LAKELAND CARE Together, we build better lives.	
Use of Restrictive Measures Policy & Procedure	
This Policy Applies to: ☒ Lakeland Care Inc. (LCI) – All Staff ☒ Lakeland Care Plus – All Staff	**Developed Date**: March 2013
Review/Approval Frequency: Biennially	**Last LCI Review Date**: October 2024
Last DHS Approval: N/A	**Policy Owner**: Care Management
Authorization & Date: 	8/11/20

Purpose: to outline Lakeland Care, Inc.'s (LCI) expectations to its employees, subcontractors, and community partners as it relates to the use of restrictive measures.

Scope: This policy applies to LCI members and all service providers contracted with LCI.These requirements apply to requests for use of restrictive measures for all members; in all target groups; living in non-institutional settings. These requirements apply to any individual/provider who receives payment from LCI to provide direct support services to a member. This does not apply to unpaid caregivers. Inappropriate use of restrictive measures by unpaid caregivers may be considered abuse/neglect under Wis. Statute and should be reported as appropriate.

Definitions:

Abuse: as defined by Wis. Stats.s. 46.90(1)(a), means any of the following:

- **Physical Abuse**: intentional or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.
- **Emotional Abuse**: language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harass, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.
- **Sexual Assault**: a violation of criminal assault law, Wis. Stats.s. 940.225 (1), (2), (3), or (3m).
- **Treatment without consent**: the administration of medication to an individual who has not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.
- **Unreasonable confinement or restraint**: the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from their living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with the state and federal standards governing confinement and restraint.

Adult Incident Reporting System (AIRS): manages incidents occurring at the member and provider levels, and includes the activities of incident discovery, report, response, investigation, remediation, and data collection and analysis in order to a) assure member health and safety; b) reduce member incident risk(s), and; c) enable development of strategies to prevent future incident occurrence(s).

Revision History: 03/2022, 02/2023, 02/2024, 10/2024

Behavior Supports (known as Positive Behavior Supports): components of a member's environment intended to encourage behaviors that replace challenging or dangerous behaviors and help the member attain their desired quality of life. Positive behavior supports may include but are not limited to, teaching the individual methods to communicate better with others, expanding the opportunities for developing relationships, improving the quality of living environments, schedule modification, assisting the member to learn self-calming methods or other clinical interventions.

Behavior Support Plan (BSP) (known as Positive Behavior Support Plan [PBSP]): a behavior support plan is a written document, specific to the individual, intended to inform direct support staff how to assist the individual in building prosocial and adaptive behaviors. Behavior plans also include direction on how to utilize other supports, strategies, and interventions in order to ensure safety and to decrease the individual's challenging behavior. For individuals with restrictive measures, the behavior support plan must include the following:

- Information about the use of the restrictive intervention(s);
- A description of the proposed step-by-step procedures for applying or implementing the restrictive measure, along with a description of how it will be monitored and the criteria that govern release of the individual from the measure;
- The maximum duration for the use of the measure;
- The methods or strategies the team will employ to attempt to reduce or eliminate the restrictive measure.

For individuals who have a behavior support plan, LCI must reference the plan within the member-centered plan (MCP) and save it to the electronic member record (EMR) as an addendum.

Behavior Support Team (known as Team): all relevant parties needed to develop and implement the least restrictive, most member-centered behavior intervention and behavior support plans. The Behavior Support Team must include at a minimum: the member and guardian/legal representative where applicable, LCI Care Manager and Registered Nurse, the provider agency director or designee, and medical provider or psychologist (when restrictive measures are being proposed).

Behavioral Request: team must submit a behavioral request if a restrictive measure is necessary to ensure safety during a situation when the individual's behavior will put themselves or others at imminent risk of serious harm. If the measure is necessary to act as a form of behavioral control during a medical procedure or while a medical condition exists, the team must also submit this information as a behavioral request. All behavioral requests must include a behavior support plan with details about when and how the direct support staff will use the measure, maximum length of time of use, and criteria for release from or removal of the restrictive measure.

Challenging or Dangerous Behavior: refers to the member's behavioral response during an incident that place the member or others at risk of serious harm. Restrictive measures may only be incorporated into a member's plan or used when a member's behavior puts that member or others at imminent risk of serious physical harm.

Contraindication: a factor that renders the use of a restrictive measure inadvisable, in most instances, determined by a medical professional.

De-escalation Strategies: strategies direct support staff use to help a member return to a baseline, adaptive or calm state. Strategies may include:

- Staff adopting a caring but neutral position.

- Remaining calm and using a calm tone of voice.
- Paying attention to the member; listening, focusing on feelings, and validating them; empathizing; being nonjudgmental (in both body and verbal language).
- Assisting the member to use skills they have learned to calm or to cope with the stressful situation.
- Staff working to reduce environmental stressors.
- Trying to determine what the member wants and offering solutions or alternatives.
- Drawing the member into a more pleasant, positive, and grounded state.

Emergency Restrictive Measure: an emergency, as it relates to restrictive measures, means an unanticipated situation has occurred where a member suddenly engages in dangerous behavior, placing the member or others at imminent, significant risk of physical injury, or exhibits signs known to be precursors of such behavior for the member. This may include the appearance of behavior that has not happened for years or has never been known to have occurred before, or it could include current behaviors that suddenly and unexpectedly have escalated to an intensity the Team has not seen before. Emergency use of restrictive measure also applies to situations the team does not anticipate will occur again.

Imminent Risk of Harm: an immediate and impending threat of an individual causing substantial physical injury to self or others.

Interdisciplinary Team (IDT): consists of the member, legal representative when appointed, LCI CareMnager (CM), LCI Registered Nurse Care Manager (RN or RNCM), and whomever else the member would like involved.

Interdisciplinary Team Staff (IDTS): the LCI Care Manager (CM) and LCI Registered Nurse Care Manager (RN or RNCM) assigned to provide care management services to the member. IDTS may also be reerred to as the care team.
IDTS will ensure the member is at the center of the comprehensive assessment and member centered planning process. The member will have meaningful opportunity to participate throughout the care planning process, live as independent as possible, and take an active role in decision-making.

