation of hurricane shutters and the location of emergencies shut offs for utilities at the RT and CRH facilities. This will continue to be completed annually.

Management and Disposal of Bio-Hazardous Waste: Stericycle continues to come on a quarterly cycle to collect bio hazardous waste. We obtained a permit for Bio-hazardous waste removal with the Department of Health in March 2015. Nurse Manager scheduled Bio-Hazardous training for all direct care staff.

Infection Control: The Infection Control Plan was updated significantly in 2013. An Influenza Plan was added and influenza vaccines were offered to staff and residents. Delinquent infection control reporting was improved. Coordination with Human Resources and department managers with regards to call outs due to illness was improved. In 2014, we continued to follow the Infection Control Plan and documented results of our Influenza Campaign setting goals for 2015.

All First Aid kits were updated and replaced for 2015. Isolation gowns and masks were stocked per the updated infection control plan. Safety Officer will continue to update these items as needed.

Performance Evaluation and Critique Summary

It is expected that the Annual Safety Plan Report and Evaluation, including the seven key function annual evaluations, will, in the long term, present a proactive approach to identifying potential safety issues, resolving safety issues, and preventing future occurrences of safety issues.

ANNUAL REVIEW OF THE ENVIRONMENT OF CARE
Tennessee
2015

Overview

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Management Team

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The Management team may take any necessary action to ensure safety when conditions exist that pose an immediate threat to life or health, or pose a threat to equipment or facilities.

Policies, procedures, protocols, safety and risk management data will be reviewed annually by the Management team to evaluation program effectiveness and make performance improvements.

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Staff may also bring concerns, ideas or suggestions to the direct attention of the Safety Officer, without an incident report being initiated. The communication may be informal, may come through the weekly staff meeting, or may be a formal letter of suggestion.

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  Policy: EC-09
- Management & Disposal of Bio-Hazardous Waste
  Policy: EC-12
- Infection Control
  Policies: IC-01 through IC-09

Evaluation

Fire Plan: The fire plan was updated in 2015 to reflect additional Supportive Residential homes to identify Fire Plan and designated safe yards for evacuation. We also changed the designated safe place for Smoky Mountain Lodge as the middle of the parking lot instead of the mailboxes. All fire safety inspections were completed by external agencies. Internal, monthly inspections of smoke detectors, fire extinguishers and egress lighting began in April 2013, per JCHAO standards. Improved documentation of inspections and tests also began in April 2013. The fire drill report was improved. Drills were happening at the same time of day; this was moved to one on each shift and 50% unannounced in 2014 with a goal to have at least 50% completed in two minutes or less.

Shelter in Place Plan: (Formerly Evacuation Plan) This plan was edited when we began to pursue the Joint Commission Accreditation. A HVA continued to be completed annually with identified risks prioritized. We did an inventory of internal and external resources/assets as well as an audit of expiration dates, battery replacements and availability of resources/assets. The shelter in place plan was reviewed at the Management Team meeting in November 2014 and distributed to staff. Utility Shut off training provided to all managers.

Evacuation Plan: The evacuation plan was reviewed during the November 2014 Management Team meeting. Staff drives to evacuation site at least weekly so on drill was needed.

Security: Documents in the medical record and financial files continue to move to electronic forms and storage. Best Notes added the option of an electronic pin that allows residents to sign documents with a unique pin. This function was expanded to admissions and consents documents with the exception of the Authorization to Release Confidential Information.

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Pasadena Villa Network of Services

Annual Risk Management Report of Incidents

YEAR: **Program:**

	Q1	Q2	Q3	Q4
Number of Incidents:	0	0	0	0
ADC:				
Admissions:				
Discharges:				

Types of Incidents Involving Residents:		Q1	Q2	Q3	Q4
AR	Adverse Med Reaction				
AB	Aggressive Behavior				
SB	Sexual Behavior				
AI	Accident or Injury				
C	Contraband/Weapon				
T	Theft				
M	Medical Emergency/Transfer				
P	Psychiatric Emergency/Transfer				
SA	Self-Harm or Suicide Attempt				
E	Elopement				
W	Walk-off				
F	Fall				
CG	Complaint/Grievance				
O	Other				
		0	0	0	0

Types of Incidents Involving Others:		Q1	Q2	Q3	Q4
ME	Medication Error				
AB	Aggressive Behavior				
SB	Sexual Behavior				
AI	Accident or Injury				
C	Contraband/Weapon				
T	Theft				
PT	Parking Ticket				
VO	Driving Violation				
AA	Auto Accident				
BC	Breech of Confidentiality				
F	Fall				
O	Other				
		0	0	0	0

Types of Incidents Inolving Facilities:		Q1	Q2	Q3	Q4
FA	Fire Alarm				
DV	Damaged Vehicle				
DP	Damaged Property				
DF	Damaged Furnishings				
S	Security				
IA	Injured Animal				
O	Other				
		0	0	0	0

Reviewed by:

Title

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Approved Abbreviations for Renaissance Healthcare Group, LLC

2^o	Secondary to
I8O	Intake and output
AA	Alcoholics Anonymous
AB	Abortion
abd	Abdomen/Abdominal
abn	Abnormal
a.c.	Before meals
ID	Intradermal
i.e.	For example
ACLS	Advanced cardiac life support
act	Activity
ad. lib.	As desired
ADL	Activities of daily living
IM	Intramuscular
IN	Inches
incont	Incontinent
inf	Inferior
AFA	Arm, forearm
AH	Auditory hallucinations
int.	Internal
INT.	Initial
IO	Intraocular
IOP	Intraocular pressure
irreg	Irregular
a.m.	Before noon
AMA	Against medical advice
amd	Ambulate/ambulatory
AMI	Acute myocardial infarction
AMS	Altered mental status
amt.	Amount
approx.	Approximately
appt.	Appointment
ISOL	Isolation
IU/L	International units per liter
IU/ML	International units per milliliter
IV	Intravenous
JCAHO	Joint Commission on Accreditation of Healthcare Organization
ARNP	Advanced Registered Nurse Practitioner
ASAP	As soon as possible
asst.	Assistant/assistance
K	Potassium
kg. KG	kg kilogram

KVO	Keep vein open
L	Liter
AU	Both ears
BC	Birth control
BM	Bowl movement
B/P	Blood pressure
bs	Bowl sounds
BS	Breath sounds
B/S	bedside
Lab/Lab	Laboratory
Lap.	Laparotomy
lat.	Lateral
lax.	Laxative
lb.	LB pounds
LD	Learning disability
lg.	Large
liq	Liquid
LL	Left leg
Ca	Calcium
cal.	Calorie
cap	Capsule
CBR	Complete bed rest
CDR	Center for Disease Control
LOA	Leave of absence
LOS	Length of stay
LPN	Licensed practical nurse
chg	Change
ck	Check
cl	Clear
cm.	Centimeter
CNA	Certified Nurse Assistant
M	Male
max	Maximum
mcg	Microgram
C/O	Complain of
conf.	Conference
cont.	Continue
cont'd	Continued
CP	Chest pain
CPR	Cardiopulmonary resuscitation MCM/L micromoles per liter
M.D.	Doctor of Medicine
Meds	Medication
Mg	Magnesium
MG/mg	Milligram

