West Virginia Bureau of Senior Services

West Virginia
Bureau of Senior Services
Aging Well in
West Virginia

Lighthouse Program
Policy Manual

Effective July 1, 2015

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Table of Contents

Attachments

Number	Form Name	Instructions
1	Confidentiality Agreement – Board Member	Yes
2	Confidentiality Agreement – Employees and Volunteers	Yes
3	SAEF	Yes
4	Rights and Responsibilities Form	Yes
5	Rights and Responsibilities Posting	Yes
6	Denial/Reduction of Services Action Letter	Yes
7	Grievance Procedures Form	Yes
8	Grievance Procedures Posting	Yes
9	Personal Conduct Policy Form and Posting	Yes
10	Board Certification	Yes
11	State Cost Share Chart	No
12	Lighthouse State Cost Share Invoice	Yes
13	Lighthouse Cost Share Accountability Form	Yes
14	Lighthouse RN Assessment	Yes
15	Lighthouse Plan of Care	Yes
16	Lighthouse Eligibility Determination Form	Yes
17	Lighthouse Six-Month Call Log	Yes
18	Lighthouse Direct Care Worker Service Log	Yes

NOTE: For a copy of forms and instructions, go to www.wvseniorservices.gov, click on *Documents Center* then *Program Specific Documents* to either complete a form in a fillable PDF file, or print and complete form in ink. To alter any of the above state and Lighthouse specific forms, you must have written approval from the Director of Lighthouse Program at the Bureau of Senior Services.

I. INTRODUCTION

The Lighthouse Program began in 2007. Realizing the vast need for in-home assistance for seniors who did not qualify for other programs Governor Joe Manchin III introduced legislation that was passed by the 78th Legislature of West Virginia to expand senior services throughout the state.

Lighthouse is unique in that it is funded entirely by the State of West Virginia. It is administered by the West Virginia Bureau of Senior Services (the Bureau) while direct services are delivered through the local Title III-B provider.

This program is designed to assist those seniors who have functional needs in their homes. Services are provided by a direct care worker employed by a County Aging Provider Agency after an applicant for the program has been determined medically eligible by the provider's registered nurse (RN). Direct care workers provide personal assistance, stand-by assistance, supervision, or cues for persons having difficulties with activities of daily living in the following areas: bathing, dressing, grooming, eating, walking, transferring, and toileting. Care is provided in the service recipient's residence.

Lighthouse is considered a program of last resort and cannot be provided in conjunction with or in place of Medicaid funded in-home care service programs. If applicants for the Lighthouse program appear to qualify for the Aged and Disabled Waiver, Traumatic Brain Injury Waiver or Medicaid Personal Care, they should be referred to any of these programs. Lighthouse services can be provided to applicants while they are actively pursuing application for one of the Medicaid programs but cannot be used to provide care to individuals who appear likely eligible for Medicaid services but refuse to apply.

Title III-B Personal Care services cannot be blended/supplemented with Lighthouse services within the same month. They must be provided separately due to the different cost sharing/contribution requirements. Providers must report them correctly in SAMS.

Lighthouse services may be provided in conjunction with the Family Alzheimer's In-Home Respite program (FAIR), Hospice Care and Veteran In-Home Care as long as there is no duplication of services. Services may not overlap, and special caution must be used to ensure that hours of service are properly and accurately billed to the appropriate funding source. Additional caution is necessary to ensure that State cost share income for Lighthouse and federal cost share income for Title III programs are placed into separate accounts and handled according to each program's policies.

If the Lighthouse service recipient is receiving services through another program, the Lighthouse RN must work with the other program when developing the Plan of Care to avoid duplication of activities. For example, if a Lighthouse service recipient is getting a bath on Mondays from their Hospice worker, the Lighthouse Plan of Care should not have a bath listed on Mondays.

Preference will be given to older individuals with greatest economic and/or social needs (with particular attention to low-income individuals, including low-income minority individuals, individuals with limited English proficiency, individuals at risk for institutional placement and individuals residing in rural areas). (Refer to Policy Section XX regarding prioritization of services.)

This manual sets forth the WV Bureau of Senior Service's requirements for Lighthouse services provided to eligible West Virginians. The goals and objectives of this program are focused on providing services that are person-centered and that promote choice, independence, respect, dignity, and community integration. The Bureau has a grant agreement with each Title III-B provider agency to manage and implement the Lighthouse Program. Provider agency board of directors, with local input via public meetings, determines service priorities for the Lighthouse program.

II. DEFINITIONS

A. Definitions Specific to Lighthouse

Direct Care Worker – An in-home worker who is employed by the county aging provider agency. For Lighthouse, the direct care worker provides assistance as outlined on the Plan of Care to service recipients having two or more deficits in the following: bathing, grooming, dressing, toileting, transferring, repositioning, walking, feeding, preparing meals, grocery/pharmacy shopping.

Direct Care Worker Service Log - Form used to document tasks performed by the Direct Care Worker under the Lighthouse program.

Environmental Tasks - Includes light housekeeping, dishwashing, making/changing a Service recipient's bed and Service recipient's laundry.

Hardship Waiver - Document that removes part or all of the state cost share that a service recipient is required to pay for services. A hardship waiver must be kept in the service recipient's chart if granted by the Lighthouse Nurse. Hardship waivers do not exempt the provider agency obligation of collecting a minimum of $1.00 per hour of service provided.

LED - Lighthouse Eligibility Determination form which establishes if a service recipient is medically eligible for Lighthouse services.

Service Recipient - Person requiring much assistance or greater in two or more of the following areas: bathing, grooming, dressing, toileting, transferring, repositioning, walking, eating, preparing meals, grocery/pharmacy shopping.

B. Other Definitions

Abuse - (WV Code §61-2-29) Infliction or threat to inflict physical pain or injury on an incapacitated adult or elder person.

Activities of Daily Living (ADL) - Activities that a person ordinarily performs during the course of a day such as mobility (walking/transferring), personal hygiene, bathing, dressing, grooming, and eating.

By-laws - Rules established by an organization to regulate itself.

Competency Based Curriculum - A training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum must have goals, objectives, and an evaluation system to demonstrate competency in training areas.

Documented Specialist – A person who concentrates primarily on a particular subject or activity, a person highly skilled in a specific and restricted field. Someone that possesses supporting documentation i.e. a degree in the designated area, training verifications, certifications, and/or vita (a brief biographical sketch) with listed experience that would designate that individual as a specialist in a designated area.

Elder Abuse - Any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.

Emergency Contingency Service Operation Plan (ECSOP) - A written plan which details who is responsible for what activities in the event of an emergency, whether it is a natural or man-made incident.

Ethnicity - Consistent with Office of Management and Budget (OMB) requirements ethnicity categories are Hispanic or Latino or Not Hispanic or Latino. (AoA Title III/VII Reporting Requirements Appendix - http://www.aoa.gov)

Ex-Officio - A member of a body (a board, committee, etc.) who is part of it by virtue of holding another office but has no voting rights on board actions.

Felony - A criminal offense designated as a felony under state or federal law.

Financial Exploitation - A type of neglect of an incapacitated adult involving the illegal or unethical use or willful dissipation of his/her funds, property or other assets by a formal or informal caregiver, family member, or legal representative - either directly as the perpetrator or indirectly by allowing or enabling the condition which permitted the financial exploitation. Examples of financial exploitation include cashing a person's checks without authorization, forging a person's signature, misusing, or stealing a person's money or possessions or deceiving a person into signing any contract, will, or other document.

Frail - Functionally impaired because the individual is unable to perform at least two (2) activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision or due to cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. (OAA102(a)(22)(A)(i) and (B).)

Greatest Economic Need - A need resulting from an income level at or below the federal established poverty line. (OAA102(a)(23).)

Greatest Social Need – A service recipient is classified as "greatest social need" if they have a disability not fully corrected or needs assistance to leave the home **OR** any **TWO** of the following apply: 1) they are a member of a racial or ethnic minority 2) they are 75 years of age or older 3) they lack a telephone 4) they have a language/literacy barrier 5) they live alone 6) they lack a means of transportation 7) they are geographically isolated.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule - The HIPAA Privacy rule regulates the use and disclosure of Protected Health Information (PHI) held by covered entities.

Incapacitated Adult – In the context of abuse/neglect, any person who by reason of physical, mental or other infirmity is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health. (WV Code 9-6-1(4)).

