Lake Prince At Home, LLC

COMPLIANCE AND ETHICS PROGRAM MANUAL - Lake Prince At Home (July 5, 2024)

[Nondiscrimination and language assistance information appears at the end of this document.]

I. Introduction

Lake Prince At Home, LLC (LPAH) recognizes the problems that both deliberate and accidental misconduct in the healthcare industry can pose to society. Our Compliance and Ethics Program strives to create a culture that promotes understanding of and adherence to applicable federal, state and local laws and regulations. EveryAge is committed to ensuring that it operates under the highest ethical and moral standards and in compliance with all applicable laws. We believe this commitment is consistent with our history and reputation in the community and our values and mission as a healthcare provider.

Mission Statement: A Christian ministry providing vibrant living, diverse programs of outreach and compassionate services.

II. Fundamental Elements of an Effective Compliance and Ethics Program

- The U.S. Sentencing Commission Guidelines and the Office of Inspector General have outlined fundamental elements that comprise an effective Compliance and Ethics Program. Our program includes each of these elements: 1) Written policies, procedures and Standards of Conduct approved by the governing body; 2) Compliance leadership and oversight; 3) Training and education; 4) Effective lines of communication with the compliance officer and disclosure programs; 5) Enforcing standards, consequences and incentives; 6) Risk assessment, auditing, and monitoring; and 7) Responding to detected offenses and corrective action initiatives. We also conduct annual evaluations of our program's effectiveness.

The Compliance and Ethics Program addresses each of the required elements specified in the CHAP Compliance Program Standards [Effective 6.1.2024]:

- Designated compliance officer and committee with the overall responsibility of maintaining regulatory knowledge and monitoring regulatory compliance; staff education; identifying organizational compliance gaps; facilitating regular compliance meetings; participating in organizational policy review and update to ensure relevant regulatory updates as applicable; preparing of compliance information for the governing board; and ensuring ethical marketing practice.

- Established written compliance and ethics standards, policies, and procedures provide a roadmap for relevant individuals to follow that are relevant to day-to-day responsibilities, available to those who need them, and re-evaluated regularly.

- The organization takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations by any of the organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report suspected as well as an alternate method of reporting suspected violations anonymously without fear of retribution, and having a process for ensuring the integrity of any reported data.

- Documenting investigation of compliance issues, implementation of corrective action, and period review of problem areas to ensure compliance.

- Consistent enforcement of the organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the organization's compliance and ethics program. Employees, contractors, and medical and clinical staff members are routinely checked against government sanctions lists, including the OIG's List of Excluded Individuals/Entities.

- The organization takes steps to effectively communicate the standards, policies, and procedures in the organization's compliance and ethics program to the organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training or orientation programs, or disseminating information that explains in a practical manner what is required under the program. All staff, whether employed directly or under arrangement, participate in LPAH in-service programs and/or compliance reminders about actual and potential compliance issues and regulatory updates as applicable.

A. Overview of the Compliance and Ethics Program

1. Governing Body

LPAH is committed to operating as a good corporate citizen of our community, state, and nation. Accordingly, in a resolution dated August 28, 2019, our Board of Directors delineated the organization's commitment to comply with all laws that affect its various operations. In its efforts to help ensure that operations are being conducted in compliance with the law, the Board established the Compliance Department and appointed a Compliance Officer to maintain the Compliance and Ethics Program. The Board is ultimately responsible for supervising the work of the Compliance Officer and adopting and maintaining the Standards of Conduct and compliance policies.

The Board consults with advisors as necessary; ensures that integrity hotline cases and correspondence are treated confidentially; coordinates with the Compliance Officer to ensure the adequacy of the Compliance and Ethics Program; receives reports related to state or federal survey inspection reports, deficiencies and corrective actions; receives routine reports containing quality of care data; ensures that appropriate corrective measures are instituted and maintained in response to identified quality issues; ensures the Compliance and Ethics Program evolves to meet changing needs; reviews the performance of the organization and employees in light of the Compliance and Ethics Program; ensures that the organization meets applicable standards of business, legal, and ethical compliance; ensures that matters related to education, training, and communication in connection with the Compliance and Ethics Program are properly disseminated, understood, and followed; takes action as appropriate and necessary to ensure that the organization conducts its activities in compliance with applicable laws and regulations and sound business ethics; and ensures that appropriate corrective action is taken, including employee disciplinary action, in response to verified violations of applicable laws or policies.

2. Written Policies and Procedures

An effective Compliance and Ethics Program defines the expected conduct of its members through the establishment of written, dynamic policies and procedures. EveryAge has developed and

implemented written policies and procedures that address the operation of the compliance program, compliance with applicable statutes, regulations, and Federal health care program requirements, including but not limited to compliance with the Anti-Kickback Statute, Stark Law, False Claims Act, HIPAA Privacy and Security Rules, and the regulations and other guidance documents related to these regulatory requirements; duties and workflows within the organization, documentation requirements, defined oversight roles, and internal controls to mitigate compliance risks specific to the organization.

Within our organization, these policies and procedures begin with the Mission Statement, Statement of Values, and Code of Ethics, which provide a framework. This conduct is more specifically defined in our Standards of Conduct, Compliance Manual, and Employee Handbook.

To manage known risks effectively, adherence to policies and procedures is reviewed on a periodic basis. In addition, newly identified risks result in the promulgation of new policies and procedures or revisions to old ones as well as corrective action plans where necessary, to address those risks.

Detailed policies outlining important compliance activities are maintained by the Compliance Officer and are readily accessible to team members throughout the organization on the information systems network.

3. Compliance Officer

The Chief Quality and Compliance Officer has been appointed by the Board to serve as the [Chief] Compliance Officer and HIPAA Privacy Officer. The Compliance Officer is charged with the responsibility of meeting the organization's compliance objectives. The Compliance Officer will not have any noncompliance job responsibilities that may interfere with or be perceived as a conflict of interest with the ability to perform the duties as outlined below. The Compliance Officer works closely with team members to establish systems which enhance each employee's ability to understand and adhere to the complex laws and regulations that govern our business. In doing so, the Compliance Officer reports compliance activities directly to the President/CEO and the Board of Directors.