Isolation: the involuntary physical or social separation of a member from others by the actions or direction of staff, contingent upon behavior. At times, a physical or social separation from others may occur, but the intent of the action must be considered in order to determine whether isolation is occurring. For the purposes of this policy, the following are not considered isolation a restrictive measure:

- Staff separates an individual from others in order to prevent the spread of communicable disease;
- An individual goes to another area to cool down, the individual's presence in that room or area is voluntary, and there are no adverse consequences to the individual if he or she refuses to go there. If a behavior plan includes a directive to an individual that he or she go to another area to calm down, it must be clear if this is a suggestion the individual may refuse without any adverse consequences.
- An individual decides on their own, without any suggestions or prompting from staff, to go to another area, this is voluntary and does not constitute isolation. If staff suggests to an individual that he or she should go to another area to calm down and the individual chooses to go, this is also voluntary and does not constitute isolation.
- An individual is engaging in dangerous behaviors in an area where peers are located, and staff directs the peers to leave the area.

An individual voluntarily walks to a room built for seclusion, the staff do not engage the locking mechanism, and the individual may leave the room at any time, even if they are not calm.

Isolation by staff withdrawal: isolation by staff withdrawal occurs in situations where, for safety reasons, the support team determines staff should withdraw from the member due to the presence of behaviors that present imminent risk of harm to staff. When staff withdraws, they retreat to a predesignated room or area for a specific amount time to allow the member to calm.It is considered to be isolation by staff withdrawal when the member is either unlikely to follow, or unable to follow, or unable to reach staff after they have retreated to the designated area.Typically, this involves staff locking the door between them and the member, but not always. If staff go into the office and close the door without locking it because they know the member would never try to enter the staff office, this would also be isolation by staff withdrawal. If staff goes into the basement and leaves the door open, knowing the member would never try to follow them, this would also constitute isolation by staff withdrawal. See requirements for Isolation by Staff Withdrawal in the Policy.

Manual Restraint: includes physical holds and escorts, involves one or more people holding the limbs or other parts of the body of a member in order to restrict or prevent the member's movement. For the purpose of this policy, the following actions are not considered manual restraints:

- Holding a member's limbs or body to provide support for the achieving of functional body positions and equilibrium, such as supporting someone to walk, achieving a sitting or standing position.
- Holding a member's limbs or body to prevent him or her from accidentally falling.
- Use of self-protection and blocking techniques in response to aggressive behaviors.
- Use of graduated guidance - assisting the member to move, but not restricting or forcing body movement, as part of an approved intervention.

Mechanical Support: any apparatus used to provide proper alignment of an individual's body or to help an individual maintain their balance. Mechanical supports include but are not limited to, postural supports, position devices, and orthopedic devices. The team must utilize a qualified professional to design a plan for use of mechanical supports in accordance with good body mechanics, with concern for circulation, and with allowance for change in position.Mechanical supports must not impair or inhibit visual or auditory capabilities or prevent or impair speech or other methods of communication. The team must assess all mechanical supports to determine if it is a medical restrictive measure; such devices may become restrictive measures and require approval if the use prevents or limits functional access to parts of their body, or limits intentional, controlled, and purposeful movements or mobility and cannot easily be removed by the member. See requirements for use of Mechanical Supports in the Policy.

Medical Procedure Restraint: restraints utilized to accomplish a specific diagnostic or therapeutic procedure ordered by a medical professional.

DHS does not need to approve medical procedure restraints used while under the care of medical professionals in a medical or dental office or while receiving treatment in a clinic or hospital, as long as the medical provider is directing staff who accompanies the individual.

LCI must submit an application to DHS for approval of a medical procedure restraint when the procedure is occurring in the individual's home, day program, or other non-medical setting. The use of the restraint must only occur for the minimum duration necessary to complete the procedure. If the medical procedure restraint is necessary as a form of behavioral control, LCI must submit a behavioral request.

Medical Provider: a medical provider, as it relates to restrictive measures, means a physician, psychiatrist, nurse practitioner (NP), or physician assistant (PA) who regularly provides care for the individual and is aware of the individual's long-term care support needs.

Medical Request: if a restrictive measure is necessary to ensure the safety of a member due to a medical procedure or condition, which is not related to a challenging and dangerous behavior (meaning the medical condition is not caused by intentional behavior or an intentional behavior is not occurring because of a medical condition) the Team must submit a medical request with a service plan or protocol. The service plan or protocol must provide details about when and how the direct support staff will use the measure, maximum length of time of use, and criteria for release from or removal of the restrictive measure. The protocol should also include information related to regular inspection of all devices to ensure they remain in good working condition.

Neglect: the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. "Neglect" does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual's previously executed declaration or do-not-resuscitate order under Ch. 154, Wis. Stats, a power of attorney for health care under Ch. 155, Wis. Stats., or as otherwise authorized by law.

Protective Equipment: includes devices that restrict movement or limit access to areas of one's body. Protective equipment refers to devices applied to any part of an individual's body to prevent tissue damage or other physical harm **and** the individual cannot easily remove the device. Protective equipment must not impair or inhibit visual or auditory capabilities or prevent or impair speech or other methods of communication. Protective equipment includes, but is not limited to:

- Helmets, with or without face guards
- Gloves or mitts
- Enclosed beds
- Wheelchair seatbelts
- Shower chair seatbelts
- Bedrails
- Wrist cuffs
- Ankle straps
- Goggles
- Pads worn on the body
- Clothing or adaptive equipment specially designed or modified to restrict access to a body part

DHS does not consider the following protective equipment devices to be restrictive measures:

- Mechanical supports as defined in this policy.
- Wheelchair seat belts or foot straps, bed rails, and other transportation safety devices such as stretcher belts intended to prevent an individual from accidentally falling or slipping during transport.
- Motor vehicle seat belts or harnesses with buckle guards or similar devices in place to ensure a passenger is unable to remove the safety belt in a motor vehicle.
- Professionally designed therapeutic devices to promote optimal motor functioning.

Provider: any individual/agency who receives payment from a Medicaid-funded long-term support program to provide direct support services to an individual. Common examples are providers, provider agency staff, paid family caregivers, and participant-hired workers (PHWs).