C-Section CS-cesarean section

CV	Cardiovascular
CVA	Cerebrovascular accident
CXR	Chest x-ray
MHT	Mental health technician
MI	Myocardial infraction
misc	Miscellaneous
ml	Milliliter
ML 100 ML	Milliliters per 100 milliliter
MM, mm	Millimeter
MOM	Milk of magnesia
MRI	Magnetic resorance imaging
MRI#	Medical record number
MSW	Master of social work
MVA	Motor vehicle accident
MVI	Multivitamin
Na	Sodium
N.A.	Narcotics Anonymous
N/A	Not applicable
DBP	Diastolic Blood pressure
D&C	Dilatation and curettage
D/C	Discontinue, discharge
DCF	Department of children & family
DDS	Doctor of Dental surgery
D.E.A.	Drug Enforcement Agency
del.	Delusions
neg	Negative
nml	Normal
NH	Nursing home
NIDDM	Non-isulin dependent diabetes mellitus
NKA	No known allergies
Dept/dept	Department
detox	Detoxification
Diff	Differential count
Dig	Digoxin
DKA	Diabetic Ketoacidosis
DM	Diabetes Mellitus
DNR	Do not resuscitate
D.O.	Doctor of Osteopathy
DOA	Dead on arrival
DOB	Date of birth
DON	Director of nursing
Dr.	Doctor/Physician
dsg	Dressing
NPO	Nothing per os
Nsg	Nursing

NSR	Normal sinus rhythm
NSAID	Non-steroidal anti-inflammatory drug
NTG	Nitroglycerin
N/V	Nausea and vomiting
OB	Obstetrics
O2	Oxygen
OCHD	Orange Co. health Department
DT	Delirium tremens
DVT	Deep vein thrombosis
Dx	Diagnosis
oint.	Ointment
o.k.	Okay
OR	Operating room
Oriented x3	oriented to person, place & time
ECG, EKG	Electrocardiogram
ECT	Electroconvulsive therapy
ED	Emergency department
ed	Education
EEG	Electroencephalogram
EENT	eyes, ears, nose, throat
e.g.	Example
EMS	Emergency Medical System
EMT	Emergency Medical Technician
O.S.	Left eye
OT	Occupational therapist/therapy
OTA	Occupational therapist assistant
OTC	Over the counter
O.U.	Both eyes
P.A.	Physician's assistant
E.P.A.	Extra-pyramidal side effects
ET	Endotraceal
ETOH	Ethyl Alcohol
p.c.	After meals
P/E	Physical examination
PCM	Patient Care Manger
PERLA	Pupils equal & reactive to light
ex	Exercise
F	Female
fax	Facsimile
FBS	Fasting blood sugar
FB	Foreign body
FDA	Food and drug administration
p.m.	Afternoon
FHx	Family history
fl	Fluid

Freq.	Frequency
Fri.	Friday
Po/PO	By mouth
pos.	Positive
Post-op	Postoperative
p.r.n.	As necessary
F/U	Follow up
FX	Fracture
gal.	Gallon
gm	GM gram
gtt	Drop
GYN	Gynecology
H&H	Hemoglobin and hematocrit
H&P	History and physical
HA	Headache
HOH	Hard of hearing
LH	Pasadena Villa at Lake Highland
Pre-op	Preoperative
Pt.	Patient
PT	Physical therapy/therapist
PT/NR	Prothrombintime
Px	Prognosis
q2*h	Every 2 hours (*3,4,…)
q a.m.	Every morning
q.d.	QD everyday
q.h.	Every hour
q.h.s.	Every night at bedtime
q.i.d.	Four times a day
q.o.d.	Fvery other day
qt.	Quart
PV	Pasadena Villa
RBC	Red blood cells
HR	Heart rate
h.s.	At bedtime
HTN	Hypertension
resp.	Respiration
RHG	Renaissance Healthcare Group, LLC
R/O	Rule Out
R.Ph.	Registered Pharmacist
RR	Respiratory rate
r/t	Related to
Rx	Prescription
T/O	Telephone order
Tsp	Teaspoon
Tues.	Tuesday

Tx	Treatment
UA	Urinalysis
UO	Urine output
SA	Pasadena Villa at Summerlin Ave
Sat	Saturday
SBP	Systolic blood pressure
S.I.	Suicide Ideation
SNF	Skilled Nursing Facility
S/O	Significant Other
SOB	Shortness of Breath
UTI	Urinary Tract Infection
vc's	Verbal Cues
VD	Venereal Disease
V.O.	Verbal Order
V.S.	Vital Signs
WBC	White blood cells
SQ	Subcutaneous
Stat/STAT	at once
STD	Sexually transmitted disease
Sun.	Sunday
supp.	Suppository
Wed.	Wednesday
WNL	Within Normal Limits
W/Wt	Weight
X/x	Times
XR	X-Ray
SW	Social Work
L	Left
R	Right
M	Male
F	Female
△	Change
tab.	Tablet
TB	Tuberculosis
=	Greater than or equal to
<	Less than
~	Approximate
=	equals
#	number
@	At
tbsp.	Tablespoon
Thurs.	Thursday
1x	Once
2x	Twice
%	Percent/Percentage

+	Positive/present
-	Negative/absent
‘	Foot/feet
“	Inches
2o	Secondary
w/c	With
w/o, s	Without
a	Before
x	Except
p	After
q	Every

VOLUNTARY ART WORK RELEASE FORM

Resident Name: _____

I agree to release my art work to Pasadena Villa to use and/or display, and/or photograph my artwork for the following purposes:
__ Exhibition
__ Publication in a professional journal
__ Presentation at professional conferences
__ Educational purposes
__ I do wish to remain anonymous
__ I do not wish to remain anonymous

I understand that there are times when my work with in art therapy, will be discussed with a clinical supervisor and/or in consultation with other mental health professionals. I understand that all efforts will be made to keep my identity anonymous and confidential unless I specify otherwise.

Pasadena Villa Network of Services will make every effort to safeguard your artwork and to notify you immediately of any loss or damage, to provide an appropriate format for presentation and/or exhibit of artwork, to bear other costs related to exhibition, to return artwork immediately if consent is withdrawn.

Expiration Date of Authorization

This authorization is effective for 12 months from the date of signature unless revoked or terminated by the resident or the resident's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Pasadena Villa. You should contact any Clinical Staff to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Resident Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Therapist Signature_____ Date_____

Authorization to Release Confidential Information

Resident Name	Date of Birth

Information to be Used or Disclosed includes:

☐	Psychiatric Admission Evaluation	☐	Labs
☐	Psychosocial History	☐	Treatment Plans
☐	Medication Administration Record	☐	Physician's Orders
☐	Nursing Assessment	☐	Physician's Progress Notes
☐	Discharge Summary	☐	(Please specify)

I hereby authorize Renaissance Healthcare Group and its subsidiaries to:

☐Disclose information to: ☐Receive information from

For the purpose of:

_____

Name of person or organization

Address, phone, fax

Expiration Date of Authorization
This authorization is effective for 12 months from the date of signature unless revoked or terminated by the resident or the resident's personal representative.

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Signature

Signature of Resident Date

Signature of Witness Date

Signature of Resident Representative/Guardian Date

Complaint/Grievance Follow-Up

Name of Person Expressing Grievance: _____ Date Reported: _____

Phone Number (or method to contact): _____

Resident Name: _____ Date of Admission: _____

Relationship to Resident: _____

Nature of Complaint: _____

_____

_____

_____

_____

_____

_____

_____

Pertinent Investigational Information: _____

_____

_____

_____

_____

_____

Problem Resolution/Follow Up: _____

_____

_____

_____

_____

_____ _____

Staff Person Addressing Grievance/Title Date Resolved

*Please forward to the Patient Advocate or Compliance Officer when complete.

Reviewed by: _____

Pasadena Villa
Network of Services

Hyperglycemia/Hypoglycemia

Diabetic Protocol

Resident will need to be stabilized for 1 week prior to admission if non-compliant with medications.

Resident will need to have available 3-4 weeks of blood glucose monitoring available for nursing to review.

Blood sugar will need to be taken 3-4x's daily and more if needed. Nursing will monitor and chart in records.

Resident will need to be self-accountable and responsible for all insulin administration with insulin pens and insulin pumps.