The duties of the Compliance Officer include but are not limited to:

a) Supervises the implementation of the Compliance and Ethics Program.

b) Serves as Chair of the Compliance Committee and works closely with senior management, compliance liaisons at the Communities, and the Board to set compliance direction and strategy;

c) Maintains, distributes and promotes the Standards of Conduct and Compliance and Ethics Policies (Appendix A), to be followed by employees, agents, volunteers and independent contractors, that establishes standards of conduct, clearly identifies prohibited conduct, establishes the manner in which compliance is monitored, and the mechanisms by which prohibited conduct is reported to the Compliance Officer.

d) Coordinates compliance activities with the Executive Directors at the Communities who serve as members of the Compliance Committee and assume the responsibilities of compliance liaisons at their Communities.

e) Coordinates compliance awareness education of employees, agents, volunteers and contractors through training programs, emails, printed materials, and other means.

f) Assists supervisory team members to establish multi-level mechanisms (including periodic audits) to monitor compliance with standards set forth in compliance policies and documents implementation and results.

g) Reviews high-risk compliance areas for effectiveness in reducing the likelihood of noncompliance with applicable laws, regulations, and policies.

h) Maintains current knowledge of laws and regulations, keeping abreast of recent changes that may affect policies, procedures and processes through personal research, seminars, peer contact, and bench-marking compliance monitoring practices and implementation strategies with other entities.

i) Provides advice and guidance to team members and agents to facilitate compliance with statutory, regulatory, and policy requirements.

j) Assists Human Resources and Compliance Committee in provision of processes to help ensure no retaliation for employee good faith reporting of noncompliance.

k) Implements and oversees a confidential system for employees and others to seek guidance on business conduct and to report suspected compliance violations;

l) Provides oversight of policies and procedures for exercising due diligence in hiring/screening employees, vendors, and affiliates against appropriate governmental exclusion/debarment/suspension lists to ensure eligibility for hire and/or to participate in federally funded healthcare programs.

m) Coordinates investigations of all suspected intentional and accidental misconduct and works with appropriate parties to handle violations promptly, properly, and consistently.

n) Ensures completion of annual risk assessment and preparation of compliance work plan by Compliance Committee for Board approval.

o) Proposes modifications to the Compliance and Ethics Program, if necessary, to prevent recurrence of problems or to address new risks.

p) Coordinates HHS/OIG List of Excluded Individuals/Entities (LEIE), CMS Preclusion List, General Services Administration's System for Award Management (SAM), and state Medicaid excluded parties screening and procedures to ensure the organization does not delegate substantial discretionary authority to individuals who have a propensity to engage in criminal, civil, and administrative violations, which could cause the organization to generate an inappropriate bill to be paid directly from a federal healthcare program.

q) Works with Chief Financial Officer regarding regular financial audits by outside auditors.

r) Coordinates a regular review of the Compliance and Ethics Program's effectiveness.

s) Coordinates policy management; and

t) Prepares periodic and annual reports for the Board, other senior leadership, and the Compliance Committee describing the compliance efforts undertaken during the year, identifying emerging industry trends posing risks to future operations, including the identification, investigation, and resolution of potential or actual instances of noncompliance, government compliance investigation, enforcement, or penalties, and any changes necessary to improve the Compliance and Ethics Program.

4. Compliance Committee Charter

The role of the Compliance Committee is to assist and support the Compliance Officer in implementing, operating, and monitoring fulfilling his or her responsibilities of maintaining the Compliance and Ethics Program. This includes ensuring in order to monitor the organization and ensure consistent application of relevant laws and rules, to proactively identifying problem areas, and

to recommending, establishing, and implementing, as appropriate, solutions and system improvements. The tone and expectations of the compliance program and committee are established and maintained by the organization's leadership, including the Board and the President & CEO.

The duties of the Compliance Committee include:

a) Meeting at least on a quarterly basis, or more frequently as necessary to enable reasonable oversight of the Compliance Program.

b) Assists the Compliance Officer in analyzing risk areas, including legal risks, operations issues, and quality of care issues and the implementation and oversight of the annual compliance work plan;

c) Assists in evaluating, reviewing, and updating policies and procedures, including compliance manual and program;

d) Works with Compliance Officer in developing standards of conduct;

e) Assists in monitoring internal controls for carrying out the policies and procedures;

f) Assessing education and training needs and effectiveness, and regularly reviewing required training.

g) Assessing effectiveness of the disclosure program and other reporting mechanisms for inquiries, and potential noncompliance and FWA concerns.

h) Conducting the Compliance Program risk assessments and the development of the monitoring and auditing work plan.

i) Evaluating the effectiveness of the compliance workplan and any action plans for risk remediation.

j) Reviewing the effectiveness of the Compliance Program.

k) Supporting the Compliance Officer's needs for sufficient staff and resources to carry out his/her duties.

l) The committee composition may include but is not limited to representatives from compliance, operations, administration, risk management, quality assurance, clinical services, finance, information technology, human resources, health information, foundation, and marketing. Members of the Compliance Committee should have decision-making authority in their respective areas of expertise.

5. Preventing Individuals Involved in Illegal Activities from Exercising Discretionary Authority

The Compliance Officer works with the Human Resources Department to help ensure that:

a) No individual who has engaged in certain illegal or unethical behavior as determined by the Compliance Officer/Committee and/or who has been convicted of healthcare-related crimes is allowed to occupy positions within the organization, which involve the exercise of discretionary authority.

b) Any applicant for an employment position with the organization is required to disclose whether he or she has been employed under a different name and whether he or she has ever been convicted of a crime, including healthcare-related crimes.

Designated team members reasonably inquire into the status of each prospective employee and agent, including, but not limited to the following:

a) Conduct background checks on newly hired employees to determine whether any history of engaging in illegal or unethical behavior exists, which would prohibit continued employment due to the nature of the offense as related to the job position.

b) Conduct a review of the System of Award Management (SAM) List of Parties Excluded from Federal Programs, the CMS Preclusion List, and the HHS/OIG Cumulative Sanction Report, and the state Medicaid exclusion lists for contractors providing services to healthcare facilities which could cause the organization to generate an inappropriate bill which would be paid directly from a federal healthcare program.

c) Conduct a written review and approval process for Arrangements to ensure that all Arrangements do not violate the Anti-Kickback Statute and the Stark Law.

d) The organization's management in consultation with the Human Resources Department and the Compliance Officer will remove any person in a position of authority if there is any evidence that the person is not willing to comply with the requirements of the Standards of Conduct and Compliance Policies.

e) The organization's management in consultation with the Human Resources Department and the Compliance Officer will terminate employees or its relationship with agents, and independent contractors, who are excluded from participation in federal or state Medicaid programs, including immediate removal from direct responsibility or involvement in any federally funded healthcare programs.

f) The organization's management in consultation with the Human Resources Department and the Compliance Officer will remove from direct responsibility or involvement in any federally funded healthcare programs any employees or agents with pending criminal charges relating to healthcare or any proposed exclusion from participation in federally funded healthcare programs.