Informal Supports - Family, friends, neighbors, or anyone who provides a service to an individual but is not reimbursed.

Instrumental Activities of Daily Living (IADL's) - Activities that are not necessary for fundamental functioning, but they assist an individual with living independently in a community. Examples: light housework, managing money and grocery shopping.

Legal Representative - A personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Misdemeanor - A serious criminal offense designated as a misdemeanor by state or federal law.

National Aging Program Information System (NAPIS) - Annual performance reporting requirements established by the Administration on Aging for Older Americans Act programs. The system includes the State Program Report (SPR).

Neglect - (WV Code §9-6-1) The a) failure to provide the necessities of life to an incapacitated adult or facility resident with the intent to coerce or physically harm the incapacitated adult or resident and b) the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or resident.

Notification of Grant Award (NGA) - Grant from the Bureau awarding state and federal funds to provider agencies for the delivery of aging services, in lieu of bidding out the provision of services.

Nutrition Screening - Completion of a nutrition screening checklist (Nutritional Health Assessment) on the Services Assessment and Evaluation Form (SAEF) for eligible service recipients to determine if they are at nutritional risk. A score of six (6) or higher is considered high nutritional risk. Nutritional screening data is a federal collection requirement of the National Aging Program Information System (NAPIS), found in the Federal Register, Volume 59, No. 188, September 29, 1994.

Person-Centered Care - A process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life.

Personally Identifiable Information - Information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

Prioritization of Services - To assess and rate an individual for services (Lighthouse) and prioritize and provide services based on those with the highest need. Requires the use of the Bureau's Service Assessment and Evaluation Form (SAEF), along with agency established prioritization policies using the SAEF.

Protected Health Information (PHI) - Any information held by a covered entity which concerns health status, provision of health care, or payment of health care that can be linked to an individual.

Race - Consistent with federal OMB requirements*, race categories are American Indian/ Native Alaskan, Asian, Black/African American, Native Hawaiian/Other Pacific Islander, non-minority (White, non-Hispanic), White-Hispanic, Other*. Respondents should ideally be given the opportunity for self-identification and are allowed to designate all categories that apply to them. (AoA Title III/VII Reporting Requirements Appendix – http://www.aoa.gov.)

Services Assessment and Evaluation Form (SAEF) - The Bureau assessment form which contains service recipient information such as demographics, income, nutritional assessments, ADL and IADL needs, etc. This form must be fully completed per SAEF instructions for each individual who receives Lighthouse services. Refer to SAEF Instructions regarding sections that need completed for each service.

Social Assistance Management System (SAMS) - The Bureau's official web-based data collection application utilized for service recipient tracking and reporting of services and federal NAPIS compliance.

State Cost Sharing - Process that requires service recipients in state funded programs to share in the cost of service provision through the use of a state cost share schedule and self-declaration of income. State cost share for the Lighthouse program is based upon the income of the service recipient, or, in the case of a married couple, the combined income of the service recipient and spouse, according to the current state cost share schedule.

State Health Insurance Assistance Program (SHIP) - A federal program funded by the Administration for Community Living that provides free, objective, and confidential help to West Virginia Medicare beneficiaries and their families through one-on-one counseling and assistance via telephone or in person with SHIP counselors statewide, under the direction of the State SHIP Director and the Bureau.

State Units on Aging (SUA) - Agencies of each state and territorial government designated by governors and state legislatures to administer, manage, design and advocate for benefits, programs and services for the elderly and their families.

Target Population - Persons aged 60 or older, with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, older individuals at risk for institutional placement, and older individuals residing in rural areas.

Unduplicated Service Recipient Count - Counting a service recipient only once during the reporting period. (State Fiscal Year is July 1 through June 30).

Unit Count - The number of units of service received by an unduplicated service recipient during the reporting period.

Volunteer - An uncompensated individual who provides services or support to service providers. (AoA Title III/VII Reporting Requirements Appendix – http://www.aoa.gov.)

WV Aging & Disability Resource Network (ADRN) (and partner agencies) - A network of professionally trained counselors who assist seniors, persons with a disability, their families and professionals with questions about long-term care services and supports find resources and coordinate services that may allow individuals to remain at home and active in the community for as long as possible.

WV Bureau of Senior Services (Bureau) - State Unit on Aging designated by the Governor and State Legislature to administer, manage, design and advocate for benefits, programs and services for the elderly and their families.

WV Senior Legal Aid - Legal services available to needy senior West Virginians age sixty (60) and over to assist with protecting their homes, income security, access to healthcare and other benefits and their autonomy.

III. Provider Agency Requirements and Office Criteria

To provide Lighthouse services, a county aging provider agency designated as a focal point, must meet all of the following requirements and office criteria:

1. Be located in West Virginia.
2. Have a business license issued by the State of West Virginia.
3. Have a federal tax identification number (FEIN).
4. Have an organizational chart.
5. Maintain a list of the board of directors and annually submit to the AAA a Board Certification Form. (Refer to Policy Section XV).
6. Maintain appropriate personnel information on all Lighthouse agency staff, which includes their qualifications.
7. Have written policies and procedures for processing service recipient grievances.
8. Have written policies and procedures for processing staff complaints.
9. Have written policies and procedures for the discontinuation of a service recipients services.
10. Have office space that allows for service recipient confidentiality.
11. Have an ECSOP for service recipients and office operation. (Refer to Policy Section XVI).
12. Meet Americans with Disabilities Act of 1990 (ADA) requirements for physical accessibility. (Refer to 28CFR36, as amended.)
13. Be readily identifiable to the public.
14. Maintain a primary telephone that is listed under the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone).
15. Maintain an agency secure (HIPAA compliant) e-mail address for communication with the Bureau and the AAA.
16. Be open to the public at a location within their county at least forty (40) hours per week. Observation of state and federal holidays is at the provider's discretion.
17. Contain space for securely maintaining service recipient and personnel records.
18. Maintain a contact method during any hours of service provision.
19. Provide the Bureau with a contact phone number for the Director (or designee) for emergencies.
20. Maintain on file a completed Confidentiality Agreement for each board member (Attachment 1), and a completed Confidentiality Agreement for each employee/volunteer (Attachment 2). Review annually with board members and employee/volunteers.

21. Employ qualified and appropriately trained personnel who meet minimum standards for each program. (Refer to Policy Section VIII).
22. Furnish information to the Bureau, as requested, as per the Notification of Grant Award (NGA).
23. Maintain records that fully document and support the services provided.
24. Maintain a list of current service recipients.
25. Maintain a fully completed SAEF for all service recipients that receive a Bureau funded service. The SAEF must be fully completed per instructions for each service in order to be reimbursed for services as per program requirements. (Refer to Attachment 3 for SAEF completion instructions for each service).
26. Enter all service recipient services that are funded by the Bureau into the SAMS/Harmony system.
27. Follow the Bureau's policy regarding prioritization of services. (Refer to Policy Section XX).
28. Must ensure that services are delivered, and documentation meets regulatory and professional standards before an invoice is submitted.
29. Follow the Bureau's state cost share policy (Refer to Policy Section XXI)
30. Have an annual consolidated agency budget.
31. Develop a two (2)-year plan for service operations.
32. Hold public meetings to receive input from seniors and other interested parties regarding services they want the senior service program to provide. Public comments should be considered and incorporated within the two (2)-year plan.
33. Annual audit must be presented by the auditor to the agency board of directors. (Refer to NGA for details on required audits.)
34. Must have written policies and procedures in effect regarding whistle-blowers and the intentional destruction of internal documents per Sarbanes-Oxley Act.
35. Must have written policies and procedures in effect regarding document retention and destruction (Refer to Sarbanes-Oxley Act http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf and Policy Section IV.)
36. Must have a written conflict of interest policy ensuring that board members, officers, directors, trustees and/or employees do not have interests that could give rise to conflict.
37. Must have computer(s) for staff with HIPAA secure email accounts, UMC web portal software, internet access, and current (within the last five years) software for spreadsheets.
38. Must participate in all mandatory meeting/training sessions.