Release Criteria: criteria specified in the behavior plan, which, once met, would result in the termination of the use of the specific restrictive measure for that incident. The criteria for release should identify cues that are unique to the member for determining if member is no longer

exhibiting behavior that puts someone at imminent risk of harm. The member does not have to be “calm” or compliant before the release of the restrictive measure. Upon release, staff must offer the member the opportunity to move about. If appropriate to the situation, the staff should also give the member the opportunity to have food and drink and to attend to their other needs. *The member must be released when one of the following occurs*:

- The criteria outlined in the plan is met.
- If the criteria for releasing the individual from isolation, seclusion, or protective equipment have not been met within 60 minutes of the first use of the restraint.
- When the use of an approved manual restraint has lasted 15 continuous minutes.
- When the member’s behavior has not been dangerous and he or she has been calm for five full minutes.
- If there are any threats to the member’s health or well-being from use of the measure.

Restraint: any device, garment or physical hold that restricts the voluntary movement of, or access to, any part of an individual’s body **and** the individual cannot easily remove it.

Restraint to Allow Healing: the treatment of acute medical conditions such as lacerations, fractures, post-surgical wounds, skin ulcers or infections may require the use of a restrictive measure to allow healing. The use of a restraint to allow healing must include a protocol for use. The protocol must be for the specific device or procedure, include the rationale for its use, and specify the limited period of time it may be used. LCI must submit a restrictive measures request to DHS if the restraint to allow healing will be utilized for more than three months.

Restrictive Measure (RM): the term used to encompass any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint or restraint to allow healing as defined in this policy/procedure and DHS RMGS.

Seclusion: a restrictive measure in which staff physically set the individual apart from others inside a room using locked doors equipped with a pressure-locking mechanism. Seclusion does not include the use of devices like “wander guards” or similar products that may also involve locking doors. The use of seclusion as a form of behavior modification or as a consequence for non-compliance is not allowed. Seclusion may only be used as a response to a behavior that involves an imminent risk of harm and for the shortest duration possibly to maintain safety. Half doors, gated barriers, or any barrier without a viewing window or monitor and pressurized lock that an individual cannot remove or open on their own are prohibited from being used for seclusion. Examples of appropriate use of seclusion are to ensure safety of the individual and others due to prolonged physical aggression or to clear an area of harmful items, such as broken glass. The BSP must indicate the method used to safely transport a member to seclusion. See requirements for Seclusion in the Policy.

Voluntary Movement: in relation to restrictive measures, voluntary movements are movements the individual is able to control and that are purposeful.

Unapproved Use of Restrictive Measure: instances when there is a need for a restrictive measure and the team is gathering information for DHS approval or when the current restrictive measure expired and is still being utilized. An example may be restrictive measures that were initially used in cases of emergency, that the team anticipates will be likely to occur again, or have occurred more than twice in a six month timeframe however have not yet been approved. If the team anticipates the situation that led to the use of an emergency restrictive measure is likely to occur again or has been used more than twice in six months, the situation no longer meets the definition of emergency restrictive measure and must go through the planning and approval process.

Policy:
LCI is committed to ensuring members have access to safe and respectful supports. It is LCI's belief that restrictive measures are the least desirable way to address dangerous or challenging behavior and will be considered only as an interim method of last resort, when less restrictive and less intrusive strategies, identified through a thoughtful and comprehensive behavior support plan, are proven ineffective. The use of restrictive measures with any LCI member outside an approved plan is prohibited.

LCI expects all IDTS to ensure members are free from any form of abuse, neglect, confinement, or restraint. IDTS ensure members' safety in the above noted areas through assessment, thoughtful care plan development and ongoing monitoring of positive and behavioral support plans and member centered plans. In collaboration with LCI, providers are also responsible to meet the conditions necessary to assure member health and safety. LCI strives to support and maintain members' dignity through a careful partnership between LCI providers, members, natural supports, and LCI staff. IDTS respect members' choice and preference(s) and will show consideration to members' experiences throughout the care planning process.

Behavior Support Plans must be created by the team, which consists of appropriate provider and LCI staff having direct knowledge of the member. It is the belief of LCI, that all behavior serves a purpose and function. It is imperative that the team conduct an assessment to determine the function of the behavior so that effective interventions and supports can be in place. LCI's Positive Behavioral Supports Policy and Procedure must be followed first.

When a Positive Behavioral Support Plan is not sufficient in ensuring the member's or other's health and safety, and all less restrictive support strategies and interventions have been attempted and proven ineffective, and the member's challenging and dangerous behavior, poses an immediate imminent danger to themself or others, the team may need to consider a Behavior Support Plan including the use of restrictive measures and apply for LCI and DHS approval. This plan must include: a description of the behavior the plan addresses, the proposed strategies including type of measure and duration of use, treatment rationale including a description of the risks and benefits of the proposed interventions, the provider and placing agency, identity of staff who may implement and/or authorize the implementation of the measure, the plan for staff training prior to implementing the measure, and the plan for monitoring, documenting use, measuring progress, and reducing/eliminating the measure.

LCI expects its providers to ensure training and education to its staff on the identification and applicability of restrictive measures, including, but not limited to requirements outlined in this policy.

Prohibited Practices
The following maneuvers, techniques, or procedures may not be used in any circumstance:
1. Any maneuver or technique that does not give adequate attention and care to protection of the head.
2. Any maneuver or technique that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
3. Any maneuver or technique that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the torso, or any type of choke hold.
4. Any maneuver or technique that involves pushing into a member's mouth, nose, or eyes.
5. Any maneuver or technique that utilizes pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
6. Any maneuver or technique that forces a person to remain in a prone (face down) position.

7. Any maneuver or technique that forcibly takes a member from a standing position to a horizontal (prone or supine) position or to a seated position on the floor.
8. Any maneuver or technique that creates a motion causing forcible impact on the member's head or body, or forcibly pushes a member against a hard surface.
9. The use of seclusion where the door to the room would remain locked without someone having to remain present to apply some type of constant pressure or control to the locking mechanism.

Requirements for Isolation by Staff Withdrawal
While staff have retreated to the area the individual is unwilling or unable to access, they must be able to assure the safety of the individual through an appropriate method of monitoring (such as windows, auditory monitoring, video monitoring, ceiling-mounted mirrors, peephole in door). If, at any time, staff is not able to monitor the individual directly, staff must leave the secure area to ascertain safety. The maximum amount of time an individual may be in isolation or seclusion is 60 minutes per instance of use. When submitting request for approval of the use of isolation by staff withdrawal, a diagram of the home's layout or images of the home must be provided for the review panel to ascertain how much of the home can be observed from the area staff is isolating in. Consideration must also be given to environmental risks to the individual, such as potential for self-harm or elopement. Approval will take into consideration whether the individual shares supports and any potential impact this would have on others.