Normal Daily Blood Sugar Range (70-130 daily)

Education materials will be provided by nursing for education and teaching about diabetes. Resident/Nurses will monitor carbohydrate count.

Insulin pen and insulin will be stored in refrigerator in the Nurses Station.

Residents will be required with a diagnosis of diabetes a complete medical history/physical examination by a licensed medical professional within 24-72 hours.

All insulin treated residents should have a (CBG) capillary blood glucose determination within 1-2 hours of admission.

Evaluation will be completed by admission/Tx team for review of the previous hx and past treatment of glycemic control and diabetes complications.

Finger stick blood glucose level will be measured immediately by nurses or residents.

Glucose meter will be available for patient and night staff employees to assess blood sugar during overnight shift. Glucose meter will be available in PRN CABINET for accessibility purposes. Staff will contact Nurse Manager for any diabetic management.

Management plan of diabetes to achieve normal or near-normal glycaemia with an AIC goal of <7% should be available at admission and maintained during treatment.

Summary of recommendations for glycemic, blood pressure, and lipid control for most adults with diabetes.

AIC < 7.0%

Blood Pressure < 130/80 mm Hg

LDL Cholesterol < 100 mg/dL

In adult patients with diabetes, test for lipid disorders at least annually and as needed to achieve goals with treatment.

Aspirin therapy (75-162 mg/day) in adult patients with diabetes and cardiovascular risk.

Current goals for national standards for treating adult diabetic's lipid goals of:

LDL ≤ 100

HDL > 40

Triglycerides < 150 mg/dL

Blood Pressure level of 120/80 mm hg

Resident will be required to be seen by a Endocrinologist within 1x week time of admission.

AIC monitoring will be checked 3-6 months or twice yearly.

Recommended daily allowance of ASA (Aspirin) 81 mg for lipid control and to decrease morbidity complication if ordered by medical doctor.

Aspirin therapy (75-162 mg/day) in adult patients with diabetes and cardiovascular risk.

Residents will need to be taken to ER/EMS 911 if blood glucose levels extend over 390 for diabetic management.

> 390 Hospital/ER

< 390 Insulin will be administered according to sliding scale prescribed by MD

Sliding scale will be ordered by physicians/ARNP upon admission which facility/nursing will adhere to accordingly by the following:

Hypoglycemia < 40 Hospital/ER

S/S Hypoglycemia	
Shakiness	Sleepiness
Nervousness or Anxiety	Blurred/Impaired Vision
Sweating, Chills, and Clamminess	Tingling or Numbness in the
Irritability or Impatience	lips/tongue
Rapid/Fast Heartbeat	Lightheadedness/Dizziness
Hunger/Nausea	Hot Flashes
Lack of Coordination	Seizures
Agitation	

Treating Hypoglycemia

1. Consume 15-20 grams of glucose or simple carbohydrates
2. Recheck your blood glucose after 15 minutes
3. If hypoglycemia continues, consume simple carbohydrates and recheck glucose
4. Once blood glucose returns to normal, eat small meal if your next planned meal or snack is more than an hour or two.

15 Grams of simple carbohydrates
2 Tsp. of raisins
1 oz cake icing
4 ounces of juice
1 small fruit cup
1 Tbs. sugar, honey, corn syrup
8 oz. of nonfat or 1% milk

Glucagon will be administered only during a hypoglycemic episode.

Using Glucagon (We will call 911 immediately, if this occurs) will need to be ordered for each resident upon admission.

1. Inject glucagon in buttocks, arm, and thigh
2. When individual regains consciousness (within 5-15 minutes)

   s/e nausea and vomiting

Hyperglycemia

Agitation

High blood pressure

High levels of sugar in urine

Frequent urination

Increased thirst

Trouble concentrating

Headaches

Blurred vision

Pasadena Villa
Network of Services

S/S Hyperglycemia
Shortness of breath
Breath that smells funny
Nausea and vomiting
Very dry mouth
> 390 will be sent to ER
< 390 will have insulin administered

Resident will be able to take glucometer, insulin vials, insulin pens, lancets and snacks on Social Integration outings, therapy groups MD appointments, and day and home passes and will be monitored by a staff that has had diabetes education training.

Resident will maintain and document in a carbohydrate count log for each meal and snacks.

Resident will notify nursing staff or unlicensed professional for any signs and symptoms of hypoglycemia and hyperglycemia immediately.

Resident will write a written agreement stating that she has read and reviewed diabetic policy and agrees to terms and conditions of agreement and will abide by all conditions.

If resident is non-compliant with treatment regimen and agreement with diabetic policy and poses a safety risk for own personal health, resident will be taken to ER.

Glucometer may be kept in the PRN cabinet for overnight staff to access for resident to check blood sugar during the night shift hours of 1030 pm through 700 am.

Staff is to gently touch and arouse resident throughout the night to monitor for (“dawn phenomenon) hypoglycemia signs and symptoms.

Overnight staff can check resident blood sugar if resident unable to be awaken and call 911 immediately for directions.

Glucagon injection will be administered only by the nursing staff and 911 will be called immediately thereafter. Night and overnight staff will immediately call 911.

EXPENSE REPORT

Employee: _____

Month: _____

Day	Expense	Breakfast	Lunch	Dinner	Business Meals **	Per Mile: Miles	0.57.5 Mileage	Parking/ Tolls	Hotel	Airfare	Phone	Other/ Misc.**	Totals by Day
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													0.00
21													0.00
22													0.00
23													0.00
24													0.00
25													0.00
26													0.00
27													0.00
28													0.00
29													0.00
30													0.00
31													0.00
	Totals by category	0.00	0.00	0.00	0.00	0		0.00	0.00	0.00	0.00		

ATTACH RECEIPTS FOR ALL LISTED EXPENSES

Amount Due _____

Initial Set-up; Mialing Address & Emial:

Special Notes:

Employee Signature: _____

Approval Signature: _____

Pasadena Villa
Network of Services

Family and Guardian Rights

1. Respect and treatment, which respects the dignity of all family members.

2. Freely write to and receive letters from residents.

3. Make and receive telephone calls from the resident, unless this right is suspended as a reasoned and integral part of the treatment plan.

4. Visit the resident, at reasonable times, and take the resident for visits away from the facility, unless this right is temporarily abridged by reasons clearly stated in the treatment plan, and which are shown to be detrimental to the treatment process of the resident.

5. Be informed concerning the treatment of the resident, and to be allowed to participate in planning of the treatment, and receive treatment services, if desired, which may contribute to the resident's treatment.

   NOTE: In the instance of conflict between the wishes of the parents and/or guardian and those of the resident, RHG reserves the right to observe the wishes of the resident. Such conflicts are addressed through the complaint/grievance procedure.

6. Be advised of, and give informed consent (if guardian), to all aspects of the resident's treatment, and risks, side effects, and benefits of medications.

7. Register or file a complaint or grievance concerning any aspect of the resident's treatment or care and to have a Resident Advocate, who is not directly responsible for the day-to-day care of the resident, who is capable of objectivity regarding the complaint and any staff involved.

   NOTE: The staff of RHG will aid the parent in the registering of such a complaint and shall hold parents, guardians, and the resident free from restraint, coercion, discrimination, and reprisal.

8. Independent review of the resident's treatment program at their own expense.

9. Request an internal review of the resident's treatment program.

10. Be informed of any transfer of the resident.

Pasadena Villa
Network of Services

FIRE ALARM REPORT

Directions: Please complete this form by the end of your shift for any alarm. Fill out a separate form for each alarm and deliver to the Risk Manager by the next business day morning.

Date:_____ Time of Signal_____a.m./p/m. Location: _____

Staff Present: _____ _____ _____

_____ _____ _____

Complete only the section that applies to the signal by checking the correct answers and filling in the blanks.