IV. Service Recipient Record/Documentation Requirements

Bureau contract provider agencies must abide by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Service recipients have the right to have all records and information obtained and/or created by a provider maintained in a confidential manner, in accordance with applicable state and federal laws, rules, regulations, policy and ethical standards. Providers must safeguard against personal information being disclosed to or seen by inappropriate persons or entities that could use the information in

a manner that is not in a service recipient's best interests. Lists of persons in need of services or lists of persons receiving services are to be used only for the purpose of providing services and may not be disclosed without the informed consent of each individual on the list and then only to those with a verified need to know the information. The provider must also provide access to personal records to service recipients and legal representatives as required by law.

Service recipient signatures are required for the documentation of services received. A fully completed Services Assessment and Evaluation Form (SAEF) is also required for reimbursement. (Refer to Attachment 11 for SAEF completion instructions for each service).

Providers are allowed to utilize electronic signatures in accordance with this policy and state and federal regulations regarding such. An original signature must be obtained from the service recipient before the first initial service can be provided and maintained on file. If a service recipient's signature varies after time the provider must obtain a new signature on file. If the service recipient is unable to sign, a representative may sign for them (the representative must sign the service recipients name and then their name. It must be documented in the service recipient's chart that they are unable to sign their name). Documents electronically signed are part of the service recipient's legal service record. Providers must have written policies in place to ensure that they have proper security measures to protect use of an electronic signature by anyone other than the individual to which the electronic signature belongs.

Only employees designated by the provider agency may make entries in the service recipient's record. All entries in the service recipient's record must be dated and signed or initialed per the policy for each particular service. Adequate safeguards must be maintained to protect against improper or unauthorized use and sanctions (i.e. reprimands, suspension, termination, etc.).

The section of the electronic record documenting the service provided must be authenticated by the employee who provided the described services. Any authentication method for electronic signatures must meet the following basic requirements: 1) unique to the person using it, 2) capable of verification, 3) under the sole control of the person using it, and 4) linked to the data in such a manner that if the data is changed, the signature is invalidated.

The policy must also ensure that access to a hard copy of service records can be made available to the AAA and Bureau staff and others who are authorized access to service records by law.

Providers must keep documentation for services provided to service recipients such as rosters, SAEFs, Plans of Care, RN Assessments, Direct Care Worker Service Log, and any other required service documentation for a period of five (5) years after the discontinuation/closure of Lighthouse services. If a monitoring is initiated before the expiration of the five (5) year period, the records shall be retained until the monitoring has

been completed and final reports issued. Keep all service recipient records if not discontinued or closed.

V. Personnel Record Requirements

Personnel documentation including training records, licensure, confidentiality agreements, driver's license, criminal investigation background checks (CIB), and Form I-9 must be maintained on file by providers.

Minimum credentials for professional staff (RN's, social workers, counselors, etc.) must be verified upon hire and thereafter based upon their individual professional license requirements and must be kept current. Social workers and RN's must have a current license at the time of service provision and their license must be in good standing (cannot be on probation). The provider agency must employ a registered nurse to oversee and administer the Lighthouse program.

Providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the Lighthouse program, Bureau policy and procedures and state law. Providers must also agree to make themselves, board members, employees/volunteers, and any and all records pertaining to recipient services available to any audit or desk review. Providers must develop and maintain an agency personnel manual containing agency employment policies and procedures.

VI. Service Recipient Rights and Responsibilities

Honoring individual rights and treating service recipients with respect and dignity is one of the most important components of providing quality services. All staff employed by a provider agency to directly provide or oversee services, including volunteers, have a role in contributing to the overall quality of services and in assuring that people are treated fairly and respectfully. Service recipients also have a responsibility to the provider agency to assist the agency in providing quality services to them.

A. Service Recipients Rights:

Lighthouse service recipients are entitled to the following rights:

1. To be treated with respect and dignity.
2. To be free from discrimination based on gender, race, marital status, religious affiliation, sexual orientation, national origin, disability, or age.
3. To be free from abuse, neglect, and exploitation.
4. To have personal records maintained confidentially.
5. To have access to all of their files maintained by the provider agency.
6. To have access to rules, policies and procedures pertaining to services.
7. To take part in decisions about their services.

B. Service Recipient Responsibilities:

Lighthouse service recipients have the following responsibilities:

1. To notify the provider agency at least twenty-four (24) hours prior to the day services are to be provided if services are not needed.
2. To notify the provider agency promptly of changes in medical status or service needs.
3. To comply with the Lighthouse program Plan of Care.
4. To cooperate with scheduled home-visits.
5. To notify the provider agency immediately if there is a change in status that requires any change in service or disruption of service (ex. hospital or nursing home admission, change of residence, will not be home due to an appointment, trip, etc.).
6. To maintain a safe home environment for the provider agency to provide any in-home services.
7. To maintain safe access to their home for provider agency staff who are providing in-home care.
8. To verify services were provided by signing/initialing required provider agency forms.
9. To communicate any problems with services to the provider agency.
10. To report any suspected fraud to the provider agency or the Bureau.
11. To report any incidents of abuse, neglect, or exploitation to the Adult Protective Services Hotline 1-800-352-6513 or to the provider agency.
12. To report any suspected illegal activity to their local police department or appropriate authority.
13. To be in compliance with the Personal Conduct Policy. (Refer to Policy Section XI); and
14. To adhere to all policies specific to the Lighthouse program.

The Service Recipients Rights and Responsibilities Form (Attachment 4) must be provided to and signed by service recipients prior to receiving Lighthouse services. The Service Recipients Rights and Responsibilities Posting (Attachment 5) must be posted in a visible area at the provider agency. The service recipient must be given a copy of the signed Rights and Responsibilities Form. Additionally, the service recipient must read, agree to and sign the Personal Conduct Policy.

VII. Service Recipient Grievance Rights and Procedures

Service recipients who have had a denial or reduction of services have a right to file a grievance within fifteen (15) calendar days of written notification.

All other types of complaints or issues are to be handled internally according to your agency policy. This includes suspensions related to personal conduct (alternative services are to be offered), complaints about menu items, personality conflicts between

service recipients, issues regarding what activities are offered and at what time, etc.)

Applicants who are denied eligibility for Lighthouse services also have a right to file a grievance within fifteen (15) calendar days of written notification of the denial.

All service recipients and applicants who are denied Lighthouse services or have a reduction of services, must be provided in writing a Denial/Reduction of Services Letter (Attachment 6), and a Grievance Form (Attachment 7).

All Lighthouse provider agencies will post the Grievance Procedure Posting (Attachment 8) in an area that can be seen by all applicants and service recipients at their agency location(s). Providers must explain the grievance procedure at initial application for services and annually thereafter. Grievance Forms are to be made readily available.

All filed Grievance Forms are to be maintained in an administrative file for monitoring purposes.

If a provider is dealing with an individual that is threatening or violent, they may choose to bypass the grievance procedure and instead contact their local law enforcement agency and the AAA and maintain a copy of the report on file.

The Grievance Procedure Policy consists of the following levels:

1. Level One: Lighthouse Provider Agency

The Lighthouse provider agency has seven (7) business days from the date they receive a Grievance Form to make an initial contact to schedule a meeting by telephone (or in person if all parties are in agreement), with the applicant or service recipient filing the grievance. The meeting will be conducted by the agency director (or designee) with the applicant or service recipient (and/or legal representative). The provider agency has seven (7) business days from the date of the meeting to respond in writing to the grievant [with a carbon copy (cc) to the board of directors and the Bureau]. If the applicant or service recipient is dissatisfied with the Level One decision, he/she may request that the grievance be submitted to the provider agency board of directors for a Level Two review and decision within seven (7) business days of the Level One (1) decision.

2. Level Two: Provider Agency Board of Directors

If the applicant or service recipient is dissatisfied with the Level One decision, he/she may request the grievance proceed to Level Two. The applicant or service recipient shall file a Grievance Form requesting a Level Two decision with the provider agency's board of directors within seven (7) business days of the Level One decision. The provider agency board of directors, within seven (7) business days of the receipt of the Grievance Form requesting a Level Two decision, must make an initial contact to schedule a meeting by telephone (or in person if all parties are in agreement) with the applicant or the service recipient (and/or legal representative), and the agency director (or designee). The provider agency board of directors has seven (7) business days from the date of the

meeting to respond in writing to the grievant [with a carbon copy (cc) to the Executive Director and the Bureau]. If the applicant or service recipient is dissatisfied with the Level Two decision, he/she may request that the grievance be submitted to the Bureau for a Level Three review and decision within seven (7) business days of the Level Two (2) decision. The provider agency board of directors must submit the Grievance Form as well as any additional documentation regarding the grievance, to the Bureau for the Level Three review.