6. Training and Education

Training and education is considered a necessity in order to provide Board members, team members, contractors, volunteers and agents with the knowledge and skills to carry out their responsibilities in compliance with all requirements. Orientation and continuing training and education at all levels are a significant element of our Compliance and Ethics Program. Adherence to and promotion of this program is a factor in evaluating the performance of employees at all levels. A variety of educational methods, materials, and tools will be utilized to present general and specific compliance education and training programs.

All new team members must participate in Compliance and Ethics Program training as part of orientation and receive access to the Compliance Manual at hire, which includes the Standards of Conduct and other information to promote compliance. All employees must attest to their understanding and agreement to abide by the Standards of Conduct.

Each current team member must participate in training regarding the Compliance and Ethics Program at least annually, where they will review Compliance and Ethics Program documents and complete a compliance attestation.

Some team members receive specialized targeted training due to the nature of their work based on individuals' roles and responsibilities and any compliance risks specific to those roles and responsibilities. This specialized training may focus on areas specific to their assigned responsibilities and/or include complex areas where there is high risk for noncompliance. Such roles may include billing, coding, documentation, sales and marketing, gifts and gratuities, medical necessity, etc.

All agents and team members requested to receive special training are expected to complete such training. All supervisors are responsible for ensuring that employees reporting to them have completed the training sessions applicable to that person's job duties.

The Compliance Committee should ensure that the training materials are accessible to all members of the designated audience. For example, if the entity has a culturally diverse staff, training materials may need to be available in several languages. Training may be provided in many formats to include live (in person or via videoconference), computer-based training, or a pre-recorded video. Education shall not be limited to annual formal training requirements. The compliance officer will seek opportunities to provide education on compliance topics and risks throughout the year. The Compliance Committee should ensure there is a mechanism for participants to ask questions about the content. For example, the training materials could encourage individuals to submit questions to the compliance officer via email. The training's effectiveness is evaluated by testing or written evaluations and/or monitoring and auditing activities. Records of each employee's completion of compliance training sessions are maintained according to the record retention schedule.

The Compliance Department strives to ensure that training and education for all team members and agents includes the dissemination of written policies and procedures regarding pertinent topics including but not limited to:

a) Fraud, Waste and Abuse
b) False Claims Act and Whistleblower Protections
c) Anti-Kickback Statute
d) Physician Self-Referral laws (STARK)
e) Deficit Reduction Act
f) Specific statutory and regulatory provisions
g) Applicable state civil or criminal laws
h) Detecting and preventing fraud, waste, and abuse
i) HIPAA Privacy & Security/HITECH, Identity Theft Prevention
j) Non-Retaliation

7. Effective Lines of Communication with the Compliance Officer and Disclosure Programs

An open line of communication between the compliance officer and staff, contractors, and agents, is critical to the successful implementation of a compliance program and the reduction of any potential for fraud, abuse, and waste. The Compliance Officer and Compliance Committee through a variety of methods communicate to team members, agents, volunteers and contractors, the Standards of Conduct, regulatory guidelines, and/or changes in the law. Communication methods can include one-on-one conversations, broadcast emails, mailings, education sessions, small and large-group meetings, and periodic distribution of pertinent publications.

Such lines of communication shall be accessible to all and allow compliance issues to be reported, including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified. Confidentiality and nonretaliation policies are distributed to all employees to encourage communication with the Compliance Officer and the reporting of incidents of potential fraud and other compliance concerns. See Section B. Reporting and Responding for more information.

8. Enforcement Standards: Consequences and Incentives

LPAH establishes and publicizes its procedures for identifying, investigating, and remediating (including re-training or discipline) actions that do not comply with our standards of conduct, policies and procedures, or federal and state laws.

LPAH imposes sanctions consequences as a result of noncompliant actions. Consequences can be remedial and non-punitive, punitive, or both and are consistently applied and enforced. All levels of employees are subject to the same consequences for commission of similar offenses. Sequences are appropriate when an individual's failure to detect a violation is attributable to ignorance, negligence, or reckless conduct. Intentional or reckless noncompliance may be subject to more significant sanctions.

Sanctions normally apply to the following situations:

a) Failure to report suspected problems
b) Participating in non-compliant behavior
c) Encouraging, directing, facilitating, or permitting non-compliant behavior
d) Failing to perform any obligation or duty required of team members relating to compliance with this Compliance and Ethics Program or applicable laws or regulations
e) Failure of supervisory or management personnel to detect non-compliance with applicable policies and legal requirements and this Compliance and Ethics Program, where reasonable diligence on the part of the manager or supervisor would have led to the discovery of any violations or problems.

Potential sanctions include:

a) Verbal warning
b) Written warning
c) Suspension
d) Termination, with or without liability for damages
e) Governmental prosecution

Sanctions for Employees and Volunteers

Sanctions for employees and volunteers are guided by established policies. Sanctions for contracted service providers are generally guided by the established contract policy and the terms of the contracts. Contractor relationships with any individual or entity which becomes excluded from participation in a federally funded healthcare program should be terminated upon conclusive verification of the exclusion, in accordance with federal and state law.

LPAH develops incentives and recognition opportunities to encourage participation in the compliance program. The compliance officer, compliance committee, and other leaders provide opportunities for recognition and incentives for compliance performance activities, contributions, and commitment to compliance throughout the year.

9. Risk Assessment, Auditing, and Monitoring

The Compliance Officer and Compliance Committee implements an on-going risk assessment and internal review process to identify and address the types of risks facing the organization, the

probability of those risks occurring, and the impact those risks would have on the organization. Such risks include, but are not limited to, the risk associated with submitting claims for items and services furnished to Medicare and Medicaid program beneficiaries and the Anti-Kickback Statute and Stark Law risks associated with arrangements. The Compliance Officer conducts assessments and interviews with key personnel dealing with operational and billing issues. The Compliance Committee also reviews issues identified in the OIG annual work plans, CMS Bulletins, Recovery Audit Contractor audit plans, new federal and state laws and regulations, and changes to federal and state laws and regulations to determine those items that present a risk to the organization. The Compliance Committee quantifies the risks and develops the annual work plans that identify those areas that will be monitored or reviewed and the timeframe for accomplishing those reviews. The results of the risk assessment and the annual work plan are submitted to the Board of Directors and the Board approves the annual work plan. The Compliance Committee utilizes the annual work plan to develop a detailed annual audit and monitoring plan.