During isolation by staff withdrawal, the individual will have access to most, if not all, of the home while staff is in another area. If a behavior plan states staff need to move away from an individual or give the individual space in response to a behavior, it must clearly define giving space. (For example, is staff supposed to simply move a few feet away from the individual, yet remain in the same room?) These details are necessary to ensure applications to use isolation by staff withdrawal are clear and staff clearly knows the expectations in these types of situations.

Requirements for Seclusion
Seclusion will only be permitted with the use of a pressure-locking mechanism that requires the constant manual application of some form of pressure to maintain the locked condition. Locking an individual in any room where the door would or could stay locked without constant pressure will not be permitted under any circumstance. The maximum amount of time an individual may be in isolation or seclusion is 60 minutes per instance of use. Other requirements around the use of seclusion include continuous visual monitoring, safety precautions specific to the individual's needs (non-breakable windows, recessed lighting, adequate ventilation, padded walls or floors), and adequate room size.

When LCI submits a request to use seclusion, information should be provided as to whether it is a newly constructed seclusion room or has previously been inspected and approved. The Bureau of Adult Quality and Oversight (BAQO) and Bureau of Adult Programs and Policy (BAPP) requires inspection and approval of newly constructed seclusion rooms by the DHS Restrictive Measures Coordinator, or a designee, prior to use. LCI must arrange with the Restrictive Measures Coordinator, or designee, to travel to the home and complete the inspection prior to the use of the new seclusion room. The minimum acceptable standards for a seclusion room are:
1. The room must be at least the size of a small bedroom so there is sufficient space for the individual to move.
2. Features are in place to allow staff to engage in continuous visual monitoring of an individual in the room, such as an observation window with ceiling-mounted mirrors or video cameras.
3. The room must have adequate ventilation, heating, and cooling.

4. The locking mechanism must be a pressure-locking device, such as magnetic locks or another mechanical device that requires the continual presence of support staff to apply pressure to keep the door lock engaged.
5. Padding of the walls and floors is required in the room if the individual is likely to engage in self-harm (such as head-banging or hitting walls) to the extent that such behavior could cause significant injury if the padding was not present.
6. There must be efforts to ensure the individual would not be able to reach or damage any light fixtures in the room (such as recessed lighting, covered lighting, or high ceilings).
7. There must be protective covering over any electrical outlets in the room.
8. There must be protective covering or specialized windows in place to ensure the individual would not be able to break any windows in the room.
9. If a mirror is located in the room to ensure staff can see all areas of it, the mirror must be made of a non-breakable material or have protective covering around it to prevent the individual from being able to break the mirror.
10. Half doors, gated barriers, or any barrier without a viewing window or monitor and pressurized lock that an individual cannot remove or open on their own, are not permitted for the use of seclusion.

LCI Restrictive Measures Review Committee (RMRC)
The LCI RMRC will consist of a minimum of ten members. The RMRC will be comprised of LCI employees who have clinical expertise in supporting members. The RM Specialist will be LCI Primary Restrictive Measures Lead; and the Behavioral Health Supervisor will be secondary.

All new application requests for the use of restrictive measures will be reviewed by a representative from Care Management and Behavioral Health whenever possible. All subsequent restrictive measures applications and expedited reviews are reviewed by a subset of RMRC members, which serve on a rotating basis. The RMRC and other internal or external consultants, as appropriate, will review any proposed or initial behavior plan, which includes the provision of restrictive measures. The committee must either approve the proposal as submitted, approve the proposal with conditions, request additional information, or deny the proposal. Decisions will be in writing to the member, legal decision maker, and provider. Written communication will identify the measures separately, and describe reasons for the return or denial, include any conditions of approval along with adequate descriptions of these conditions. The RM Specialist and Behavioral Health Supervisor, as designated by LCI, will sign notifications. Denials will also offer the individual/legal decision-maker the right to grieve the decision. Communication and guidance will be offered to the provider on any revisions that could be made to remedy the defects in a returned or denied application. The RMRC must approve the request before LCI submits the request to DHS. The RMRC will report all activities to the Quality and Care Management Practice Director and LCI's Quality Management Program.

Training
LCI staff are trained and oriented on the Adult Protective Service and Elder Abuse and Neglect systems, the requirements on reporting and responding to complaints, allegations and/or direct observations, and the relevant elements of the Wisconsin Guardianship Statute (Ch. 54). The reporting process will be outlined through a Memorandum of Understanding specific to each county served by LCI.

IDTS will be trained at least every three years on the Restrictive Measures Policy and Procedure. Upon hire, IDTS will be trained on LCI Restrictive Measures Policy and Procedure during orientation. IDT training includes elements from the Restrictive Measures Guidelines and Standards. LCI Care Management Best Practice Department tracks all employee training.

LCI RMRC members are trained on Restrictive Measures Policy and Procedure and RM application review processes prior to serving on the Committee by the RM Specialist. LCI RMRC ensures that RM applications include the provision of at least annual training by the provider to their staff regarding the measures contained within the application.

All staff involved in the administration of restrictive measures must receive adequate training. Training must occur prior to implementing any restrictive measure, and at minimum, annually as noted above. Assurance of training of individuals involved in the administration of the RM is the responsibility of the team. Training must include proactive strategies to intervene at the first signs of tension to prevent escalation. Information about how to use specific restrictive measure techniques or devices properly and how to inspect the device or equipment must be included in training. A specific training curriculum is not required but may be requested from teams to show the qualifications of the individuals conducting the training of provider staff.

LCI's Service Provider Contract outlines the necessary requirements relating to restrictive measures. As needed, LCI providers will be trained on Restrictive Measures related to the DHS contract, DHS Restrictive Measures Guidelines and Standards (RMGS), and LCI Policy and Procedure. This information can be found on the LCI website as well.