Level Three: State Review Team

If the applicant or service recipient is dissatisfied with the Level Two decision, he/she may request the grievance proceed to Level Three. The applicant or service recipient shall file the Grievance Form requesting a Level Three decision with the Bureau within seven (7) business days of the Level Two decision. Level Three will consist of a review team comprised of the AAA Director (from the grievant's region), the Lighthouse Program Director, and the Commissioner (or designee) from the Bureau. The review team, within seven (7) business days of the receipt of the Grievance Form requesting a Level Three, must make an initial contact to schedule a meeting by telephone (or in person if all parties are in agreement), with the applicant or service recipient (and/or legal representative) to review the Level One and Two decisions. The review team has seven (7) business days from the date of the meeting to respond in writing to the grievant (cc the Executive Director, board of directors and AAA). The decision by the Bureau is final and not appealable.

VIII. Staff Training Requirements

All new provider staff who administer the Lighthouse program must notify the Bureau within fourteen (14) days of hire, and receive training (Lighthouse policy manual and processes, budget processes, etc.) from the Bureau staff within the first thirty (30) calendar days of employment.

Direct care workers who provide Lighthouse Program services must be at least eighteen (18) years of age and must have the following competency-based training before providing services:

1. **Cardiopulmonary Resuscitation (CPR) -** must be provided by a certified CPR trainer and must include a physical demonstration exam to show the ability to perform CPR. Employees must have a current CPR card or certificate issued by the certifying entity and maintained in their personnel file.

2. **First Aid -** must be provided by a certified trainer, the agency RN or a qualified internet provider. Employees must have proof of current First Aid training maintained in their personnel file.

3. **Universal Precautions training** – must be provided by the agency RN, a documented specialist in this content area or a qualified internet training provider.

4. **Personal Care Skills -** training on assisting service recipients with ADLs such as bathing, grooming, feeding, toileting, transferring, positioning and ambulation. Training must be provided by the agency RN.

5. **Heath Insurance Portability and Accountability Act (HIPAA) -** training must include agency staff responsibilities regarding securing Protected Health Information (PHI). Training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

6. **Service Recipient Health and Welfare -** training must include emergency plan response, fall prevention, reporting service recipient issues or environmental concerns to the appropriate agency staff, home safety and risk management and training specific to any service recipient's special needs (e.g. mental health, specific equipment, special diets, etc.). Training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

7. **Abuse, Neglect and Exploitation and Reporting Requirements -** training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider. All employees must have annual trainings on abuse, neglect and exploitation.

8. **Person-Centered Care -** training on collaborative and respectful partnerships between staff and service recipients that promotes equal partnerships in planning, developing and monitoring care. Training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

   These training requirements apply to all employees providing direct care services, as well as volunteers doing the same type of work. It is the provider's responsibility to determine if any additional agency employees/volunteers beyond the ones required in this policy manual should have these trainings (or additional trainings) to ensure the health and safety of their service recipients.

A. Annual Direct-Care Worker Training

CPR, First Aid, Universal Precautions, Abuse, Neglect, Exploitation, and HIPAA training must be kept current as follows:

1. CPR is current as defined by the terms of the certifying agency. Employees must have a current CPR card or certificate issued by the certifying entity and maintained in their personnel file.

2. First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, is current as defined by the terms of that entity. If first aid is provided by the agency RN or a qualified internet provider, it must be renewed within twelve (12) months or less. Training will be determined current in the month it initially occurred. (ex.: If First Aid training was conducted May 10, 2020, it will be valid through May 31, 2021.)

3. HIPAA, Universal Precautions, and Abuse, Neglect and Exploitation must be renewed within twelve (12) months or less. Training will be determined current in the month it initially occurred. (See example above.)

In addition, direct care workers must receive four (4) more hours of continuing training each year, which include topics related to caring for individuals. Service recipient specific on-the-job-training or qualified internet training can be counted toward this requirement.

B. Training Documentation

Documentation for training conducted by the agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date of the training, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee. Training documentation for internet-based training must include the person's name, the name of the internet provider and either a certificate or other documentation proving successful completion of the training. Training documentation for CPR must be a card or certificate issued from the certifying entity and must be signed by both the trainer and the trainee.

IX. Financial Staff

Provider agency employees who perform agency financial responsibilities such as accounts payable, accounts receivable, payroll, audits, budgets, general ledger, financial reports, etc. should preferably have an Associate's degree in accounting or business administration but at a minimum should have an Associate's degree in any subject area and at least two (2) years of responsible accounting or bookkeeping experience. They should have the ability to perform computerized accounting and knowledge of local, state, and federal regulatory and reporting requirements. It is recommended that provider agency employees who perform financial responsibilities be bonded.

X. Criminal Investigation Background Checks

The WV Clearance for Access: Registry & Employment Screening is administered by the Department of Health & Human Resources (DHHR) and the WV State Police Criminal Investigation Bureau in consultation with the Centers for Medicare & Medicaid Services, the Department of Justice and the Federal Bureau of Investigation. Title VI, Subtitle B, Part III, Subtitle C, Section 6201 of the Patient Protection and Affordable Care Act of 2010 (PL 111-148 established the framework for a nationwide program for states to conduct background checks. The West Virginia State Police contracts with a private agency to securely capture and transmit fingerprints to be processed through the State Police and the FBI.

It is the provider's responsibility to determine which of their agency employees are required by law to have criminal investigation background checks. It is also the provider's responsibility to determine any additional employees, beyond the requirements of the law, they deem should have a background check to ensure the health and safety of their service recipients, the confidentiality and safety from misuse of Protected Health Information (PHI) and Personally Identifiable Information (PII) and the financial integrity and security of their agency.

For additional information reference West Virginia Code Chapter 16 Article 49 and/or www.wvdhhr.org/oig/wvcares.

A. Pre-Screening

All direct access personnel (including volunteers) will be prescreened for negative findings by way of an internet search of registries and licensure databases through DHHR's designated website, WV Clearance for Access: Registry & Employment Screening (WV CARES).

"Direct access personnel" is defined as an individual who has direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel do not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations, or similar services for the covered provider.

If the applicant has a negative finding on any required registry or licensure database, the applicant will be notified, in writing, of such finding. Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Negative findings that would disqualify an applicant in the WV CARES Rule:

1. State or federal health and social services program-related crimes.
2. Patient abuse or neglect.
3. Health care fraud.
4. Felony drug crimes.
5. Crimes against care-dependent or vulnerable individuals.
6. Felony crimes against the person.
7. Felony crimes against property.
8. Sexual Offenses.
9. Crimes against chastity, morality, and decency; and
10. Crimes against public justice.

B. Fingerprinting

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record information check and may be employed as a provisional employee not to exceed sixty (60) days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the State Police Criminal Identification Bureau and the Federal Bureau of Investigation to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

C. Employment Fitness Determination

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the State Police shall notify WV CARES of the results for the purpose of making an employment fitness determination.

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of "eligible" and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant's fitness determination must be maintained in the applicant's personnel file.

D. Provisional Employees

Provisional basis employment for no more than sixty (60) days may occur when:

1. An applicant does not have a negative finding on a required registry or licensure database and the employment fitness determination is pending the criminal history record information; or

2. An applicant has requested a variance of the employment fitness determination and a decision is pending.

All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received.

The provisional employee, pending the employment fitness determination, must affirm, in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination.

Provisional employees who have requested a variance shall not be required to sign such a statement.

E. Variance

The applicant, or the hiring entity on the applicant's behalf, may file a written request for a variance of the fitness determination with WV CARES within thirty (30) days of notification of an ineligible fitness determination.

A variance may be granted if mitigating circumstances surrounding the negative finding or disqualifying offense is provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include:

1. The passage of time.

2. Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues.

3. A demonstration of rehabilitation such as character references, employment history, education, and training; and

4. The relevancy of the particular disqualifying information with respect to the type of employment sought.

The applicant and the hiring entity will receive written notification of the variance decision within sixty (60) days of receipt of the request.

F. Appeals

If the applicant believes that his or her criminal history record information within the State of West Virginia is incorrect or incomplete, he or she may challenge the accuracy of such information by writing to the State Police for a personal review.

If the applicant believes that his or her criminal history record information from outside the State of West Virginia is incorrect or incomplete, he or she may appeal the accuracy of such information by contacting the Federal Bureau of Investigation for instructions.