Monitoring And Auditing Systems

Generally. The Compliance Committee performs a compliance risk assessment on an annual basis and develops a work plan for auditing and monitoring based on risks identified. The Compliance Officer supervises and coordinates systems for periodic monitoring and auditing compliance with legal requirements. Tools and procedures are developed to be used at the facility and corporate office level to monitor on-going compliance efforts by the facilities and corporate office.

Billing, Coding, and Reimbursement Audits. The Compliance Officer monitors the conduct of periodic audits of billing/coding and clinical documentation. The Compliance Officer and Chief Operating Officer coordinate regular meetings with contracted therapy provider to monitor therapy utilization, clinical documentation, and billing issues. Audit procedures are implemented that are designed primarily to determine accuracy and validity of coding and billing submitted to Medicare/Medicaid, other federal health programs, and other payors. In addition, special attention will be given to reviewing the reasons given for claim denials and frequent billings of certain procedure codes, and to analyzing other facts which may suggest inappropriate conduct.

Any suspected incidents of non-compliance will be reported to the Compliance Officer, Compliance Committee, and the Department Manager where such suspected noncompliance is occurring. Suspected fraudulent activities will be reported to General Counsel and the Board.

The Compliance Officer coordinates the ongoing review of industry publications, including OIG Special Fraud Alerts, to identify failures to comply with any applicable requirements, examine all applicable statutes and regulations including those pertaining to fraud, waste and abuse, Medical Record Coding, Medicare/Medicaid billing, and antitrust.

10. Vendor Relationships

Policies are followed to help ensure relationships with vendors are maintained in compliance with applicable laws, statutes, and regulations. Policies and written agreements, when applicable, address issues including but not limited to:

a) Compliance with Anti-Kickback Statutes and Physician Self-Referral (Stark) Laws

b) Gifts and Gratuities/Inducements for Referrals

c) HIPAA Privacy and Security/Identity Theft Prevention

d) Maintaining Licensure and Certification

e) Screening (Exclusion from Federal Healthcare Programs and State Medicaid Programs)

f) Civil Rights/Nondiscrimination

g) Compliance With Federal and State Regulations for Specific Licensed/Certified Healthcare programs

h) Liability Insurance Coverage

i) Maintenance of Required Clinical and Financial Records

j) Written Agreements Requirements for Services Billed to Medicare/Medicaid

k) Sanctions For Compliance Violations

B. Reporting and Responding

1. Reporting System

The organization has both a voluntary and mandatory reporting system. The organization's integrity hotline is a voluntary reporting system which can be accessed by anyone, including employees, agents, residents and referring healthcare practitioners. The organization has established a mandatory reporting policy that requires employees and agents to report any suspected violations of the Standards of Conduct, Compliance policies, Operational policies or any law or regulation.

2. Integrity Hotline 1-844-995-4905 or EveryAge.ethicspoint.com

The organization has established an integrity hotline, a toll-free service that allows employees and consumers to report any issues or concerns regarding adherence to our Compliance and Ethics Program. This service allows individuals to report their concerns confidentially or anonymously without fear of retaliation. The integrity hotline is available for calls or online reporting 24 hours a day, 7 days a week.

3. Mandatory Reporting Policy

Any employee who suspects that another employee or agent has violated the Standards of Conduct, Compliance policies, Operational policies, or any law or regulation, should immediately report his/her suspicion to the employee's direct supervisor, the Community Executive, Compliance Officer, or the Chief Human Resources Officer. An employee, who for any reason is uncomfortable reporting a suspected violation to any of the above-referenced individuals, is encouraged to report his/her concerns to the integrity hotline. All reports of suspected violations will be treated confidentially to the extent permitted by law. The organization will promptly and thoroughly investigate any suspected violation in as confidential a manner as possible and take appropriate disciplinary action if warranted. EveryAge has a zero tolerance for retaliation or reprisal towards any individual who reports a suspected compliance violation.

It is important to the integrity of our operation that all claims of suspected violations be thoroughly reviewed and investigated so that appropriate action can be taken, as necessary.

4. Investigating Reports of Noncompliance

Violations of the Compliance and Ethics Program, failures to comply with applicable federal and state law, and other types of misconduct threaten our organization's status as a reliable, honest, and trustworthy provider, capable of participating in federal healthcare program. The organization strives

to ensure that all allegations of failure to comply are promptly and thoroughly investigated and that there is a prompt and appropriate response to all government inquiries.

The Compliance Officer coordinates investigations and works with the Chief Human Resources Officer and other members of the Compliance Committee, to investigate compliance violations. These are general guidelines to be utilized when investigating reports of potential compliance violations. The guidelines may need to be altered for cases which are reported anonymously or through an integrity hotline, or as otherwise deemed appropriate. The extent of the investigation will vary depending upon the issues and circumstances.

a) Interview the complainant as soon as possible after the report of the alleged violation. Interviews can be held over the telephone or the chat feature on the Integrity Hotline portal, or in person and should be private and confidential. Encourage the complainant to disclose all facts and other relevant information regarding this or any other alleged violation. If appropriate, request a signed written summary of his/her complaint. Remind the complainant that the organization will not tolerate any form of retaliation for having made the complaint, and that the complainant should immediately report any retaliation or threatened retaliation to the Compliance Officer or to the Human Resources department. Even if the Complainant states that he/she does not want anyone to “get in trouble,” or does not want an investigation to occur, the investigator should explain to the complainant that the organization has a legal responsibility to investigate any allegation that is other than trivial.

b) Interview and/or request written statements from any witnesses or other persons with knowledge regarding the alleged violation, which based on the circumstances may include residents, vendors, and other providers, as appropriate. Interviews should take place in as confidential a manner as possible. Explain to the witnesses that the organization will not tolerate any form of retaliation for having participated in the investigation, and that the witness should immediately report any retaliation or threatened retaliation to the Compliance Officer or to the Human Resources department. Encourage the witnesses to disclose all facts and relevant information to enable the organization to make an informed decision. Non-employee witnesses should not be compelled to talk. When appropriate, witnesses who are employees should be required to submit a written statement. Refusal by an employee to cooperate with an investigation will be subject to disciplinary action up to and including termination. Carefully document interviews. If no witnesses are named, the Compliance Officer should make a determination as to whether the scope of the investigation should be broadened. The Compliance Officer should also make a determination as to whether it is appropriate at that time to refer the matter to a criminal and/or civil law enforcement agency.