Obtaining Approval prior to a member move
Intensive Treatment Programs (ITP): LCI must have DHS approval for all use of restrictive measures prior to a member's discharge from an ITP. Planning for discharge must begin at the time of admission; and the team should discuss all restrictive measures that may be needed in a community setting.

Change in Provider: LCI must resubmit a restrictive measure request within 90 days of a member moving programs with the same provider or when member transitions to a new provider. Until DHS grants approval, the provider must complete an incident report for each use of the unapproved restrictive measure in any new setting.

Reduction and Elimination Plans
All plans including the use of restrictive measures must include a reduction/elimination plan. Restrictive measures cannot be a long-term solution for addressing dangerous or challenging behavior but should instead be thought of as a temporary strategy the team will work towards eliminating as soon as possible. The reduction/elimination plan should include what alternative support methods the team will attempt to work towards that will reduce and/or eliminate the need for using restrictive measures. There should also be measurable goals or benchmarks that, once met, would lead the team to consider the elimination of the use of the measures.

Procedure for Seeking Approval for Restrictive Measures:
In the event the IDT assesses and identifies the necessity for a restrictive measure, the following steps must be followed within appropriate timeframes.

1. IDTS will notify the RM Specialist and work closely with the member, guardian/legal representative, provider(s), and other supports as indicated, to draft the application for the use of restrictive measures.
    a. The RM Specialist will use the LCI Restrictive Measures Database Template for all restrictive measures applications. The RM Specialist will follow the template instructions and accompanying checklist to ensure all information is obtained and/or completed accurately and thoroughly.
2. The RM Specialist will ensure all necessary documentation is included in the application.
3. If there is missing documentation, the RM Specialist will collaborate with the IDTS, member, guardian/legal representative, provider(s), and other supports to promptly obtain necessary items. Upon ensuring the application contains all necessary documentation, the RM Specialist will disseminate the application to the RMRC.

a. Unless an expedited review is requested, the RMRC will complete the review within three weeks which includes offering relevant comments and feedback to the IDTS.
b. Applications will be reviewed by the RMRC at regularly scheduled meetings or earlier when indicated, and not less than monthly.
c. Applications and decisions will be processed within 30 days of submission unless the RMRC requests additional clarification or information be obtained.
d. The RMRC will make decisions regarding all applications as one of the following: approve as submitted, approve with conditions, deny, or request additional information.
    i. LCI's RM Specialist will compile all feedback offered by the RMRC and complete a written decision letter or letter to request additional information.
    ii. In instances where the RMRC denies any RM application, requests additional information, or approves with conditions, the RM Specialist will schedule a meeting with the CM Supervisor, IDTS and provider(s) to discuss the RMRC's feedback, decision, or request for additional information. A copy of the written letter will be distributed to all parties prior to or at the time of this meeting by the RM Specialist.
    iii. In instances where the RMRC approves the entire RM application as submitted, the RM Specialist will complete the approval letter and distribute to IDTS, CM Supervisor, and provider(s).
    iv. IDTS will be responsible to save a copy of the RMRC decision letter or request for additional information in the EMR.
    v. IDTS will be responsible to ensure a copy of the RMRC's decision letter is provided to the member/legal decision maker.

4. The Team will be required to respond to the questions and requests for additional information in the letter, within two weeks. The Team must request an extension from the Behavioral Health Supervisor if the team needs additional time to gather the requested information. If the RM Specialist does not receive requested information within 45 business days of the date of request for additional information, the request closes and a denial will be issued.
5. The RM Specialist will complete a final review of the application.
6. The RM Specialist will enter the application (for all target groups) into the Long-Term Care Information Exchange System (IES): https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html.
7. DHS may deny the RM application pending additional information, requiring the Team provide clarification on DHS feedback/questions. This feedback will be shared through the DHS RM Database and will be relayed through the LCI RM Specialist.
8. The RM Specialist will ensure all questions are answered in the response letter.
9. The RM Specialist will complete a final review and submit the response letter and all updated documents to DHS via the database application within 14 days of DHS's decision to deny the request pending additional information.
10. DHS will notify the LCI RM Specialist of application approval status via written letter. Approval will be granted for up to one year unless the request was expedited; in the case of an expedited review the RM will be approved for no more than six months.
11. The RM Specialist will provide copies of the letter to the CM Supervisor and IDTS. IDTS must ensure copies are given to the provider and member/legal representative and attached to the member record.
12. IDTS will obtain from providers the monthly RM utilization data for all certified medical and behavioral restrictive measures and monthly target behavior data for all certified behavioral measures. IDTS will enter the information into the appropriate section of the member record by the 15th day of the subsequent month.
13. The RM Specialist will obtain data from the member record and submit all monthly RM utilization and target behavior data for members with certified RM plans to DHS via the RM database, by the 45th day following the end of each quarter.

14. IDTS will conduct a review of existing RM approvals at a minimum of every six months in conjunction with the MCP review.
15. At a minimum, the RM Specialist will schedule proactive RM consults with the IDTS and CM Supervisor approximately one (1) to two (2) months prior to the RM expiration date for members with certified RMs, to discuss RM utilization and target behavior data, review of PBSP and RM reduction/elimination efforts.
16. If necessary, the RM Specialist will re-apply for continuation of an existing RM by submitting an application through LCI's RMRC on an annual basis; the application must be submitted within 75 – 90 days prior to the current approval lapse date for reevaluation and approval.
    a. Renewal applications must be submitted to DHS through the DHS RM Database no less than 45 days prior to the lapse date.

Use of Restrictive Measures in Division of Quality Assurance (DQA) – Bureau of Assisted Living (BAL) Licensed Assisted Living Facilities

Use of restrictive measures for all Wisconsin residents of state licensed assisted living facilities requires Department approval by the Bureau of Assisted Living (BAL). As the licensing authority, BAL must approve all requests before providers implement the practice.Providers may also need to seek input from LCI prior to submitting a request to the BAL regional office for Waiver, Approval, Variance and Exception (WAVE) determination.BAL licensed providers must complete the application process outlined in these guidelines prior to submitting the request to the BAL regional office for WAVE determination.Use of restrictive measures in a Division of Quality Assurance (DQA) licensed setting to a non-Medicaid waiver individual, must follow the DQA process and requirements for approval found in the DQA guidance memo: www.dhs.wisconsin.gov/dqa/memos/15-003.pdf.