Trouble Signal:

1. Signal related to phone lines/dialer Yes___ No___
   Signal related to fire alarm panel Yes___ No___

2. Monitoring Company was called Yes___ No___ Time:___a.m./p.m.
3. System was restored to operational status: Yes___ No___
   System was restored by: Plant Operation Staff ___ Monitoring Company___Other Staff Member ___ Other___

ALARM SIGNAL

1. Alarm was activated in Zone _____ (Refer to panel, not keypad)

2. Device that activated alarm was: S#_____ P#:_____ H#:_____ Sprinklers
   (Refer to Fire/Safety Info Book for device map to determine location number)

3. Fire Department responded to alarm: Yes___ No___ Time:___a.m./p.m.

4. Monitoring Company was called: Yes___ No___ Time___a.m./p.m.

5. System was restored to operational status Yes___ No___ Time__a.m./p.m.

6. System was restored by: Plant Operations Staff ___ Monitoring Company___
   Other Staff Member ___ Fire Department___ Other___

IMPORTANT: If the monitoring company is called out to perform work on the device, it is imperative that the Service Tech mark on his work order, the device number and the building number.

Describe why signal occurred:_____

_____

Completed by:_____

Date_____ Time_____a.m./p.m.

Fire Drill Report

Date: _____

Time/Shift: _____

Location: Villa SML TLLC CRH-S Denton Court CRH-H CRH-NS CRH-LS Goose Gap

Start Time: **Stop Time:**

Goal is less than 2 minutes

Number of staff evacuated during the drill:

Number of residents evacuated during the drill:

Number of visitors evacuated during the drill:

Time to Safe Meeting Point:

Safe Meeting Point:

Census taken:	Y	N
MAR taken:	Y	N
All Doors Closed:	Y	N
Signals Tested:	Y	N
Off Site Monitoring Tested:	Y	N
Unannounced:	Y	N

_____

Safety Officer

Pasadena Villa Network of Services
HVA

Total category = 6–9 requires written plan	**Probability**	**Risk**	**Preparedness**
Total category = 4–5 consider written plan	0=none	0=none	0=none
Total category = 4 or < no requirement	1=low	1=disruptive	1=poor
	2=med	2=healty/safety risk	2=fair
	3=high	3=life threatening	3=good

Type of Emergency/Disaster	**Probability of Event 0-1-2-3 Scale**	**Risk of Event 0-1-2-3 Scale**	**Preparedness of Event 0-1-2-3 Scale**	**Total**	**Policy**
Acts of Terrorism (include chemical and biological, extensive physical damage, and loss of life)					
Bomb Threat					
Civil Disorder (riot, strike)					
Communications Failure					
Drought					
Earthquake					
Explosion					
Fire					
Flood					
Hail Storm					
Hazardous Material Incident—Decontamination					
Heat Alert					
Hostage Event					
Hurricane					
Ice Storm					
Information Systems Failure					
Landslide					
Mass Casualty Incident					
Thunderstorm					
Tornado					
Patient Transportation Accident					
Utility Failure					
Workplace Violence					
Winter Storm (includes blizzard, ice storm)					
Suicide					

HBV Declination

I understand that due to my occupational exposure to blood or other potentially infectious material; I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

___ I am declining the HBV vaccine because I have already received it and can provide documentation.

___ I am declining the HBV vaccine because I have already received it and cannot provide documentation.

___ I am declining the HBV vaccine for other reasons.

_____ _____

Employee Signature Date

_____ _____

Facility Representative Date

State of Tennessee

PUBLIC CHAPTER NO. 258

HOUSE BILL NO. 829

By Representatives Hensley, Hardaway

Substituted for: Senate Bill No. 817

By Senators Crowe, Overbey

AN ACT to amend Tennessee Code Annotated, Title 68, Chapter 11, Part 3, relative to authentication of verbal orders.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated Title 68, Chapter 11, Part 3, is amended by adding a new section as follows:

68-11-313.

(a)(1) A hospital licensed pursuant to this chapter shall require that all verbal orders be authenticated by a physician or authorized individual who has the authority to issue verbal orders in accordance with hospital policies or medical staff bylaws.

(2) The policies or bylaws shall require that: authentication of a verbal order occurs within forty-eight (48) hours after the time the order is made unless a read-back and verify process pursuant to subdivision (a)(3) is used. The individual receiving a verbal order shall record the date and time of the verbal order, and sign the verbal order in accordance with hospital policies or medical staff bylaws.

(3) A hospital policy may provide for a read-back and verify process for verbal orders. A read-back and verify process shall require that the individual receiving the order immediately read back the order to the physician or authorized individual, who shall immediately verify that the read-back order is correct. The individual receiving the verbal order shall record that the order was read back and verified. If the read-back and verify process is followed, the verbal order shall be authenticated no later than fourteen (14) days after the date of the verbal order.

(b) Nothing in this subsection shall be interpreted to encourage the more frequent use of verbal orders by the medical staff of a hospital.

(c) Hospital policies or medical staff bylaws may establish a variety of modalities for communicating verbal orders and a read-back and verify process including, but not limited to, oral or electronic means so long as the provisions of subdivisions (a)(2) and (3) are met.

(d) For the purposes of this section, telephone orders are considered verbal orders.

SECTION 2. This act shall take effect on July 1, 2011, the public welfare requiring it.

HOUSE BILL NO. 829

PASSED: May 11, 2011

BETH HARWELL, SPEAKER
HOUSE OF REPRESENTATIVES

RON RAMSEY
SPEAKER OF THE SENATE

APPROVED this 23rd day of May 2011

BILL HASLAM, GOVERNOR

Pasadena Villa Network of Services

Incident Report

Instructions: An Incident Report is completed when an unusual event with potentially harmful outcome occurs which is not consistent with the routine care of a resident and/or the desired operation of the facility. Only one Incident Report is needed per incident, therefore only one staff member needs to fill out the report though several may be involved/participate. *Please complete all sections and forward to the CSM.*Do not put Incident Reports in the medical record*

Person(s) involved in incident: **Specify:** (drop list) **Location** (drop list)

Staff Completing the report:

Level of Care:

Date of Report:

Date of event: **Time of event:** **Shift:**

Category of Event

Resident Staff Facility

Describe Event or Situation, including who was involved:

	Yes or No	Date	Time
Was a physician called or medical treatment sought?			

Staff Invervention/Action:

Results/Outcome/Next Steps:

Pasadena Villa Network of Services

Post Incident Follow-Up

1. Was this an adverse incident/unusual occurrence that prompted reporting to the state?

Reportable Incident:

Date of report:

Time of report:

Outcome:

If yes to above, complete #2

2. Root Cause Analysis Initiated? Date Scheduled:

3. Workers Compensation Initiated?

Date of Report:

Reported to Human Resources?