c) Investigate the alleged compliance violation in a confidential manner. Explain to those being interviewed or being asked to submit written statements that a complaint has been made concerning a possible compliance violation, and that no conclusions or decisions have been made by the organization. Advise any personnel involved in the investigation that disciplinary action up to and including termination will occur if he/she is not truthful or makes any material omissions. Carefully document interviews and/or obtain written statements.

d) Make an initial determination as to whether the alleged compliance violation occurred, and the appropriate disciplinary action that should result if an employee is involved in the compliance violation.

e) If the Chief Human Resources Officer agrees that a violation has occurred after reviewing the

Compliance Officer's investigation, he/she should make a final determination as to appropriate discipline. If a senior manager has engaged in a compliance violation, the Compliance Officer may elect to refer final authority on the appropriate discipline to the President or the Board of Directors.

f) Notify the complainant informing him/her when the organization's investigation has concluded. The communication should emphasize the organization's anti-retaliation policy.

g) Prepare and submit any necessary government report.

h) Submit any necessary refund to the appropriate government agency or third-party payor.

i) Prepare any necessary notices or disclosures and report the findings to the President and Board of Directors.

5. Responding to Government Investigations

Government investigators may arrive unannounced at our offices or at the homes of present or former employees and seek interviews and documentation. The organization maintains a mechanism for the orderly response to government investigations and audits to enable us to protect the interests of clients, team members and the organization, as well as appropriately cooperate with the investigation. The organization will cooperate with any appropriately authorized government investigations or audit; however, we will assert all protections afforded by law in any such investigation or audit.

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III. Standards of Conduct

Introduction

Lake Prince At Home, LLC (LPAH) has adopted a Compliance and Ethics Program to help ensure that LPAH operates in full compliance with applicable laws. An important component of the program is the Standards of Conduct, which sets out basic principles which all of LPAH and LPAH subsidiaries, directors, officers, team members and agents must follow. These Standards apply to all business operations and team members. Agents of LPAH, such as volunteers, contractors or external advisors and consultants, should also be directed to conduct themselves in a manner consistent with these Standards when they are acting on behalf of LPAH. If you have any questions about the Standards or its applicability to a particular situation, please contact your supervisor or the Compliance Officer.

The Compliance and Ethics Program and these Standards are not intended to and should not be deemed or construed to provide any rights, contractual or otherwise, to any team members or to any third parties. The Standards of Conduct are comprised of the following principles:

STANDARDS OF CONDUCT: Principle 1

Our team members and agents strive for honesty and integrity while delivering quality services that are necessary to attain or maintain the physical, psychosocial, mental and spiritual well-being of our clients.

- A fundamental principle on which LPAH will operate its business is full compliance with applicable laws. LPAH will also conduct its business in conformance with sound ethical standards. Achieving business results by illegal acts or unethical conduct is not acceptable. Our team members and agents should act in compliance with the requirements of applicable law and these Standards in a sound ethical manner when conducting business and operations.
- Our team members and agents should respect a person's dignity and treat him or her with consideration, courtesy and respect, with recognition of the needs of the ill, aged, cognitively impaired and dying.
- Our team members and agents should maintain the integrity and reputation of our organization and maintain truthful communications with our clients.
- Our team members and agents should observe appropriate standards of informed consent and refusal of treatment.
- Our team members and contracted agents should ensure that only the medically necessary intensity and duration of services are provided to clients and billed to Medicare, based on individual client needs and not levels of reimbursement.
- In order to make intelligent decisions, our clients should receive information about our organization, policies and procedures, charges, and who will provide services on behalf of our organization.
- Our team members and agents strive to provide appropriate and sufficient treatment and services based on an accurate assessment and plan of care that address their conditions.
- Our team members and agents should have sufficient education, licenses, background experience, on the job training and supervision to render services to our clients.
- No deficiency or error should be ignored or covered up. A problem should be brought to the attention of those who can properly assess and resolve the problem.

- Team members and agents should receive clear instructions about what is expected of them.
- Our team members and agents should strive to do their jobs so that no harm is caused to our clients, ourselves or the public.
- Our team members and agents should protect each client from neglect; verbal, mental or physical abuse; exploitation; misappropriation of personal property; corporal punishment; and involuntary seclusion. Any such incident should be reported to the agency Administrator and other officials of our organization for investigating and reporting, as required by law. Team members and agents are responsible for reporting reasonable suspicions of a crime against a client to the designated State Agency and local law enforcement in accordance with Federal and State reporting requirements.
- Our team members and agents should protect clients against the inappropriate use of physical or chemical restraints.
- Our team members and agents should provide clients with personal privacy and access to their personal records, and should respect and protect the confidentiality of medical, financial and other personal information records. Team members and agents should refrain from revealing any personal or confidential information unless supported by legitimate business or client care purposes and in accordance with law.
- Our team members and agents should safeguard financial affairs of each client we serve.

STANDARDS OF CONDUCT: Principle 2

Our team members and agents strive to comply with all applicable laws and regulations that affect our various businesses.

- Team members and agents should promptly report all suspected violations of the Standards of Conduct, compliance policies, operational policies, laws or regulations.
- Our team members and agents should not pursue any business opportunity that requires engaging in unethical or illegal activity.
- Neither our organization, nor our team members or agents should pay team members, physicians, or other healthcare professionals, directly or indirectly, in cash or by any other means, for referrals. Every payment to a referral source must also be supported by proper documentation that the services contracted for were in fact provided.
- No team member or agent is authorized to enter into any joint venture, partnership or other risk sharing arrangement with any entity that is a potential or actual referral source unless the arrangement has been reviewed and approved by our legal counsel.
- Our team members and agents should be completely honest in all dealings with government agencies and representatives.
- Team members or agents who perform billing and/or coding of claims must take every reasonable precaution to help ensure that their work is accurate, timely and in compliance with federal and state laws and regulations and our policies.
- No misrepresentations should be made and no false bills or requests for payment or other documents should be submitted to government agencies or representatives. No falsification of medical, time or other records pertaining to Client care and services or billing for such care and services will be tolerated.

- Our team members and agents should bill only for services that are medically indicated, ordered by the physician, actually rendered and which are fully documented in the client's clinical records. If the services must be coded, then only billing codes that accurately describe the services provided should be used.
- Team members certifying the correctness of records submitted to government agencies, including claims or requests for payment, should have knowledge that the information is accurate and complete before giving such certification. Team members should act promptly to investigate and correct problem if errors in claims that have been submitted are discovered. Complete and thorough clinical and billing records should be maintained.
- All drugs or other controlled substances should be maintained, dispensed and transported in conformance with all applicable laws and regulations.
- Our team members, agents and business associates have a responsibility to safeguard protected health information in compliance with HIPAA and HITECH Act requirements. Protected Health Information (PHI) violations should be reported to the Compliance Officer or IT Director (HIPAA Security Officer) immediately so the required investigation can be initiated.