In instances where the requested measure does not meet the definition of a restrictive measure as outlined in these guidelines and standards, the licensed provider must follow the process outlined in the above-referenced DQA guidance memo. The licensed provider should consult Wis. Admin. Code chs. DHS 83, DHS 88, or DHS 89 licensing requirements regarding the need to assure waiver participant health and safety and least restrictive treatment.

Licensed providers should consult the "Restrictive Measures Request Process" information at this link:https://www.dhs.wisconsin.gov/regulations/waiver-variance-assisted-living.htm

Expedited Reviews

LCI will expedite reviews of requests for restrictive measures in situations such as the health and safety of the member/supports are at imminent risk and unplanned uses of restrictive measures have been used and/or when the member's current placement is more restrictive than their needs require. A subset of the RMRC will review expedited applications within one week of receipt of the application and supporting documentation from IDTS.

A request for expedited review must contain the usual submission information, including required attachments, but DHS will accelerate the review timeframe. In the case of an expedited review, the RM(s) will be approved for no longer than six months. A renewal submission is required to DHS 45 business days prior to expiration. If DHS approves an expedited request without the required medical provider's authorization, LCI will have 30 business days to submit the medical provider's authorization to DHS once the individual has moved into the new home.

Criteria for Approval for All Reviews

1. A signed and dated form authorizing the use of the restrictive measure which includes authorization/approval by providers, and the individual (or legal decision maker, if applicable), and IDTS, and LCI RM Committee. These signatures are obtained annually.
2. An authorization or approval from a medical provider is required for all restrictive measure requests. The team must obtain a medical provider's authorization annually. The medical

approval must list the requested restraints and must include any contraindications for the use of the restraint. Providers may not use any measures if the medical provider has indicated any contraindications.

3. Documentation that the provider has tried less restrictive strategies and interventions that were ineffective.
4. The plan details use of the measure only when the individual's behavioral response presents an immediate danger to self or other people. This does not include property damage, yelling, throwing objects, verbal threats, etc.
5. A plan or protocol detailing use of the measure(s) when applying for a Medical Request.
6. A Behavioral Support Plan or document detailing how to support the person during incidents that may lead to imminent risk of harm when applying for a Behavioral Request.
7. Information supporting how the restrictive measure proposed is the least restrictive approach available to achieve an acceptable level of safety for the individual. This applies to each measure proposed and to the interactive effects, if any, of all such measures.
8. There is a detailed description and images of each requested restrictive measure. The images must not be of the individual or have any likeness or identifying aspects to the individual.
9. When requesting initial approval and upon renewal of isolation or seclusion rooms, photos of the room and seclusion room locking mechanism must be included with the request. The photos must demonstrate how staff continuously monitor the individual while Seclusion is in use.
10. A floor plan of the home indicating the isolation space and location of any mirrors, cameras, windows, etc. used to monitor the individual during isolation must be included with the application when applying for initial approval and renewal for use of Isolation via Staff Withdrawal.
11. The plan specifies frequencies and intervals for monitoring an individual during use of a restrictive measure for signs and symptoms of adverse effects on their health and wellbeing specified. The selection of the frequency of monitoring depends on the individual and the measure used but must not be less than once every 30 minutes and in the plan must clearly indicate the frequency. When plans include the use of isolation or seclusion, staff must ensure continuous visual monitoring.
12. The plan outlines the maximum duration of continuous application of the measure for each instance of use.
13. The plan outlines the release criteria from the measure. Staff must release the individual from the measure when the criterion identified in the plan is met. Release criterion needs to be specific to the individual. The criteria for release should also identify cues that are unique to the individual for determining if they are no longer posing imminent risk of harm to self or others.
14. The provider does not use restrictive measures in lieu of adequate staffing, adequate staff training, or for staff convenience.
15. The staff adequately ensures the health, safety, welfare, dignity, and other rights while the restrictive measure is in use.
16. All staff involved in the use or monitoring of the restrictive measure must receive training prior to implementing it to ensure staff uses the measure properly. Staff must receive ongoing training on the use of the measure, at minimum, annually.
17. The team's supervision, monitoring plan, and backup arrangements are adequate to ensure effective responses to unanticipated reactions to the measure that might arise.
18. The request contains a reasonable plan for reducing or eliminating the need for using the measure as soon as possible. Teams should not think of restrictive measures as the solution for addressing the dangerous or challenging behavior but should instead think of them as a temporary strategy used to maintain safety.
19. The plan includes a measurable benchmark that would lead the team to consider eliminating the use of the measure in an effort to determine whether the plan is effective.

20. The request includes information related to how, protective equipment or other types of devices are checked regularly to ensure they remain in good working condition.
21. The request includes information about how often the team will meet to engage in a formal review of the use of the restrictive measure to ensure it remains the most effective method to meet the individual's support needs.
22. A data summary about use of the restrictive measure(s) and the team's analysis of the data.

Requirements for Denial or Pending Additional Items Notices
If LCI RMRC requires additional information or clarification prior to approving a request, the RM Specialist will generally have two weeks to complete necessary updates and forward the request on to DHS, pending no additional concerns or requirements.

If DHS requires clarification or more information prior to approving or denying a request, DHS will send a denial pending additional items notice to LCI through the DHS Database. The LCI RM Specialist will have up to 14 days to complete the necessary requirements. LCI RM Specialist may request additional time from the DHS RM Coordinator when needed, however, if DHS does not receive response within 45 business days, the request will close.

Contesting Restrictive Measures Related Decisions
All decisions made with respect to restrictive measures are subject to grievance, other than suspension of use, if there is disagreement with the decision. A grievance may come from a member, their legal decision maker, a provider *on behalf of the member* and with the member's consent, or any person filing on behalf of the member with their consent. Members who receive treatment for mental health, substance abuse, or developmental disability may also follow the grievance process outlined in Wis. Admin. Code Ch. DHS 94 to grieve decisions related to the use of a restrictive measure. The member, their legal decision maker, a provider acting on behalf of the individual or their legal decision maker, or any person filing on behalf of an individual, who wishes to contest or grieve decisions of DHS or LCI, related to the use of restrictive measures, should follow this clients rights complaint process: https://www.dhs.wisconsin.gov/clientrights/complaints.htm

Family Care members or legal decision makers have the right to file a grievance regarding LCI RMRC decisions related to the use of a restrictive measure. The existing LCI grievance process applies to all member grievances related to the use of or denial of use of restrictive measures, other than the decision to suspend use. LCI has a written description of the grievance policy and procedure including member rights, including the right to be free from restrictive measures and the right to prompt and adequate treatment. Members or their legal decision makers who wish to contest or grieve LCI decisions related to the use of restrictive measures should follow this process. Members may file a grievance by contacting the IDTS or the LCI Member Rights Specialist.