If the purported discrepancies are at the charge or final disposition level, the applicant must address this with the court or arresting agency that submitted the record to the State Police.

The applicant shall not be employed during the appeal process.

G. Responsibility of the Hiring Entity

Monthly registry rechecks – The WV CARES system will provide monthly rechecks of all current employees against the required registries. The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine whether or not the potential match is a negative finding for the employee. The hiring entity must maintain documentation establishing no negative findings for current employees. NOTE: This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

H. Record Retention

Documents related to the background checks for all direct access personnel must be maintained by the hiring entity for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.

2. The employee's eligible employment fitness determination.

3. Any variance granted by the Secretary, if applicable; and

4. For provisional employees, the hiring entity shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of the hiring entity to maintain state and federal background check documentation that all direct access personnel are eligible to work or employing an applicant or engaging an independent contractor who is ineligible to work may subject the hiring entity to civil money penalties.

I. Change in Employment

If an individual applies for employment at another long-term care provider, the applicant is not required to submit to fingerprinting and a criminal background check if:

1. The individual previously submitted to fingerprinting and a full state and federal criminal background check as required by this policy.

2. The prior criminal background check confirmed that the individual did not have a disqualifying offense.

3. The individual received prior approval from the Secretary to work for or with the health care facility or independent health contractor, if applicable; and,

4. No new criminal activity that constitutes a disqualifying offense has been reported.

The WV CARES system retains all fitness determinations made for individuals.

XI. Personal Conduct Policy

Individuals that display inappropriate, disruptive and/or threatening behaviors, despite staff's attempt to mediate and counsel, may be suspended from visiting the Senior Center and/or from receiving services for a period of time. During a suspension from the Senior Center, a service recipient may continue to receive services, if that service can be delivered at the persons residence, if doing so does not present a health and safety risk for staff.

Any suspensions require documentation of any and all attempts to mediate the behavior, a formal letter of action to the service recipient with a Grievance Form (Attachment 7). Providers are required to immediately notify the Bureau and the board of directors of any suspensions.

The Personal Conduct Policy Posting/Form (Attachment 9) must be posted at provider agency locations and reviewed, signed and dated by in-home service recipients. It must be maintained in their file and a copy left in the service recipient's home.

Service recipients who present ongoing or egregious, inappropriate or threatening behavior may be permanently suspended from receiving in-home services. A permanent suspension would only be warranted in extreme situations that would generally also include involvement with law enforcement, mental health professionals and/or Adult Protective Services. Documentation must be maintained, and the Bureau must be consulted and approve any permanent suspension.

XII. Voluntary Program Termination or Agency Closure (Notification of Grant Award Amendment or Termination)

A provider may terminate participation in the entire OAA Title III program with one-hundred twenty (120) calendar days' written notification of voluntary termination. If a provider requests to terminate participation in one or more OAA services, the Bureau may terminate their entire OAA grant agreement as well as their state funded programs (Lighthouse, FAIR and LIFE) to ensure comprehensive service delivery and the maximum co-location and coordination of services for older individuals as required per federal regulations. (OAA 102(a)(21) and 306(a)(3)(A).) The written termination notification must be submitted to the AAA and the Bureau simultaneously. The provider must also provide a complete list of all current Title III service recipients and indicate which Title III service(s) they receive. The provider must work with the AAA and the Bureau on assets and service transfers and location of all service sites.

Upon termination, if requested by the state, the contract entity shall deliver to the Bureau, or any other person designated by the Bureau, all service recipient records and service delivery/utilization reports and records. Access numbers for the Bureau's web-based data collection system will be inactivated.

XIII. Involuntary Program Termination or Agency Closure for Cause (Notification of Grant Award Amendment or Termination)

The Bureau, or the AAA in consultation with the Bureau, may administratively terminate a county provider from participation in the Lighthouse program, at any time, for violation of the rules and regulations, non-performance or for the conviction of any crime related to service delivery. If the provider is a corporation, its owners, officers, or employees who have violated the rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Lighthouse program. After suspension or termination, the provider may request a review by AAA and the Bureau.

Upon termination for non-performance, or any other breach, if requested by the state, the contract entity shall deliver to the Bureau, or any other person designated by the Bureau, all service recipient records, service delivery/utilization reports or other requested information related to Lighthouse funds and/or services.

XIV. Notification of Grant Award (NGA)

The NGA shall terminate by its terms at the end of the current applicable state fiscal year. The Bureau shall have the authority to determine if any subsequent agreement is offered to the service provider. This contract does not renew automatically. Upon expiration of the term of the NGA, if requested by the state, the contract entity shall deliver to the Bureau, or any other person designated by the Bureau, all service recipient records, service delivery/utilization reports, or other requested information related to Lighthouse funds and/or services.

XV. Board of Director Requirements

The board of directors for any provider agency that wishes to receive grant funding from the Bureau and is organized as a nonprofit corporation, must act in accordance with the provision of the West Virginia Nonprofit Corporation Act. The provider agency must maintain by-laws as required by West Virginia Code and must have in-place a comprehensive, board-approved policies and procedures manual, including a fiscal manual.

Any board of directors of a service provider organized as a nonprofit corporation must also meet, at a minimum, the following Bureau requirements:

1. The board must consist of at least seven (7) members with the following minimum composition requirements:

A) Two (2) individuals sixty (60) years of age or older who are service recipients in programs offered by the provider agency or are eligible to participate in such programs.

and

B) Two (2) representatives of agencies located within the provider agency's service area and/or professionals (e.g., attorney, CPA, physician, United Way, Family Resource Network).

If the provider agency is administered by a governmental entity, this requirement will not apply. However, every effort will be made to include individuals sixty (60) years of age or older, if only in an ex-officio capacity. Other exceptions or modifications to these requirements may be requested in writing, and consideration will be given to demonstrations of good cause.

2. Term Limits - board members can serve no more than ten (10) consecutive years. Elected officials at the discretion of the agency may be exempt from board term limits as long as they are holding office.

3. Current staff members cannot serve on the board unless in an ex-officio capacity.

4. Board members cannot be employed by the provider agency for at least one (1) year after serving as a board member. Provider agency employees cannot serve as a board member for at least one (1) year from their agency employment end date.

5. Immediate family members (parents, children, siblings, spouse, parents-in-law, children-in-law, grandparents, grandchildren, step-parents, step-siblings, stepchildren, and individuals in a legal guardianship) of agency staff cannot serve on the board. Immediate family members (same list as above) of board members cannot be employed by the provider agency. The provider agency must have a nepotism policy in place regarding these restrictions. The nepotism policy must restrict family members from supervising other family members employed by the agency.

6. Each board member will be required to complete at least one (1) board training in a two (2) -year period. This training will be provided or approved by the AAA.

7. Maintain on file a signed Confidentiality Agreement (Attachment 1) for each board member.

8. Copies of all approved board minutes and financial reports are to be sent to the AAA within one (1) week of approval.

9. Annually complete a Board Certification Form (Attachment 10) and submit to the AAA by July 1.

The AAA and/or Bureau will review the by-laws of the provider agency when it monitors the agency and will have the authority, if necessary, to request modification of the by-laws that will bring the provider agency into compliance with grant conditions. For more information, refer to West Virginia Code, West Virginia Non-Profit Corporation Act at www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=31e

Emergency Contingency Service Operation Plan (ECSOP)

All provider agencies funded by the Bureau must have in place an ECSOP approved by the AAA and the Bureau. The ECSOP describes how contingency services are provided to eligible service recipients during times of inclement weather and/or natural disasters.

The ECSOP is to be submitted to the AAA annually along with their providers' annual Title III Program Services Plan. The ECSOP regarding Lighthouse services must address at a minimum:

1. Emergency Closure of Services Operations

   a. Guidelines for the authority within the provider agency for the closure of regular service(s) and authorization for implementation of contingency services.

b. Guidelines for notifying staff, service recipients and the general public.
c. Guidelines for identifying and having emergency plans in place for high need/risk service recipients (i.e. service recipients that use oxygen). (Cooperate with county health departments on county emergency plans.)

d. Guidelines for notifying the AAA and the Bureau.