STANDARDS OF CONDUCT: Principle 3

Our team members and agents strive to engage in ethical business relationships and practices.

- Our organization strives to not employ or contract with any person or entity ineligible to participate in federally funded healthcare programs. We conduct pre-engagement and periodic exclusion screening.
- Team members or agents should not use or reveal any confidential information concerning our organization or use, for personal gain, confidential information obtained as a team member or agent of our organization.
- Team members and agents should be honest in doing their jobs; should safeguard passwords, user ID codes, electronic signatures and any other authorization they have that allows access to protected information.
- Team members and agents should be honest and forthright in any representations made to Clients, vendors, payers, other team members or agents and the community.
- All reports or other information required to be provided to any federal, state or local government agency should be accurate, complete and filed on time.
- The source or amount of payment should not determine the quality of care that we deliver.
- During nonworking time, team members are not permitted to provide any services for compensation to Clients or their representatives.
- Team members and agents should not offer or give any bribe, payment, gift or thing of value to any person or entity with whom LPAH has or is seeking any business or regulatory relationship except for gifts of nominal value which are legal and given in the ordinary course of business. Team members must promptly report the offering of gifts above a nominal value to the agency Administrator.
- Team members and agents may not request or accept any gift or gratuity in any amount from a Client, Client's family member or representative, that is cash or a cash equivalent including a check, a gift card, a credit or discount for a service or product, a personal loan, or payment for a service or product received by the team member or agent. Gifts which are not cash, or a cash equivalent may be accepted from a Client, Client's family or representative only if they have not been requested and do not exceed $25.00 in value in

any calendar year. Any gift accepted by a team member or agent must be reported to the agency Administrator and documented immediately.

- Team members and agents should not directly or indirectly authorize, pay, promise, deliver or solicit payment, gratuity, or favor for the purpose of influencing any political official or government employee in the discharge of that person's responsibilities. Team members and agents should not entertain government personnel in connection with the Organization's business.

STANDARDS OF CONDUCT: Principle 4

Our team members and agents strive to avoid either conflicts of interest or the appearance of impropriety.

- Team members and agents should not have other jobs that interfere with their ability to perform their duties at our agency.
- Team members and agents should avoid any activity that conflicts with the interests of our organization or its clients. They should try to avoid even the appearance of an impropriety. If a team member or agent suspects that a conflict may exist or be created, then he or she should consult with management.
- Placing business with any firm in which there is a family relationship may constitute a conflict of interest. Team members and agents must report any potential conflicts of interest concerning themselves or their family members to management.
- Team members and agents should not engage in any financial, business or other activity which competes with LPAH business which may interfere or appear to interfere with the performance of their duties that involve the use of LPAH property, facilities, or resources, except to the extent consistent with the conflict of interest policies. Team members should not become involved, directly or indirectly, in outside commercial activities that could improperly influence their actions. For example, a team member or agent may not be an officer, director, manager or consultant of a potential competitor, client, or supplier of our organization without first disclosing that relationship to management.
- There should not be any business activities conducted between LPAH and other entities, which would give the appearance of corruption, bribery, facilitation payments or other types of inappropriate inducement. Other than compensation from LPAH and as consistent with the conflict of interest policies, team members should not have a financial or other personal interest in a transaction between LPAH or any of its business operations and a vendor, supplier, provider or customer.
- Team members and agents should not accept or provide benefits that could be seen as creating conflict between their personal interests and our organization's legitimate business interests or could be seen as inducing or rewarding the referral or generation of business. This includes accepting expensive meals, gifts, refreshments, transportation, lodging or entertainment provided or received in connection with the job. The value of free passes for educational sessions, conferences, expositions and related lodging provided by an individual vendor may not exceed $50.00 per year.
- Gifts and benefits given to or received from clinicians or referral sources are not appropriate. Occasional gifts that are limited to reasonable meal expenditures or entertainment or that are of nominal value are discouraged, although not prohibited. Gifts of cash or can be converted to cash are prohibited.
- Team members may not be appointed to serve as an agent in a general power of attorney or a healthcare power of attorney for clients unless the team member is an immediate family member of the individual or

has been appointed to serve as the individual's agent through legal proceedings. Team members may not serve as a notary or as a witness in executing a healthcare power of attorney for any client. Team members may not serve as a witness for a client in executing a general power of attorney, or any other document where there is potential for a conflict of interest.

- All political activities relating to LPAH should be conducted in full compliance with applicable law. No LPAH funds or property should be used for any political contribution or purpose unless first approved by the Political Action Committee. Team members may make direct contributions of their own money to political candidates and activities, but these contributions will not be reimbursed.
- Team members and agents should comply with applicable antitrust laws. There should be no discussions or agreements with competitors regarding price or other terms for product sales, prices paid to suppliers or providers dividing up customers or geographic markets, or joint action to boycott or coerce certain customers, suppliers or providers.
- LPAH and its team members and agents should not engage in unfair competition or deceptive trade practices including misrepresentation of LPAH products or operations.

STANDARDS OF CONDUCT: Principle 5

Our team members and agents strive to protect our property and respect the property rights of others with whom we do business.

- All team members and agents are personally responsible and accountable for the proper expenditure of our funds and for the proper use of company property and must obtain authorization prior to committing or spending our organization's funds.
- Medical waste or other hazardous materials should be disposed as required by law.
- Team members and agents may not use our resources or the resources of a client for personal or improper purposes or permit others to do so.
- Surplus, obsolete or junked property should be disposed of in accordance with written procedures.
- Books and records should be created, maintained, retained or destroyed in accordance with the schedule outlined in the record retention and destruction policy.
- Team members and agents have a duty to be productive during the time that is paid for by our organization.
- Team members and agents may only use computer systems, networks and software consistent with our license(s) and/or rights. They should take all reasonable steps to protect computer systems and software from unauthorized access or intrusion.
- Any improper financial gain to the team member through misconduct involving misuse of our property or a client's property is prohibited, including the outright theft of property or embezzlement of money. Team members and agents should report any observed misuse of property to management.
- Drugs and other pharmaceuticals should be safely stored, secured, inventoried, and missing supplies should be reported promptly to supervisors.
- Team members and agents should maintain confidentiality of LPAH business information and of information relating to LPAH's vendors, suppliers, providers and customers. Our confidential and proprietary information is valuable and team members should not use any confidential or propriety information except as appropriate

for business. Team members should not seek to improperly obtain or to misuse confidential information of LPAH's competitors.