4. Internal Response (Must be completed)

Causes of Incident:

Steps taken to prevent similar incidents:

Additional Staff Feedback:

Title

Staff Involved: _____

_____

_____

_____

(for internal use)

Reviewed by Manager/Name: Date:

Reviewed by Risk Manager:

Date Reviewed by Governing Board (if applicable):

Date Reviewed by Management Team:

Additional Comments:

Pasadena Villa
Network of Services

Infection Control Report

Use Black Ink Only

Name: _____

Circle One: **Resident** **Visitor** **Employee**

Date Symptom Developed: _____ **Time:** _____

Describe Condition or Symptom Noticed: _____

_____

Please Check If Appropriate:

_____ **Abnormal Finding of Physical Examination**
_____ **Laboratory Studies Suggestive of Infection**
_____ **Temperature Elevated Above 100 degrees Orally**
_____ **Any Resident in Bed 24 hours With Suspicious Problems**
_____ **Nausea, Vomiting, Diarrhea of Continuous or Severe Nature**
_____ **History of Hepatitis, VDRL, TB Within Last Year**
_____ **Purulent Wound or Skin Infection**
_____ **Location of Draining Lesions** _____
_____ **Abnormal Discharge from Any Orifice** _____
_____ **Positive Tine Test/Positive Chest X-Ray**

Was Physician Called? Yes_____ **No** _____

Physician Responding: _____

Medical Aid and/or Nursing Intervention:

Action/Education:

Signature of Person Initiating Report: _____**Date:** _____

Infection Control Designee: _____ **Date:** _____

Pasadena Villa Network of Services

Infection Control Report

Instructions: An Infection Control Report is completed by a nurse whenever there is a suspicion or confirmation of infection disease in a staff or resident.. *Do not include Infection Control Reports in the medical record*

Name (person with infection): _____

Select One: _____ **Date of report:** _____

Date symptoms developed: _____ **Time:** _____

Description of Condition or Symptoms Noticed:

Please select if appropriate: _____

other: _____

Was the physician or nurse practitioner called? _____

Who responded? _____

Nursing Intervention, action or education:

Person Completing Report: _____

Nurse Manager Review: _____

Resident	Abnormal finding on physical examination
Visitor	Laboratory studies suggestive of infection
Employee	Temperature elevated above 100 degrees orally
	Any resident in bed 24 hours with suspicious problems
	Nausea, vomiting, diarrhea of continuous or severe nature
	History of Hepatitis, VDRL, TB within the last year

Purulent wound or skin infection
Draining lesions
Abnormal discharge from any orifice
Positive Tine test/positive chest x-ray
Self-report

Influenza Vaccine Consent/Waiver

I am aware of the influenza policy and have had a chance to have my questions answered about influenza vaccination. * I understand the benefits and risks of the vaccine, and:

___ I agree to have the influenza vaccine for the influenza season. If you have already received the influenza vaccine for this influenza season, please specify the date_____.

___ I decline influenza vaccination for the influenza season. I understand that I may rescind this declination at any time. Please specify reason(s) for the declination
_____.

_____ _____

Employee Signature Date

Question	Yes	No
Did you receive the influenza vaccine during last year's influenza season?		
Have you had a severe (life threatening) allergic reaction to any component of the vaccine including egg protein or to a previous dose of any influenza vaccination?		
Do you have a history of allergy to eggs? If yes, please consult with your physician before receiving the vaccine.		
Do you have a history of Guillain-Barre syndrome (a severe paralytic illness, also called GBS) that has occurred within 6 weeks of receipt of a prior influenza vaccine? If yes, please consult with your physician before receiving the vaccine.		

Administration of Vaccine:

___ LAIV ___ TIV

Administrator Name: _____

Date Administered: _____

LANGUAGE INTERPRETER CONSENT FORM

I hereby give my permission for Pasadena Villa Psychiatric Residential Treatment Centers to use over the phone interpretation services through MasterWord Services, Inc. for the purposes of communicating my medical information, coordinating my care and communicating with my family. I understand that the interpreter will have access to my medical information, only through the interpretation of this information. I understand that the interpreter will NOT have access to my written medical records.

Language Interpretation required: _____

Permission Granted by: _____
(Signature of Resident, or Guardian)

Permission Granted by: _____
(Signature of Family Members Utilizing Interpretation Service)

_____
(Signature of Family Members Utilizing Interpretation Service)

Date of Signatures: _____

Witnessed by: _____

NOTICE OF NON DISCRIMINATION

This is to notify all persons that Renaissance Healthcare Group, LLC does not discriminate against any person because of his/her race, color, religious creed, national origin, sex, sexual orientation, which shall not include persons whose sexual orientation involves children as the sex object, age, ancestry, disability, marital status or political affiliation in the provision of or access to services, employment and activities.

This is in accordance with all applicable federal and state law, including, but not limited to, Section 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, as amended, the Florida Administrative Code and all relevant Florida Statutes.

David Nissen is designated to administer compliance with the law and regulations.

For further information about our policies and grievance procedures for the resolution of complaints contact:

David Nissen for Affirmative Action/Equal Opportunity issues.

George Kachmarik, PhD, for Programmatic Access and ADA issues.

NEW EMPLOYEE ORIENTATION, ANNUAL RE-ORIENTATION AND STAFF DEVELOPMENT PLAN 2015

I. Orientation of New Employees

On the first day of employment, the employee will attend new hire orientation and meet with a human resources representative to review and complete all personnel forms and to ensure his/her employee file is complete. At this time, the employee will be given information and documentation regarding the following:

Policy & Procedure Review
Employee Handbook Acknowledgement
Job Description & Organizational Chart
CPR/First Aid Certification (direct care staff)
Crisis Prevention Intervention (direct care staff)
Complaints & Grievances
Prevention of Workplace Violence
Prevention of Sexual Harassment & Discrimination
Cultural Diversity
Defensive Driving
Fire, Weather & Evacuation Plans & Procedures
Blood Bourne Pathogens
Therapeutic Boundaries (direct care staff)
Resident Rights & Responsibilities
Reporting of Abuse & Neglect (direct care staff)
HIPAA
Charting & Documentation (direct care staff)
Environmental Safety & Incident Reporting

The Orientation Checklist will assist the employee and his/her supervisor to track the new employee's progress toward completing the department orientation period. It is the responsibility of the new employee to give to the supervisor the checklist on a daily basis for review during the orientation period. All checklists will become part of the employee's file.

The Checklist will include supervised and monitored on-the-job training, review of policies and procedures, departmental training and required personnel documents. Employee training will be updated throughout the year as the needs of residents and staff change.

II. Annual Re-Orientation

On an annual basis, each employee will complete a re-orientation through Essential Learning. This re-orientation process is intended to provide our employees the opportunity to continually enhance skills and knowledge to improve service delivery and customer service. Additional trainings may be provided by Department.

The annual re-orientation staff will include the following:

Policy & Procedure Review
Job Description & Organizational Chart (at the time of Annual Review)
CPR/First Aid Certification
Crisis Prevention Intervention (direct care staff)
Blood borne pathogens (direct care staff)
Emergency Preparedness
Fire, Weather & Evacuation Plans & Procedures
Resident Rights & Responsibilities
Cultural Diversity

III. Staff Development

Staff development shall be planned and conducted on a regular and continuing basis, under the direction of the Compliance Officer and/or Human Resource Manager. Documentation of these sessions shall be included in the Human Resource file. Attendance at additional professional workshops and conferences should also be documented and placed in the employees' human resources file.

IV. Documentation

All Orientation, Re-Orientation and Staff Development activities will be documented in each employee's human resources file.

Pasadena Villa
Network of Services

Quarterly Peer Review

Quarter _____ Year _____ Resident Name _____

Please fill in each blank. The form must be completed in its entirety.