2. Contingency Services

a. Guidelines for contingency services when utilized as a precautionary measure for impending emergencies.
b. Guidelines for contingency services, when appropriate, during emergency closure of standard service operations. (Cooperate with county health departments on county emergency plans.)
c. Guidelines for contingency services during emergencies beyond normal service operation hours.

Emergency closure of service operations that exceed two (2) days or ten percent (10%) of the regularly scheduled days of service operations in any month shall be reviewed by the AAA and/or the Bureau for possible repayment of corresponding budget amounts, as outlined in the NGA, or for adjustment in financial awards in the fee-for-service programs.

XVI. Grant Funds

Federal and state grant funds cannot be used to pay West Virginia Directors of Senior and Community Services, Inc. dues.

XVII. Documentation

All Lighthouse services must be documented per policy (including service recipient signatures) and entered into SAMS (refer to each service area for specific requirements for each service). Services that are not documented per policy will result in no reimbursement or a payback of funds for services.

The SAEF must be fully completed per instructions for each Lighthouse service in order to be reimbursed for services as per program requirements. Only one (1) SAEF is required for a service recipient who receives more than one (1) service.

All services must be entered into SAMS by the tenth (10th) calendar day of each month.

Providers must use the forms developed and implemented by the Bureau. If your agency wants to modify or use a different form, you must submit a written request with the proposed form to the Bureau and receive written approval.

XVIII. Provider Agency Billing

Invoices for all Lighthouse services will be sent to the Bureau and are due to the Bureau on the tenth (10th) calendar day of each month. Additionally, a SAMS roster or report is required that lists the names of service recipients and the units of service during the period covered. Lighthouse services will be billed at least monthly. Invoices not received by the deadline may be processed with the next month's invoice. Invoices for services and/or expenses will not be accepted after thirty (30) calendar days.

Final year end fund requests and/or invoices must be received by the Bureau within thirty (30) calendar days of the grant's end. All state funds expire on June 30 of each fiscal year.

For services whose services unit is one (1) hour, you must round to the nearest 1/4th or an hour (.25 unit).

¼ hour = .25 unit

½ hour = .50 unit

¾ hour = .75 unit

1 hour = 1 unit

[Example: If a service recipient received a service for eight (8) minutes, the Roster would reflect .25 unit (or ¼ hour). If a service recipient received a service for thirty-three (33) minutes, the Roster would reflect .50 units (or ½ hour)].

XIX. Prioritization of Services

Lighthouse services must be prioritized based on a combination of SAEF scores and the prioritization processes established by the provider agency's board of directors.

If there is a waitlist for Lighthouse services, individuals must be prioritized and must be served based on SAEF scores and prioritization policy established by the provider agency using the SAEF. Instructions on the prioritization scoring system are included in the SAEF (Attachment 3).

XX. State Cost Share

Lighthouse is a state-funded program, and there is a requirement that service recipients share in the cost of their service, using a state cost share schedule based on the individual income of the service recipient or, in the case of a married couple, the combined income of the service recipient and spouse. When assessing an individual's eligibility for state cost sharing, it must be based solely on a confidential self-declaration of income (not considering assets, savings, or other property owned by the individual). All income is to be considered. The state cost share amount is based on the service recipient or the service recipient and spouse's incomes. Other household members' incomes are not to

be considered. Spouse's income is not counted if there is a legal separation. Income does not include any allowance and/or stipend that the individual or married couple receive for other services provided to them. Monthly medical expenses must also be deducted from declared income before applying the State Cost Share Chart (Attachment 11). Medical expenses may include insurance premiums, copays, prescriptions, dental, etc. Medical expenses can vary, and provider agencies should use their professional judgment in determining if an expense is an actual medical expense.

State Cost Share Invoice (Attachment 12). State Cost Share funds collected and **deposited** in any given fiscal year are considered state cost share income for that fiscal year and should be reported as such. Use the date the state cost share funds were deposited to determine when to account for them. (Example: If state cost share funds are due to the provider agency for hours of service provided in June but are collected and deposited in July, then those funds would be considered part of the fiscal year that began in July.) State cost share income collected annually is reported to the Bureau on the State Cost Share Accountability Form (Attachment 13). If an applicant does not want to share this information, then 100% state cost share may be charged.

All monies collected through Lighthouse state cost share are to be pooled with FAIR state cost share funds and utilized to provide additional hours of service in either Lighthouse or FAIR at the appropriate hourly rate in the county where the state cost shares were collected. State cost shares collected may not be used to reimburse the provider agency for hours of service that exceed the program maximum of sixty (60) hours per month. Lighthouse state cost share income may be carried over to the following fiscal year. It must be utilized by December 31 of the fiscal year following the fiscal year in which it was collected. The Bureau may change the state cost share schedule at its discretion.

If it is determined that paying the appropriate state cost share would cause a hardship for the service recipient, the reasons for the hardship should be clearly documented in the service recipient's file and an hourly amount worked out that is acceptable to both the provider agency and the service recipient. A Hardship Waiver may be granted and needs to be reevaluated annually. At the end of the fiscal year, total state cost shares collected must be equal to or greater than the hours of service provided, or the provider agency must make up the difference from other sources. Hardship Waivers should be limited.

Service recipients must be prioritized (Refer to Policy Section XX) and must be made aware of the share of costs that they will be charged for the Lighthouse services they receive. At the end of each month, all Lighthouse service recipients will receive the State Cost Share Invoice (Attachment 12), detailing services provided and their share of the cost of those services, which they are expected to pay. If a service recipient chooses not to participate in state cost sharing, the provider agency, following their Board approved policy, will determine whether to continue services for that service recipient, discontinue services or to offer a hardship waiver. If the decision is made to discontinue services for non-payment, the service recipient will be notified in writing. A Grievance Form (Attachment 7) must accompany the written notice and the service recipient must be given ample time to respond, according to provider agency's board approved policy.

Funds received from state cost share must be logged in by service, deposited and tracked in the accounting system as state cost share revenue for Lighthouse/FAIR. All revenues must be counted and balanced by two (2) people. A receipt must be provided to service recipients for state cost share with the monthly State Cost Share Invoice (Attachment 12).

Assessments and Reassessments: An initial assessment and annual reassessment are required for all Lighthouse service recipients. For every initial assessment and annual reassessment conducted for Lighthouse, the provider agency may deduct the current approved amount from current year state cost share income to help offset non-billable costs associated with Lighthouse program administration.

In order to deduct for the initial assessment, the applicant must actually receive services through the program for which the assessment was conducted. It may not be deducted if an assessment is done for someone who does not ultimately receive services through the Lighthouse program. Deductions are limited to one assessment per year, although if the service recipient is getting services from both Lighthouse and FAIR, the provider agency may deduct the current approved amount annually for the Lighthouse initial assessment or reassessment and the same amount for the FAIR initial assessment or reassessment. The provider agency cannot deduct more than the total amount of state cost share income collected in the current year. If an assessment is conducted in one fiscal year and services begin in the next fiscal year, then the provider agency would deduct the approved amount in the fiscal year that the service begins.

Documentation of assessments to be deducted, at a minimum, must include service recipient's name, assessment date, and start date of service or date of reassessment and must be maintained in provider agency office for fiscal monitoring purposes. It does not have to be submitted with the annual State Cost Share Accountability Form.

The amount of state cost share income deducted for assessments and reassessments will be reported annually to the Bureau on the State Cost Share Accountability Form.

Each service recipient will be reassessed at least annually, more frequently if needs or income of the service recipient or the care receiver change. Reassessment includes a home visit, completion of a new SAEF and determination of appropriate state cost share.

XXI. Lighthouse Program

A. Lighthouse Services

The Lighthouse Program provides support in four (4) areas:

1. **Personal Care:** Bathing, dressing, grooming, and toileting.
2. **Mobility:** Transferring, walking and repositioning.

3. **Nutrition:** Meal preparation, eating, special dietary needs, and grocery and/or pharmacy shopping.
4. **Environment:** Light housecleaning, making and changing the service recipient's bed, dishwashing, and service recipient's laundry. This cannot exceed 1/3 of the monthly hours a service recipient receives. This is based on the registered nurse assessment. The Lighthouse Program does not provide only housekeeping. Personal care has to be provided to receive housekeeping services.

Environmental services are direct and practical assistance with household tasks and related activities. Environmental services assist individuals who have lost the ability to perform instrumental activities of daily living that allow them to live in a clean, safe, and healthy home environment. Environmental services must be provided in the home and cannot exceed more than one-third (1/3) of the monthly hours that a service recipient receives. Light housekeeping cannot exceed sixty (60) minutes per week. The 2/3 (two-third), 1/3 (one-third) rule still must apply.