STANDARDS OF CONDUCT Principle 6

Our team members and agents strive to respect each other as human beings and professionals.

- All team members and agents should show proper respect and consideration for each other, regardless of position or station. All team members and agents are responsible for ensuring that the work environment is free of discrimination or harassment due to age, race, gender, color, religion, national origin, disability, and sex (including sexual orientation and gender identity) or covered veteran status. Discriminatory treatment, harassment, abuse, or intimidation will not be tolerated.
- All team members and agents should maintain confidentiality in the workplace among themselves, our clients, family members and guests in an effort to maintain a harmonious work environment. Personal information about self or others should not be disclosed to individuals who do not have a "need to know" for conducting business in the workplace. When requesting or providing personal information, it should be limited to the minimum amount necessary to get the job done.
- Quality care can only be delivered through the use of qualified, competent team members. Our organization will contribute to team member or agent competence by making available continuing job-related education and training, and team members are responsible for completion of assigned training and education.
- Applicants and team members should be afforded equal employment and advancement opportunities, according to our policies.
- Team members and agents should conform to the standards of their respective professions and exercise sound judgment in the performance of their duties in a way that promotes the public's trust in our organization. No team member or agent should subordinate his or her professional standards, judgment or objectivity to any individual. Any differences of opinion in professional judgment should be referred to appropriate management levels for resolution in accordance with standard grievance procedures.
- Team members and agents are expected to provide only truthful and accurate information when reporting a compliance concern for investigation and/or providing information to investigators during an investigation.
- Team members and agents should follow safe work practices and comply with all applicable safety standards and health regulations.
- We strive to maintain a working environment free from all forms of sexual harassment including the creation of a hostile working environment or intimidation. By way of example, unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature are prohibited and will not be tolerated.
- We promote a tobacco, drug and alcohol-free workplace in accordance with our policies which team members and agents are required to follow.
- We do not permit any action of retaliation or reprisal to be taken against an individual who reports a violation of law, regulation, standard, procedure, or policy.

These Standards have been distributed to all team members and agents and sets forth general standards applicable to all business and operations. In addition, there are a number of more detailed and specific

policies covering particular subject matters. LPAH will communicate those specific policies to team members who are particularly affected by and who must comply with them in the course of LPAH business. A current set of such policies is available at LPAH worksites (and on the computer network). A team member who does not already have network access may review them by contacting his/her supervisor or the Compliance Officer.

IV. Pertinent Laws and Statutes

Federal Civil False Claims Act

Pursuant to the Deficit Reduction Act of 2005, LPAH is required to provide to team members contractors and agents, educational information on the Federal and State False Claims Acts and whistleblower protection laws aimed at preventing and detecting fraud, waste and abuse in healthcare programs. Annual compliance training addresses False Claims Act provisions and whistleblower protections, and such information appears in the Employee Handbook.

The federal civil False Claims Act, 31 U.S.C. § 3729, et seq., ("FCA") was originally enacted in 1863 to combat fraud perpetrated by defense contractors against the United States Government during the Civil War. The current version of the FCA was enacted in 1982 and was amended in 1986; however, the FCA's purpose, to protect the United States government from fraud, waste and abuse, remains unchanged.

The FCA prohibits any "person" from:

A. Knowingly submitting a false or fraudulent claim for payment to the federal government or causing such a claim to be submitted;

B. Knowingly making or using a false record or statement to secure payment from the federal government for a false or fraudulent claim or causing such a false record or statement to be made or used; or

C. Conspiring to get a false or fraudulent claim paid by the federal government.

The FCA specifically states that a person acts "knowingly" when that person: (1) has actual knowledge of the information, (2) deliberately ignores the truth or falsity of the information, or (3) recklessly disregards the truth or falsity of the information. The FCA also defines the term "claim" as any request or demand for money or property where the United States government provides any portion of the money or property which is requested or demanded.

A person who has violated the FCA must repay all of the falsely obtained reimbursement and is liable for a civil penalty of up to $11,000 and three times the amount of actual damages the federal government sustained for each false claim that was submitted. In addition, a person who has violated the FCA may be terminated from participation in federal healthcare programs, including the Medicare and Medicaid programs.

Both the United States Attorney General and private citizens may bring lawsuits alleging a violation of the FCA. When brought by private citizens, these actions are known as qui tam lawsuits, and the citizens who file these suits are known as "relators" or "whistleblowers." When a relator brings a qui tam action, the United States government may choose to intervene in the lawsuit and exercise primary responsibility for prosecuting, dismissing, or settling the claim. If the government declines to intervene, the relator can pursue the suit individually. As a reward for filing the action, a qui tam relator may receive between fifteen and thirty percent of the sum recovered for the government, in addition to attorneys' fees and other expenses. Alternatively, if a court determines that a relator's suit was frivolous, clearly vexatious, or brought primarily to harass the defendant, the relator will have to reimburse the defendant for the fees and costs it spent defending the lawsuit.

The FCA offers "whistleblower protection" to individuals who bring suit pursuant to the FCA. If these individuals are discharged, demoted, suspended, threatened, harassed, or discriminated against because of their involvement in an FCA claim, the individual may bring suit against his or her employer. A court may then determine

that the individual is entitled to reinstatement, twice the amount of back pay plus interest, attorneys' fees, and other costs and expenses.

Federal Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986, 31 U.S.C. § 3801, *et seq*., ("PFCRA") imposes administrative remedies against a person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false to certain federal agencies, including the United States Department of Health and Human Services. The PFCRA states that a person "knows or has reason to know" that a claim or statement is false if the person: (1) has actual knowledge that the claim or statement is false, fictitious, or fraudulent, (2) deliberately ignores the truth or falsity of the claim or statement, or (3) acts in reckless disregard of the truth or falsity of the claim or statement. The PFCRA, like the FCA, defines a "claim" as any request or demand for money or property where the United States government provides any portion of the money or property which is requested or demanded.

A person who violates the PFCRA may be assessed civil money penalties of up to $5,000 per false claim and as much as twice the amount of each claim. The PFCRA generally applies to claims valued at less than $150,000. Alleged violations of the PFCRA are investigated by the agency to which the false claim was submitted, and enforcement actions may be brought only with the approval of the United States Attorney General.