Physician Being Reviewed: _____

Physician Completing Review: _____

INDICATOR	SCORE
Was the resident level of care appropriate?	☐Y ☐N ☐NA
Were services delivered in the least restrictive environment possible?	☐Y ☐N ☐NA
Were resident rights protected?	☐Y ☐ N ☐NA
When permitted by the resident, the resident's family or significant others are involved in resident assessment, treatment planning and discharge planning?	☐Y ☐N ☐ NA
Is the admission evaluation complete (including diagnosis given and all five axes addressed)?	☐Y ☐N ☐NA
Do the physician's progress notes provide a timely description of the resident's course of care?	☐Y ☐N ☐NA
Are minimum therapeutic dosages of medication prescribed and appropriately administered?	☐Y ☐N ☐NA
Were medical emergencies handled appropriately?	☐Y ☐N ☐NA
Were abnormal results and pertinent findings addressed?	☐Y ☐ N ☐NA
Was appropriate consultation requested if needed?	☐Y ☐N ☐NA
Was this a specialty case, such as suicide, death, violence, staff abuse, and resident abuse?	☐Y ☐N ☐NA
Was the length of stay for each resident appropriate?	☐Y ☐ N ☐NA
Was the outcome consistent with the clinical picture?	☐Y ☐ N ☐ NA
Were delay in receiving services minimal?	☐Y ☐N ☐NA

Additional Remarks or recommendations: ☐No Additional

Actions: ☐None Required

Pasadena Villa
Network of Services

Peer Competency Assessment

General Competencies	Poor	Needs Improvement	Meets Standard	Exceeds Standard	Outstanding	Unknown
Resident Care Judgment, interviewing skills, diagnostic formulation, treatment planning and case management	☐1	☐2	☐3	☐4	☐5	☐0
Professionalism Medical record keeping, flexibility, punctuality, reliability, responsibility, recognition of limits of competence, ethical behavior, maintenance of treatment boundaries, acceptance of feedback, sensitivity to issues of gender and cultural diversity.	☐1	☐2	☐3	☐4	☐5	☐0
Interpersonal and Communication Skills Rapport with residents, relations with staff, teaching interest and skills, and ability to function as a team member.	☐1	☐2	☐3	☐4	☐5	☐0
Systems-Based Practice Ability to function within this treatment setting, conformity to facility expectations, attention to policies and procedures, compliance with safety.	☐1	☐2	☐3	☐4	☐5	☐0

Recommendations for Improvement: ☐None

Signature, title Date

Pasadena Villa Psychiatric Residential Treatment Centers

AUTHORIZATION FOR USE OF IMAGE, VOICE, PERFORMANCE OR LIKENESS

I hereby permit and authorize Pasadena Villa Psychiatric Residential Treatment Centers, (hereinafter "PVPRTC"), and its employees, agents and representatives who are acting on behalf of PVPRTC to use my likeness and/or name in any photograph, image, video, motion picture, performance or sound recording (collectively referred to herein as my "Likeness") for purposes related to its advertising, publicizing or marketing its programs or for any other commercial or lawful purpose, and to use and license others to use it for such purposes, without any compensation to me.

I understand and agree that these materials will become the property of PVPRTC and will not be returned. I hereby irrevocably authorize PVPRTC to edit, alter, copy, exhibit, publish, or broadcast my likeness at any time by means of any media, including print, video presentations, television, radio and satellite transmissions or rebroadcasts, news bulletins, mailers, billboards or signs, brochures, website placements, podcasts or other digital delivery publications.

In addition, I waive any right of privacy associated with the Likeness as well as the right to inspect or approve the finished product, including written or electronic copy, wherein my Likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my Likeness. I hereby hold harmless and release and forever discharge PVPRTC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read before signing and I fully understand the contents and meaning of this release.
By signing below, I <u>permit</u> PVPRTC to utilize images, voice, performances or my likeness.

_____ _____
(Signature) (Date)

_____ _____
(Printed or Typed Name) Phone

By signing below, I would like to <u>refuse</u> any type of authorization for the use of images, voice, performances or my likeness.

_____ _____
(Signature) (Date)

_____ _____
(Printed or Typed Name) Phone

Annual Proactive Risk Assessment

Risk (New or Identified on this Tour, Does not include ongoing)	Risk Score	Probability Score	Observations on which risk assessment is based	Outcome
NEEDLES / SHARPS/ BLOOD / BODY FLUID				
TB EXPOSURE				
MEDICATION ERROR				
CHEMICAL/GAS VAPOR FUME EXPOSURE				
ERGONOMICS				
EVACUATION/LIFTING RESIDENT				
FALLS				
BEING HIT BY FALLING OBJECTS				
ASSAULT				
THEFT				
ELECTRICAL				
FIRE				
RESIDENT HARM/SUICIDE				
Other risk observed which is not listed above.				

RISK FACTOR FOR HAZARDS	
1	VIRTUALLY NO RISK
2	MINIMAL RISK
3	MODERATE RISK
4	HIGH RISK
5	SEVERE RISK W/ HISTORY

PROBABILITY FACTOR FOR HAZARDS	
1	VIRTUALLY NO RISK
2	MINIMAL RISK
3	MODERATE RISK
4	HIGH RISK
5	SEVERE RISK W/ HISTORY

OUTCOME
C= CHANGE IN PROCESS REQUIRED
T=TRAINING REQUIRED
P=POLICY AND PROCEDURE REQUIRED
E=PPE/SAFETY EQUIPMENT REQUIRED

Comments:			
Name of Team Completing Assessment	**Title**	**Date of Assessment**	
	Facilities & Fleet Manager		
	Program Director		
	Assistant Program Director		
	Executive Director		
	Nurse Manager		
	Compliance Officer		

POLICIES AND PROCEDURES

RENAISSANCE HEALTHCARE GROUP, LLC

QUALITY ASSURANCE AND PEFORMANCE IMPROVEMENT PLAN 2015

We believe in, and are committed to, a Person-Centered Approach to continuous quality and performance improvement in all areas of our operations, including leadership, management, service delivery, human resources, and relationship-building with clients, families, referents, outside professionals, and other stakeholders.

Our Person-Centered Approach is rooted in the belief that our company's most important assets are our employees – team members who work collaboratively to provide the best mental health services in the country. Our Person-Centered Approach provides an environment for our employees to help our residents improve their quality of life through improvement in mental, emotional, spiritual and physical health. It is our belief that improvements in quality of life are measured by the quality of social functioning and familial relationships that emerge from successful treatment.

Given these beliefs, we pride ourselves in the development of creative and prompt solutions to issues, as we strive to meet the dynamic and changing needs of our clients, families and referents. This theme is central to our Quality Assurance and Performance Improvement Plan.

I.Purpose

The purpose of the Quality Assurance and Performance Improvement Plan is to provide an ongoing process by which Pasadena Villa objectively and systematically monitors and evaluates the quality and appropriateness of resident care, identifies acceptable levels of care, finds and implements opportunities to improve care, and resolves and/or submits proposals for the resolution of problems to the Administration and/or Governing Board.

II. Objectives

Objectives of the Quality Assurance and Performance Improvement Plan are:

- To emphasize the role of the leaders of the organization in improving quality
- To routinely use assessment and improvement activities that move beyond the strictly clinical and on to the interrelated governance, managerial, support and clinical processes that affect resident outcomes
- To use other sources of feedback, other than ongoing monitoring, in order to trigger evaluation and improvement of care activities

- To establish the organization of assessment and improvement activities around the functions of patient care services
- To focus on the processes of care and service, rather than on the performance of individuals
- To emphasize continuous improvement rather than merely identifying and solving problems
- To continuously improve over time. To operationalize and monitor Peer Review and Utilization Review activities conducted under policy PI-06.

III. Authority and Responsibility

Governing Board -The Governing Board charges the leadership of Pasadena Villa and the professional staff with the obligation of operating and implementing this Plan.

Administration -The responsibility for monitoring and evaluating resident care services is the responsibility of the Administration

(Executive Director and Program Directors), but may be delegated to various facility staff on the Quality Assurance and Performance Improvement Team, consisting of the Managing Director, Clinical Director, Compliance Officer, Program Directors, Assistant Program Directors, Nurse Mangers, Human Resource Director, Fleet and Facilities Directors, Intake Director, Marketing and Referral Relations Director, Culinary Managers, and any other staff member or facility professional who either wishes to participate in the Team or is requested to participate due to a specific issue to be addressed by the Team.

Quality Assurance and Performance Improvement Team -The Quality Assurance and Performance Improvement Team shall report areas for improvement and/or problems identified by staff members, professional staff, residents, families, visitors or vendors.

IV. Quality Improvement Activities

The Quality Assurance and Performance Improvement Team is responsible for the monitoring and evaluation of activities. At a minimum, this includes monitoring these key functions: clinical record

review through chart audits, peer reviews and utilization review; infection control; incident report/risk management review; satisfaction surveys and outcome measures review.