Grievance of DHS Decisions
DHS assumes the entire Team is in agreement about the need for use of restrictive measure(s). If the Team agrees about RM use and DHS either denies or imposes unacceptable conditions on approval, LCI may contact the Bureau of Adult Quality and Oversight Restrictive Measures Coordinator directly or by general email at: dhsbmcrm@dhs.wisconsin.gov to discuss the denial or imposed conditions of approval. LCI may work with the provider to update documents and submit an updated or new restrictive measure request based on the feedback DHS provided prior to the original decision to deny the measure or impose conditions of approval. DHS's restrictive measures review panel will review the updated or new request and proceed with the approval or denial process.

Suspension, Revocation, and Amended Approval

DHS and LCI staff can impose suspensions of a restrictive measure onsite without written notification effective immediately. Any continued use of the restrictive measure could be a violation of the member's rights. DHS or LCI must follow up with written notification of suspension within 5 business days even if the suspension is lifted in that time. The written notification will include the reason for suspension and action steps needed to remove the suspension. A suspension should be considered an interim step toward either restoration of approval or revocation. LCI will complete fact-finding withing 30 business days of the initial notice of suspension. If the results of the investigation indicate the restrictive measure needs to be revoked, DHS will send an approval revocation letter. No grievances of suspensions will be accepted. The provider must resubmit an application in order to use a measure.

If LCI staff revoke a restrictive measure approval, communication must be provided to DHS, the member, the legal decision maker, and the provider in writing. This communication will include the reasons for revocation and any grievance rights for all parties involved. DHS prohibits the provider from using the measure when LCI as revoked an approval.

DHS and/or LCI may amend approvals by imposing new or additional conditions if the need is determined. LCI will need to submit a new imposed conditions of approval to DHS which are subject to DHS review and approval.

Use and Continuous Monitoring of Restrictive Measures
Approval for restrictive measures should be considered a continuous process that does not end by approval decision of DHS. The team must continually monitor the use of any approved plan to ensure it is the least restrictive intervention necessary to meet the member's needs. The team must monitor the use of approved restrictive measures and ensure they are being used in accordance with the individual behavior support plan and approval. This monitoring and ongoing assessment should address whether the plan continues to be the least restrictive intervention.

Data collection is a requirement for all approved restrictive measures included in self-directed support settings. The provider must collect data including the frequency per incident and the duration of each incident – each time a restrictive measure is utilized. The data must indicate the specific restrictive measure used. The team must assess this data ongoing and provide a summary and analysis of the data with every application for use of restrictive measure. Raw data sheets from providers will not be accepted as part of the RM application. Assessment and analysis of the behavior and use of restrictive measures must be completed by the team and summary indicating findings.

During every in-person contact, IDTS will check and document in the record that each member with a PBSP and/or approved restrictive measure, have an effective, up to date PBSP and/or restrictive measure in place, and that the residential provider staff are trained and following the PBSP and/or restrictive measure appropriately.

For members residing in 1-2 bed AFH, a member of the IDT will conduct an in person visit to the member's home between 15 – 30 days after a change is made to the member's PBSP or restrictive measures plan.

Discontinuing the Use of Restrictive Measures
Providers are required to discontinue the use of a restrictive measure if:

- The team determines the use of the restrictive measure is not effective or is no longer necessary.
- The previously determined benchmark for elimination has been met. DHS will not approve applications for use of restrictive measures for "just in case" situations.
- There are medical contraindications for use of the measure.
- The MCO or DHS denies the application.

- The MCO or DHS revokes approval.
- Invocation of an on-site suspension.

The provider must remove discontinued restrictive measures from the individual's support plan or ensure it is clear that any historical restrictive measures mentioned are no longer approved and may not be used. If the provider intends to use a previously discontinued measure in an emergency, criteria in 'Emergency Use of Restrictive Measures' in this policy must be met.Following the decision to discontinue the use of a measure, LCI RM Specialist is responsible for entering the discontinuation date, the discontinue reason, and a letter of discontinuation into the previously approved request in the DHS Database. A copy of the discontinuation will be part of the member's electronic record and the team will ensure copies are also given to the Provider and member/legal representative. The team must ensure the MCP and all related documents (ex: BSP) are updated as well.

Renewing Requests for Restrictive Measures
Approval for all restrictive measures, other than requests submitted for expedited review, will expire no later than one year from the date of approval. Restrictive measure requests submitted for expedited review will expire no later than six months after the date of approval. In some instances, the review panel may approve a request for less than one year. LCI must submit a renewal request if the need to use a restrictive measure continues after the initial approval period. The team must submit the renewal to the LCI RM Specialist one month prior to the due date to DHS. LCI must submit the renewal via the DHS Database 45 business days prior to the previous approval expiration date. If an individual has approved restrictive measures and changes from one Medicaid-funded adult long-term care program to another or enrolls in a different ICA or MCO, the current plan may remain in place temporarily. LCI must submit a restrictive measures request to DHS within 90 business days of the enrollment change for members choosing LCI.
The provider must submit a data summary of use in the previous approval period. DHS will not accept copies of completed data sheets as a data summary. The team may provide additional data collection information, such as graphs or tables, as attachments to applications, as needed.

Teams are required to review restrictive measures utilization data and provide an individualized analysis. For behavioral requests, the data analysis should outline if there are any patterns, trends, or correlations to when target behaviors are more or less likely to occur and what intervention strategies have been most effective. Analysis should also describe changes to the plan, if any, the team made because of the data analysis.

If a previous approval has expired and the provider intends on continuing the use of the restrictive measure, DHS will consider this a use of an Unapproved Restrictive Measure.