Lighthouse Fund Identifiers: Lighthouse, State Cost Share, LIFE, Local

Service Unit: 1 hour

Service Limit: Lighthouse services are limited to a maximum of sixty (60) hours of service per month, based on the RN's Assessment (Attachment 14), resources available, and subsequent Plan of Care (Attachment 15). Since medical eligibility is based on only two (2) identified needs, it is anticipated that many of the service recipients in the program will not require the maximum hours of service per month.

It is possible to qualify for the Lighthouse program and not need any assistance with bathing. Service hours and the Plan of Care (Attachment 15) should be based upon the unique needs of the individual service recipient and must provide assistance in two (2) of these areas: personal care, mobility or nutrition. Maximum hours should be reserved for those service recipients who require much assistance or greater in most or all areas on the LED (Attachment 16), and the RN Assessment must clearly document the need for maximum hours.

Eligibility Requirements: There are three (3) eligibility criteria for the Lighthouse program:

1. Sixty (60) years of age or older.
2. Medically eligible based on a functional evaluation by the provider agency's RN. Two (2) needs must be identified under "Activities of Daily Living" on the Lighthouse Eligibility Determination form (LED). A need is an ADL that requires "Much Assistance" or "Total Assistance";
3. A resident of West Virginia at the time service is provided.

Documentation Requirements: The RN Assessment (Attachment 14) must be completed at the time of the initial home visit, and annually thereafter. The Assessment should be detailed enough to determine Plan of Care needs. In addition to the annual assessment, a six (6) month follow-up phone call with the service recipient and/or family member must be made, with documentation of findings and follow-up as indicated. Six (6) month calls must be completed by the provider agency RN or a designated professional agency staff member. In addition to six (6) month calls and annual reassessments, follow-up by the RN is required any time there has been an incident or change in the service recipient's condition. Additional contacts may be indicated based on the service recipient's condition and the RN's professional judgment. All contacts should be documented in the Nurse's Notes section of the service recipient's file.

Six (6) month call documentation must include the following:

1. Service recipient's name and date of call.
2. The name of the person you spoke to and how they are related to the service recipient.
3. Any cognitive issues.
4. Any issues with care.
5. Any changes in medication and/or mobility.
6. Any needed changes to the Plan of Care.
7. Satisfaction with current services.
8. Any additional comments; and,
9. The RN's signature.

If the six (6) month call (Attachment 17) is completed by someone other than the RN, the RN must sign to confirm that he/she has read and understood the call note. The six (6) month call must be completed with the service recipient or the service recipient's informal support. The call cannot be with the direct care worker. If the direct care worker is a family member, the six (6) month call must be with someone else.

Nurse's Notes: All Lighthouse service recipients shall have a Nurse's Notes section in their agency files. This section should be used to document all contact with the service recipient, including home visits, six (6) month calls, Plan of Care changes and follow up by the RN. The RN must document when the initial/annual assessment is completed or if the Plan of Care is changed for any reason. The RN should also document if the service recipient is in the hospital, rehab, or suspends services for any reason. If the direct care worker reports any problems with the service recipient, the RN needs to follow-up with the service recipient either by telephone or in person and document the findings in the Nurse's Notes.

Reassessment Requirements: Each service recipient shall be reevaluated for the Lighthouse Program at least annually for eligibility, more frequently if needs or income of the service recipient or spouse change, through the completion of a new Lighthouse Eligibility Determination (Attachment 16) by the Agency RN. Determination will be made at this time if a service recipient is still eligible, if there is a change in the state cost share

schedule, and if there needs to be a referral made to another program for services. Annual reevaluation includes a home visit, completion of a SAEF (Attachment 3), RN Assessment (Attachment 14), Plan of Care (Attachment 15) and appropriate determination of the State Cost Share (Attachment 11).

B. Job Description

Each provider agency will have a job description specifically for the Lighthouse program that reflects the duties and responsibilities of direct care workers providing Lighthouse services through this program.

C. Referral

After a referral is received, the provider agency RN shall determine appropriateness of the Lighthouse program either by telephone conversation with the applicant or by home visit. At this time, the SAEF shall be completed to determine the priority level of the applicant. All avenues of in-home services should be explored—e.g., Veterans Administration, Medicaid Personal Care, Medicaid Aged and Disabled Waiver, Medicaid TBI Waiver, private insurance, and other in-home care programs.

D. Initial Home Visit: Completion of Service Assessment and Evaluation Form (SAEF) and Lighthouse Eligibility Determination (LED) Form

Once the applicant is determined to be appropriate for Lighthouse and the provider agency has an opening in the Lighthouse program, the RN shall make a home visit. The SAEF shall be completed and medical eligibility determined with the LED at the time of the visit. At this time the information in the SAEF shall be reviewed for accuracy.

All sections of the SAEF must be completed, including the nutritional risk assessment and ADL and IADL sections. No fields should be left blank. Every Lighthouse service recipient must have a completed SAEF in the SAMS database.

The LED must be completed in its entirety. Medical eligibility for the Lighthouse program is determined by the "Activities of Daily Living" (ADL) Section of the LED. When determining the level of need for each ADL, do not use ranges. Consider how the applicant/service recipient is on **most** days and use that level of need. If at least two (2) of the Activities of Daily Living indicate "Much Assistance" or "Total Assistance," then the applicant is medically eligible to participate in the Lighthouse program. All applicants **must have** a minimum of two (2) "2's", two (2) "3's", or one (1) "2"and one (1) "3" in order to qualify. The LED must be signed by the RN.

If medically eligible, the applicant shall be advised at this time. If medically ineligible, the applicant shall be advised at this time, and the interview concluded. Referral to the local Aging and Disability Resource Network would then be appropriate.

The LED must be completed annually to determine continuing eligibility for the Program. The state cost share schedule and the provider agency's policy for payment shall be discussed with the applicant at the time of the eligibility determination.

E. RN Assessment

The RN Assessment (Attachment 14) must be completed in full by the provider agency RN at the initial visit, and must have a narrative, which includes the service recipient's living conditions, medical history, medications, diagnoses, and ability to perform personal care, mobility, nutritional, and environmental tasks. This assessment is used to develop the service recipient's Plan of Care; therefore, as much detail as possible must be included. The assessment should paint a picture of the service recipient and validate the tasks and time frames on the POC. After completion, the RN Assessment should be signed and dated by the agency RN, and the assessment should be maintained in the service recipient's file.

The RN Assessment must be completed initially and annually thereafter and whenever there are changes to the service recipient's needs and condition that the RN thinks warrants a new complete assessment. Nursing notes may be more appropriate for some types of updates and changes.

F. Plan of Care (POC)

The Plan of Care (Attachment 15) shall be developed based upon the RN Assessment and the expressed needs of the service recipient. The RN should use his/her professional judgment to determine the tasks needed and time required for each task to be completed. No tasks can be provided outside the service definitions. Time in minutes should be entered for all tasks on the POC. Times indicated will be averages and are used to determine a block of time for completion of the task. Excessive time for tasks must have thorough documentation. The RN should indicate the number of hours approved for each day under "hours approved daily" for every day of service. The hours approved daily must correlate with the total minutes indicated for each of the tasks to be performed that day. Plan of Care hours cannot exceed four (4) hours per day. Environmental tasks are incidental to the other tasks and cannot exceed one-third (1/3) of the total monthly hours that the service recipient receives. When developing the POC, the RN should include in the "Comments" section any instructions to the direct care worker related to the task. Always include the number of meals to be prepared under the comment section for "meal preparation."

Plan of Care specifics must be discussed in detail with the service recipient prior to implementation. (Since a service recipient must pay according to the state cost share schedule, it is possible that he or she may wish to limit the number of hours of service received.) A copy of the Plan of Care must be subsequently left in the home for the direct care worker to utilize and must be kept in the service recipient's record.

The POC must be completed initially, annually and as indicated with any documented change in service recipient condition. Any changes to the POC must have adequate documentation to support the tasks needed and times needed for each task to be completed. The RN documentation, either in the RN Assessment or in a nursing note, must validate the tasks and times on the POC. All changes to the Plan of Care must be documented in the Nurse's Notes section of the service recipient's record along with documentation that the changes were discussed with the service recipient prior to being made.