The channels through which the Quality Assurance and Performance Improvement Team may receive recommendations for improving services and/or reports of actual or potential problems may be formal or informal. formal channels include meeting minutes, routine reports, findings from

QI indicators, and resident and family surveys. Informal channels may include unsolicited suggestions or complaints from staff, residents, family, visitors or vendors.

In the selection of service functions for monitoring and evaluation, the following considerations shall be used:

High Volume: most frequently rendered services, assessments, procedures or modalities.

High Risk: activities, medications or procedures having the potential to harm or injure residents, staff, visitors or property

Problem Prone: activities often associated with resident or staff difficulties, complaints, errors or incidents

Response to Untoward Event: a Root Cause Analysis is conducted for all facility-defined sentinel events and near misses, addressing opportunities for prevention of future events.

V. Evaluation of Monitored Data

Initial Evaluation: areas of consideration during the evaluation of data shall include the following:

- Appropriateness of care or clinical performance
- Impact on resident care
- Identification of problems and/or opportunities for improvement of care delivery systems or clinical performance
- Potential sources of problems, including staff knowledge, behaviors or attitudes.

Re-Evaluation: a status report of succeeding data shall be submitted to the appropriate authority and shall include the following:

- Demonstration that performance/conditions have met or have not met standards

- Statement of cause when actual performance/conditions have met or have not met standards
- Recommendations for further action when initial action did not reduce or resolve the problems
- Plan for follow-up and re-evaluation

Annual Appraisal: the effectiveness of the Plan shall be assessed on an annual basis. This annual review shall measure program effectiveness, program goals, policies, procedures, and service treatment goals. Also, in applicable, a summary of QIP activities shall be submitted.

VI. Methodology

Important functions throughout the organization are continuously measured, assessed and improved. The successful outcome of improvement activities is accomplished through:

P = PLAN process changes designed to improve outcomes

D = DO take action pilot the process changes

C = CHECK the effects, study results, measure changes

A = ACT to improve the process by implementing changes

VII. Confidentiality and Immunity

Any and all documents and records that are a part of the internal Quality Assurance and Performance Improvement Plan and quality management program, as well as proceedings, reports, records of any of the activities identified in this Plan, shall be confidential and not subject to subpoena or discovery or considered admissible in a court of law under Florida Statutes.

Access to data is restricted to the Governing Board and CQI Team.

Summary reports and Team meeting minutes shall be provided for necessary meetings and activities, but are not to be removed from the facility. All copies of reports or minutes will be collected after each meeting and destroyed. Original reports and minutes shall be maintained in Administration and shall be produced upon request on a need to know basis. Program evaluation and review information shall be made available to the Department of Children and Families and the Agency for Health Care Administration, upon written request or during licensure surveys, within the limits of confidentiality pursuant to 394.459(9), F .S.

Requests for release of Quality Assurance and Performance Improvement data from individuals not otherwise authorized for review must be made to the Managing Director. Such requests are to be specific and are to describe the purpose and intended use of information requested. The authority for such review may be granted only by the Managing Director in association with facility legal counsel, when appropriate, or courts of appropriate jurisdiction.

REQUEST FOR ACCOUNTING OF PROTECTED HEALTH INFORMATION DISCLOSURES

Consistent with federal regulations, we will provide you with an accounting of certain disclosures of your protected health information. You will not receive an accounting for the following:

- Disclosures of your Protected Health Information for the purposes of treatment, payment, or the day-to-day operation of the medical practice
- Disclosures to law enforcement, correctional institutions, or for any other legally required or permitted disclosure listed on our Notice of Privacy Practices
- Disclosures that occurred prior to April 14, 2003, the effective date of the federal privacy rules
- Disclosures that occurred six or more years prior to the date of this request

We will contact you when the information you have requested is available, generally within 30 days of your request.

Name of Resident (Type or Print)

Signature of Resident Date

Telephone Number

Street Address

City, State, Zip Code

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

This form is to be used by residents who wish to request that information kept in the records of Renaissance Healthcare Group, LLC be amended. The following summarizes our policies and procedures with respect to amending resident information:

- Requests to amend information must be submitted in writing.
- Your request will be reviewed by the Compliance Officer, Clinical Director and other staff members as appropriate.
- If the Clinical Director determines that the amendment you have requested should be made, the records will be updated as required by federal regulations.
- If the Clinical Director determines that the information in our records is complete and accurate, you request will be denied. A written notice of this decision will be sent to you as required by federal regulations. You will have an opportunity to send us a written statement explaining your disagreement with this decision. That statement will be included in your records, along with any response that we believe is necessary to help future users of the information understand that information. You will be given a copy of any response that we include in the record.

Information to be Amended

Please identify the information that you believe needs to be amended in the spaces provided below. Identify the source of the information (for example, your medical records or billing records), the specific information that you believe to be incorrect and the reason you believe the information to be incorrect. If no reason is given, your request will be denied.

If you need help with this form, please contact:

Amy Teumer, Compliance Officer
(407) 896-2636

Item to be changed:_____
Data Source:_____
Change:_____
Reason:_____
_____
_____

*Response_____
_____

Item to be changed:_____
Data Source:_____
Change:_____
Reason:_____
_____
*Response:_____
_____

Attach additional copies of this page as needed.

Resident Signature

Please sign and date this form:

_____

Name of Resident

Signature of Resident Date

Signature of Resident Representative

Relationship of Resident Representative to Resident

Decision

Approved amendments
The following requests for amendment of information have been approved:

This information will be corrected and other organizations to which this information has been disclosed will be notified as required by federal regulations.

Requests for Amendment That Have Been Denied
The following requests for amendment of information have been denied for the reasons given section describing the information you have requested:

This information will not be amended in our records. If you disagree with this decision, you may submit a written statement of disagreement. Your statement must be limited to one standard letter-sized page (8 inches X 11 inches) per correction. Your disagreement will be included in our records and it, or an accurate summary of it that we will prepare, will be transmitted to any entity to whom the affected information is disclosed in the future. We also may include own comments on your statements. If we do include such a statement, you will be sent a copy of the statement.

Title of Privacy Official

Signature Date

REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

This form is used by the resident to request an opportunity to examine or copy Protected Health Information in the possession of Renaissance Healthcare Group, LLC.

Information Requested
Please describe the information that you would like to examine or copy:

_____

_____

_____

_____

Review Procedures
Your request to inspect or copy your Protected Health Information will be reviewed by the Compliance Officer and/or Clinical Director, who will determine if the information requested can be made available to you. We may legally prohibited from making certain information available to residents or resident representatives, including:

- Psychotherapy Notes
- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information that is related to medical research in which you have agreed to participate
- Information whose disclosure may result in harm or injury to you or to another person
- Information that was obtained under a promise of confidentiality

Within the limitations of the law, we will make every effort to accommodate your request.

We will complete our review of your request and either arrange for you to inspect your records within 15 days of your request, or provide you with a written explanation of any restriction on the information that we can provide you.

If we deny your request, in whole or in part, you may request that we review that decision.

_____
Name of Resident (Type or Print)

_____
Signature of Resident Date

_____
Signature of Resident Representative

_____
Relationship of Resident Representative to Resident

REVOCATION OF RELEASE OF INFORMATION

Revocation of Authorization
This notice revokes the authorization to the use and disclosure of protected health information for:

Resident Name (Please Print or Type)

That was signed on:

Date of Consent

Effect of Revocation
Protected health information that is collected on or after the date on which this form is received by Renaissance Healthcare Group, LLC will not be used or disclosed by Renaissance Healthcare Group, LLC for the purposes specified on the authorization that is revoked.

This revocation of authorization will not limit the ability of Renaissance Healthcare Group, LLC to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services, nor will it affect uses or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Other consequences of revoking authorization include:

Effective Date of Revocation
The revocation of authorization to use or disclose protected health information is effective _____/_____/_____.