Emergency Use of Restrictive Measures
LCI is required to obtain prior approval for use of restrictive measures from DHS. DHS will make exceptions to the requirement for prior approval if the situation meets the definition of an emergency use of restrictive measure. Provider agencies may use a restrictive measure in cases of emergency when the following conditions are met:

1. An emergency exists per the definition set forth in this policy.
2. The support staff has implemented all other de-escalation strategies to the extent possible.
3. Behavior poses an immediate threat of significant physical harm to self or others.
4. There is no approved behavior plan for the individual dealing with the planned use of restraint, isolation, or protective equipment intended to address this behavior, or there is an approved plan, but it failed to anticipate a significant escalation in intensity or severity of the behavior.

5. The behavior in question has either not occurred previously or could not have been reasonably foreseen to occur based on observations of the individual's behavior.
6. Provider must have a written policy and procedure indicating agency protocol for use of restraints and notification process.

LCI expects if a provider agency deems an emergency use of a restrictive measure is warranted, the restrictive measure utilized is effective, least restrictive, least intrusive, and a temporary means to assure the health and safety of the member. When using the emergency restrictive measure, staff must use the measure for the shortest time possible to eliminate imminent risk. If a behavior meeting the definition of an unanticipated emergency occurs more than two (2) times in a six (6) month period, the behavior is no longer unanticipated. Recurrent behaviors do not constitute an emergency and must be addressed in a formal support plan. DHS must approve further use of the restrictive measure within 90 business days of the second reported Emergency Restrictive Measure.

DHS does NOT permit emergency use of seclusion.

Unapproved Restrictive Measures

When the team anticipates a situation that led to use of an Emergency Restrictive Measure is likely to occur again or it has occurred more than twice in a six-month timeframe, the situation no longer meets the definition of an Emergency Restrictive Measure. Once the provider anticipates an ongoing need for the restrictive measure, DHS requires the team to go through the planning and approval process contained in this policy. The team must request approval for continued use of the measure within 90 business days of the second reported Emergency Restrictive Measure. If the provider will continue to use the restrictive measure during this time, DHS considers this the use of an unapproved restrictive measure. The Behavioral Health Supervisor will be notified through the Adult Incident Reporting System (AIRS) and forwarded on to the RM Specialist for further follow up.

Incident Reporting for Restrictive Measures

LCI must report each use of Emergency Restrictive Measure and each use of Unapproved Restrictive Measure to DHS within the timelines outlined in the Adult Incident Reporting System (AIRS) Policy and Procedure via theAIRS, regardless of injury.

LCI must immediately report all uses of Emergency Restrictive Measures to DHS.

Provider Requirements for Unapproved RM

All contracted provider agencies must report the use of unapproved Restrictive Measures to MCO staff no later than one (1) business day once the incident is discovered. Contracted provider agencies must assure the following requirements are present in an emergency use of restrictive measure:

1. A written policy describing the process used if an emergency use of restrictive measure is warranted. This policy must include the name of the specific staff person or type of position that is authorized to select and initiate the emergency use of the restrictive measure and responsible for related procedures when an emergency situation is present. At minimum, the policy must require those using the measure to obtain eventual authorization by the agency director or designee as quickly as possible after use. Authorization must be limited to the specific current emergency episode. The provider must document date, time, and method of all attempts at notification.
2. The team ensures the provider agency staff person, director, or the director's designee has established individual-specific release criteria for the specific situation. Release criteria documentation must include a description of any conditions that must be present prior to releasing the individual. The criteria for release should also identify cues that are unique to the individual for determining if he or she appears to be calm and is no longer a danger. Any

threats to an individual's health or well-being caused by the measure during its application require the immediate release from the restrictive measure and notification of supervisory personnel or medical personnel (if the individual requires immediate medical care).
    a. Support staff may use manual restraint for a maximum 15 continuous minutes. If the individual's behavior continues to pose an imminent threat of harm, the direct support staff may re-apply the manual restraint for a maximum of four 15-minute increments. The maximum amount of time an individual may be in isolation or protective equipment may be used is 60 minutes.
3. Reauthorization for the use of the restrictive measure should be obtained if an emergency recurs after release from restraint. Recurrence of the emergency two times should cause the agency to initiate the process for obtaining approval for the planned use of restrictive measures.
4. Restraint or isolation may be initially authorized in emergencies for up to one hour. After an hour, provider agencies must attempt to contact and consult with the member's medical provider and obtain a written order from the medical provider if the medical provider indicates that continued use of the measure is appropriate. The medical provider's initial written authorization is limited to a maximum of two additional hours. The medical provider may reauthorize the use of the measure selected. The provider must document medical provider authorization in the member record.
5. The provider agencies must ensure that staff applying or using any restrictive measure are adequately trained and competent in the use of the restrictive measure. Provider agencies should proactively seek the assistance of external professionals such as a behavior specialist when needed to assist staff in responding to the emergency. The provider should outline the training curriculum in the written emergency procedure policy.
6. The use of a restrictive measure for an emergency situation must be monitored and documented by provider agencies. Reporting requirements of the use of restrictive measures as part of an approved plan will be specified in the individual approval for use. The use of the emergency restrictive measure must be monitored in a manner that conforms to the requirements in this policy and procedure including collecting data on the frequency per incident and the duration (number of minutes), each restrictive measure was utilized.
7. When an emergency exists, and the dangerous/challenging behavior reaches a point where the provider staff believe they can no longer manage the situation safely or effectively, and when harm to the member, staff, or community is likely to result, staff should contact appropriate law enforcement authorities to handle the situation. Staff should follow internal provider policy and the member's individual service plan and/or behavior support plan for member specific criteria as to when law enforcement authorities should be contacted. Proactive discussions with local law enforcement and emergency protocol development are recommended.

Reference/Cross Reference(s):

- WI State Statutes: Chapters 46.90(4); 50.09(1); 51.61(1); 54; 55.043(1m, 1r)
- WI Administrative Code: DHS 132.33; DHS 132.60; DHS 82.10; DHS 83.12; DHS 88.10(3), DHS 88.11; DHS 89; DHS 94.10
- Adult Incident Reporting System (AIRS) Policy and Procedure
- Appeal and Grievance Policy and Procedure
- Positive Behavioral Supports Policy and Procedure
- Department of Health Services, Division of Long-Term Care, Family Care Contract
- DHS Restrictive Measures Guidelines and Standards