G. Direct Care Worker Service Log

The Lighthouse program direct care worker must indicate the time of arrival and departure, and initial on the Direct Care Worker Service Log (Attachment 18) only the tasks completed each day. The Service Log directly reflects the Plan of Care, a copy of which is kept in the service recipient's home for the direct care worker to utilize.

The direct care worker should initial beside every task performed each day. If a task that is on the Plan of Care is not completed, the direct care worker should not initial. Instead, they should document in the comment section, the reason that task was not completed (e.g., service recipient does not feel well enough for a bath, washing machine broken so unable to do laundry, etc.). If a task is not performed, the direct care worker should not document the time that should have been spent on that service. For example, if the Plan of Care allowed thirty (30) minutes for a bath and the service recipient refused the bath, the direct care worker should deduct thirty (30) minutes from the total time allowed for the day. Any changes or concerns regarding the service recipient should be documented by the direct care worker in the comment section of the Service Log.

At the end of the week, the service recipient must sign and date the Service Log verifying the times the direct care worker was present and that he/she received services as initialed. If the service recipient is unable to sign, a representative may sign for them (the representative must sign the service recipients name and then their name. It must be documented in the service recipient's chart that they are unable to sign their name). After the service recipient signs, the direct care worker should also sign the Service Log to verify service delivery. The Service Log must be turned in weekly, bi-weekly or semi-monthly, depending on the provider's employee pay schedule, to the RN after the service recipient and caregiver have signed; the RN then carefully reviews the service log for compliance with the POC and addresses any discrepancies prior to signing off which then begins the billing process. If any discrepancy is found, then follow-up is expected with documentation in the service recipient record. The RN signature indicates that he/she has reviewed the Service Log and agrees the POC has been followed and has completed follow-up related to any discrepancy or change noted. The RN needs to date the signature on the Service Log for the date that he/she actually signs it.

Original Service Logs must be maintained at the provider agency in the service recipient's file. All signatures should be original. Faxed copies are not allowed. Service logs must be completed in ink and white out should not be used. Service recipients must be given a copy of the Service Log if requested.

H. Service Provision

Transportation to Doctor's appointments are not allowed under Lighthouse. Services will be provided by a trained direct care worker employed by the provider agency. **The direct care worker may be any qualified individual, with the exception of the service recipient's spouse.**

Every direct care worker is required to have a satisfactory criminal background check. (For further guidance, please see Policy Section X. regarding Criminal Investigation Background Checks.)

It is required that the agency RN have Lighthouse training by the Bureau staff to ensure the quality of the program. The State Director of the Lighthouse Program is to be notified with any change in RN staff within fourteen (14) days of hire, and required training is to be completed within thirty (30) days of hire. Registered nurse professional level of care is expected at all times.

The RN must be licensed in WV. A temporary license will not be accepted.

All agency and direct care staff who work with the Lighthouse program are required to have a signed confidentiality form in their personnel record.

I. Reporting

Lighthouse services must be reported using the Harmony/SAMS Client Tracking Software. A fully completed SAEF is required to enter the Lighthouse service recipient into the SAMS system. A roster is the appropriate method for entering the service recipient's service units. Active service recipients will automatically appear on the next month's roster.

All units of Lighthouse service provided must be documented in SAMS using the service code **Lighthouse Personal Care** and the fund identifier of **Lighthouse, State Cost Share, LIFE,** or **Local** depending upon the funding used to provide the service. Special caution must be used to ensure the hours of service are properly and accurately billed to the appropriate funding source. Service units documented must be rounded to the nearest quarter of a unit (i.e. .25, .50, and .75).

J. Service Recipient Files

For monitoring purposes, each service recipient's file must include the following:

1. A SAEF for the service recipient
2. An updated SAEF for the service recipient for each annual reassessment

3. A completed LED with at least two (2) 2's, two (2) 3's or one (1) 2 and one (1) 3
4. Service Recipients/Spouses estimated income
5. Signed Service Recipient Responsibility Agreement
6. Signed Personal Conduct Policy
7. A Plan of Care for the Service Recipient
8. Nursing Assessment that matches LED and POC
9. Documentation of hardship if service recipient has been exempted from state cost share
10. Documentation of need if service recipient is receiving maximum hours of service per week; this would be mostly 2's and 3's on the LED (at least 5)
11. Evidence that the service recipient, direct care worker and nurse have read/completed direct care worker service logs
12. Completed direct care worker service logs for months of review
13. A copy of the Service Recipient's Invoice for months of review that states how much state cost share fee is being paid

XXII. MONITORING AND GRANT ADJUSTMENTS

Monitoring of the Lighthouse program will be conducted at least every twelve (12) months or more often if deemed necessary by the State Lighthouse Director or if requested by the provider agency. The provider of Lighthouse services will be monitored by the Bureau of Senior Services, or its designee. Monitoring may include on-site monitoring, desktop monitoring, home visits or telephone interviews with service recipients, and/or interviews with direct care and agency staff. Records regarding service recipients, billing records, and records of any personnel who work with the Lighthouse program shall be provided upon request.

On-site monitoring of the Lighthouse program will be conducted at least every twenty-four (24) months or more often if deemed necessary or if requested by the Lighthouse provider agency. Desktop monitoring will be completed every other year alternating with on-site visits. Both on-site and desktop monitoring will be based on the average number of service recipients per county.

The number of service recipient records reviewed will be determined as follows:

1.	0-15 service recipients	4 records reviewed
2.	16-20 service recipients	5 records reviewed
3.	21-30 service recipients	6 records reviewed
4.	31-40 service recipients	7 records reviewed
5.	41-50 service recipients	8 records reviewed
6.	51-60 service recipients	9 records reviewed
7.	61+ service recipients	10 records reviewed

Positive findings on a review may result in an increase in grant award funds. Negative review findings will lead to a Plan of Correction, and possibly a payback of funds, no reimbursement, or, in severe cases, loss of privilege to provide Lighthouse services.

A Plan of Correction will be requested when review findings, as evidenced by failure to follow program policy and procedures, indicate changes need to be made to bring the Lighthouse program in line with policy. Provider agencies will be given thirty (30) days to respond when a Plan of Correction is required in order to correct deficiencies. Technical assistance will be provided as needed and requested. In order to correct deficiencies, conditions can be added to an NGA. The Bureau may request a desktop self-audit on all case files.

Conditions that may result in the recoupment of funds, downward adjustment of grant award and/or corrective action:

1. Expiring funds between fifteen percent (15%) and thirty-three percent (33%) of annual award during the prior grant year.
2. Services provided that do not meet policy requirements.
3. Performance deficiencies that show service recipients in the provider's service area are being underserved.
4. Evidence that revenue and/or state cost share funds are not being spent appropriately.
5. Employees who do not meet the requirements for the provision of services.
6. Services provided that do not meet the documentation requirements.
7. Services provided to individuals who do not meet the eligibility requirements.
8. Failure to average $1.00 per hour of Lighthouse/FAIR service provided.
9. Providing maximum hours to the majority of service recipients being served without documentation to validate.

This is not an all-inclusive list of conditions that may result in the recoupment of funds or the downward adjustment of a grant award.

Conditions that may result in termination of all or part of grant award and corrective action:

1. Expiring more than thirty-three percent (33%) of your grant award during the prior service period.
2. Severe performance and review deficiencies, which indicate a health and safety concern for service recipients that are not corrected immediately.
3. Failure to report and/or adhere to a specified plan of correction.
4. Other severe review deficiencies.
5. Falsification of documents.
6. Accumulation of any two (2) or more of "conditions that may result in the downward adjustment of award" as defined above.

This is not an all-inclusive list of conditions that may result in termination of all or part of the grant award.

If justification for a reduction or termination of award is found, you will be notified, with explanation, in writing. You would then have five (5) business days to set up a repayment

schedule with the Bureau or submit a written appeal to the Commissioner and the State Lighthouse Director.

If you lose the privilege to provide Lighthouse services within your county, the privilege will be offered to another Title III-B provider agency within the aging network, based on their review history and location.

The Bureau has the discretion to make changes to the Lighthouse program, with ample notice to service providers, as the need arises. The Bureau retains the authority to make final decisions regarding Lighthouse grant distribution.

Monitoring Tools can be found on the Bureau's webpage at www.wvseniorservices.gov.

INDEX