Signature

Name of Resident (Print or Type)

Signature of Resident Date

Signature of Resident Representative/Guardian

ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

This tool is designed to guide through a root cause analysis for all Sentinel Events. Not all possibilities and questions will apply in every case. There may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your root causes and risk reduction.

Fill in the blanks for the questions asked using the form below.

The three columns on the right are provided to be checked:

- "Root cause" should be answered "Yes" or "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk.
- If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question such as "Why did it contribute to the likelihood of the event" or "Why did it contribute to the severity of the event?" Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- "Ask Why?" should be checked off whenever it is reasonable to ask why a particular finding occurred or didn't occur when it should have. It is expected that any significant findings that are not identified as root causes themselves have "roots." Drill down further by asking why five (5) times. Each item checked in this column should be addressed later in the analysis with a "Why?" question.
- "Take action?" should be answered "Yes" for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write the number of the associated Action Item on Page 5 in the "Take Action?" column for each of the findings that requires an action.

Pasadena Villa Network of Services

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root cause?	Ask "Why?"	Take Action
What Happended?	Sentinel Event	What are the details fo the event? (Brief Description)				
		When did the event occur? (Date, day of week, time)				
		What area/level of care/service was impacted?				
Why Did it Happen? _____ What were the most proximate factors? 	The process or activity in which the event occured	How was it supposed to happen? What are the steps in the process, as designed? (cite policies, procedures, protocols, etc				
		What steps were involved in (contributed to) the event?				
	Human Factors	What human factors were relevant to the outcome? Example: • Boredom, fatigue • Failure to follow established policies/procedures • Inadequate staffing • Lack of training • Personal problems • Rushing to complete task				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root cause?	Ask "Why?"	Take Action
		• Substance abuse • Trust				
	Equipment Factors	How did equipment performance affect outcome? Example: • Vehicle in need of repair • Availability of equipment • Equipment in need of repair • Location of equipment and its accessibility to staff and residents • Staff knowledge of or education on equipment, including applicable competencies • Correct calibration, setting, operation of alarms, displays, and controls				
	Controllable Environmental Factors	What factore directly affected the outcome? Example: • Level of care • Safety or security risks assessment • Treatment factors • Lighting or space issues				
	Uncontrollable Environmental Factors	Are they truly beyond the organization's control?				
	Other	Anything else not yet discussed.				
		What are the other areas of service could be impacted? • SML • PV • Day Treatment • TLLC • Case Management				

Pasadena Villa Network of Services

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root cause?	Ask "Why?"	Take Action
		• Animal Care • Business Office				
Why did that happen?	Human Resource Issues	Was the staff properly trained and currently competent for their responsibilities at the time of the event?				
What systems and processes underlie those proximate factors?		How did actual staffing compare with ideal levels?				
		What is the plan for dealing with staffing contingencies that would tend to reduce effective staffing levels?				
		Did staff performance during the event meet expectations?				
		How can orientation and inservice training be improved?				
	Information Management Issues	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		How might technology be introduced or redesigned to reduce risk in the future?				
	Environment of Care Issues	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				
		What emergency and failure- mode responses have been planned and tested? Were emergency management plans followed?				
	Leadership Issues: Corporate Culture	To what degree is the culture conducive to risk identification and reduction?				
	Encouragement of	What are the barriers to communication of potential risk factors?				

ROOT CAUSE ANALYSIS AND ACTION PLAN

Level of Analysis		Questions	Findings	Root cause?	Ask "Why?"	Take Action
	Communication					
	Clear Communication of Priorities	To what degree is the prevention of adverse outcomes communicated as a high priority? How?				
	Uncontrollable Factors	What can be done to protect against the effects of uncollable factors?				

Action Plan	Organization Plan of Action Risk Reduction Strategies	Position/Title Responsible Party	Method: Policy, Education, Audit, Observation & Implementation
For each of the findings identified in the analysis as needing an action, indicate the planned action expected, implementation date and associated measure of effectiveness. OR. …	Action Item #1:		
If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.	Action Item #2:		
Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.	Action Item #3:		
Consider whether pilot testing of a planned improvement should be conducted.	Action Item #4:		
Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	Action Item #5:		

	Action Item #6:		
	Action Item #7:		
	Action Item #8:		

Bibliography: Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

Date of Completion:

Contributing Attendees and Titles:

Pasadena Villa
Network of Services

ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: _____

Date: _____

Are you a recent contact to an infectious case of tuberculosis?	**YES☐ NO☐**
Have you ever had an organ transplant?	**YES☐ NO☐**
Are you a recent (within the last 5 years) immigrant from a country with a high rate of TB?	**YES☐ NO☐**
• If yes, What country?	
Have you ever injected drugs?	**YES☐ NO☐**
Have you been in jail, prison or a nursing home?	**YES☐ NO☐**
Have you ever worked in a lab that processed TB specimens?	**YES☐ NO☐**
Do you have any of the following medical Conditions	
• Diabetes?	**YES☐ NO☐**
• Chronic Kidney failure with dialysis?	**YES☐ NO☐**
• Leukemia?	**YES☐ NO☐**
• Lymphoma?	**YES☐ NO☐**
• Cancer of the head, neck or lung?	**YES☐ NO☐**
• Stomach surgery?	**YES☐ NO☐**
• Immune problems (Diagnosed with HIV disease or taken Prednisone longer than on month)?	**YES☐ NO☐**
Have you ever been told that you have an abnormal chest x-ray?	**YES☐ NO☐**
Have you had any of the following symptoms recently?	
• Cough and/or hoarseness lasting more than 3 weeks?	**YES☐ NO☐**
• Recent unexplained weight loss?	**YES☐ NO☐**
• Fever or night sweats for more than a week?	**YES☐ NO☐**
• A productive cough or coughed up blood?	**YES☐ NO☐**

Signature Date

Tetanus Vaccine Consent/Waiver

I,_____ acknowledge that Pasadena Villa Network of Services makes every effort to reduce staff, resident and visitor risk to infectious diseases. By participating in the equine/animal therapy program, I understand that all infectious risk is unavoidable and inherent in animal care facilities.

In an effort to reduce my risk, I have been offered a tetanus vaccine by Pasadena Villa Network of services.

_____ I am declining a tetanus vaccine because I am currently on this vaccine or do not wish to have one.

_____ I am declining a tetanus vaccine for other reasons

_____ I am accepting a tetanus vaccine

_____ _____

Signature of Resident/Staff Signature of Guardian (if applicable)

_____

Signature of Staff

Administration of Vaccine:

Administrator Name: _____

Date Administered: _____

RESIDENT NAME: _____

DATE: _____

CONSENT FOR AUDIO/VIDEOTAPING

This is to certify that I, _____, a resident at _____ give my consent to be audio-video taped or photographed.

For the purpose of : _____

_____.

I acknowledge that the cassette will become the property of Renaissance Healthcare Group, LLC and will be kept confidential. The cassette will be kept in Medical Records for a period not to exceed five (5) years at which time it will be incinerated.

Signed:

_____ _____
Resident Date

_____ _____
Legal Guardian (if applicable) Date

_____ _____
Witness Date

VISITOR SIGN-IN AND CONFIDENTIALITY STATEMENT

By signing below, I acknowledge that every aspect of care at Renaissance Healthcare Group, LLC is strictly confidential. The names and descriptions of residents, clients and visitors within the facility shall be held in confidence, and shall not be discussed with any other person outside of the facility. I shall adhere to all Federal and State confidentiality laws, rules, regulations and guidelines.

Visitors must sign this Confidentiality Statement upon their visit, but are not required to sign during each visit to Renaissance Healthcare Group, LLC.

Print Name	**Signature**	**Date**


Pasadena Villa
Network of Services