Virginia Fraud Against Taxpayers Act

The Virginia Fraud Against Taxpayers Act (Virginia Code §8.01-216.1 *et seq*.) protects the Commonwealth by imposing liability on anyone making a knowingly false or fraudulent claim to the Commonwealth for money or property. The statute imposes treble damages, civil penalties, attorney's fees, and costs on those who violate its terms.

Any "person" with first-hand information about false claims fraud against the Commonwealth of Virginia can hire their own *qui tam* counsel and prosecute a case in the name of the Commonwealth. Such individuals are called "relators" in the language of the statute, and they are entitled to receive anywhere from 15 to 30 percent of the Commonwealth's recovery.

A. *Examples of a possible false claim …*
   1. Making false statements regarding a claim for payment;
   2. Falsifying information in the medical record;
   3. Double billing for items or services;
   4. Billing for services or items not performed or never furnished;
   5. Billing for services where the quality of care was substandard to the extent that there appears to be no real benefit to the recipient.

B. *What should be done if a possible false claim has been made?*

   1. If a team member discovers an event that is similar to one of the examples of a false claim above, a team member is encourage to:

      a) Report to the Compliance Officer 828.465.8022 for further investigation. If the team member is not comfortable doing this;

      b) The Team member should contact the integrity hotline 1.844.995.4905 or EveryAge.ethicspoint.com.

   2. A team member is not required to report a possible FCA violation to the LPAH first. A report may be made directly to the Department of Justice or applicable state authorities. However, in many instances LPAH believes that the use of its internal reporting process is a better option because it allows our compliance

office to quickly address potential issues. LPAH encourages team members to consider first reporting suspected false claims to the Compliance Officer, but the choice is up to the team member.

3. LPAH will not retaliate against any team member for informing us or the federal or state government of a possible FCA violation.

Anti-Kickback Statute

The Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal healthcare program. Kickbacks may include:

A. Cash or gifts for referrals
B. Free rent or below fair-market value rent for medical offices
C. Free clerical staff, and
D. Excessive compensation

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (Stark Law) (42 U.S.C. Section 1395nn) prohibits doctors from referring Medicare beneficiaries for certain designated health services (e.g., clinical laboratory services, physical therapy, and home health services) to an entity in which the doctor (or one of the doctor's immediate family members) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Examples include:

A. Ownership/investment in a business
B. Compensation for referrals, and
C. Business connections with family members

Conditions of Participation

CMS develops Conditions of Participation (CoPs) that Hospice and Home Health Agencies must meet in order to begin and continue participating in the Medicare program. These health and safety standards are considered the foundation for improving quality and protecting the health and safety of Medicare beneficiaries; and they specify the institutional planning standards that Hospice and Home Health Agencies must meet. These Conditions of Participation appear in 42 Code of Federal Regulations, Part 418 (Hospice) and 42 Code of Federal Regulations, Part 484 (Home Health).

Board Approval: 8.28.19
Procedures Revised: 1.8.2021; 10.15.2021; 12.22.2021; 2.15.2023; 5.31.2024; 7.5.2024

APPENDIX A
Compliance Policies

Table of Contents

Copies Are Available Upon Request:

Compliance Office
Lake Prince At Home
100 Leonard Avenue
Newton, NC 28658
828.464.8264
Fax 828.465.8537

Chief Quality and Compliance Officer: 828.465.8022
Integrity Hotline: 1.844.995.4905 or EveryAge.ethicspoint.com; CHAP Hotline: 1.800.656.9656
Chief Human Resources Officer: 828.465.8535

Discrimination is Against the Law

Federally Funded Healthcare Programs

Lake Prince At Home (LPAH) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). Lake Prince Woods does not exclude people in health programs and activities or treat them less favorably because of race, color, national origin, age, disability, veteran status, or sex.

LPAH provides:

- Reasonable modifications and free appropriate auxiliary aids and services to people with disabilities so they can communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, please contact the Administrator, Brandi Spivey, Phone: 757-923-5542 TTY: 7-1-1

If you believe that LPAH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, veteran status, or sex, you can file a grievance with:

Brandi Spivey, Administrator
Lake Prince At Home
Telephone: 757-923-5542 TTY: 7-1-1 Fax: 757-257-0421 Email: BSpivey@everyage.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Brandi Spivey, Administrator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

OCR complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available on the Lake Prince At Home homepage at https://lakeprincewoods.org/lake-prince-at-home/.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-757-923-5542 (TTY: 7-1-1) o hable con su proveedor.

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-757-923-5542 (TTY: 7-1-1) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-757-923-5542 (Người khuyết tật: 7-1-1) hoặc trao đổi với người cung cấp dịch vụ của bạn.

注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費 提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電1-757-923-5542 (TTY:7-1-1)或與您的提供者討論。

تنبيه إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية .كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانا .اتصل على الرقم)رقم هاتف الصم والبكم :7-1-1) .(1-757-923-5542(أو تحدث إلى مقدم الخدمة

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-757-923-5542 (TTY: 7-1-1) o makipag-usap sa iyong provider.

توجه :اگر فارسی صحبت می کنید، خدمات کمک زبان رایگان در اختیار شما قرار می گیرد .خدمات کمکی و کمکی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس هستند .با شماره 1-757-923-5542 (TTY: 7-1-1) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-757-923-5542 (TTY: 7-1-1) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

دھیان دیں :اگر آپ اردو بولتے ہیں تو مفت زبان کی مدد کی خدمات ہیں۔
آپ کے لیے دستیاب ہے۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-
1-757-923-5542 (TTY: 7-1-1) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-757-923-5542 (TTY: 7-1-1) ou parlez à votre fournisseur.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-757-923-5542 (телетайп: 7-1-1) или обратитесь к своему поставщику услуг.

ध्यान दें: यहद आप ह िंदी बोलते ैं, तो आपकेहलए हनिःशुल्क भाषा स ायता सेवाएिं उपलब्ध ोती ैं। सुलभ प्रारूपोिंमेंजानकारी प्रदान करनेकेहलए उपयुक्त स ायक साधन और सेवाएँभी हनिःशुल्क उपलब्ध ै 1-757-923-5542 (TTY: 7-1-1) पर कॉल करेंया अपनेप्रदाता सेबात करें ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie: 1-757-923-5542 (TTY: 7-1-1) an oder sprechen Sie mit Ihrem Provider.

Í ŢĘőŢĽő : Þ ęŔ ĽŔ’ěőĽźĞĎőěŢĽĘ ąőŇŢĽ ŔĘő ŗŢĽÇĹőŃőńŇźą őęŔŢŃěőÞ ęĘő’ ČĘÇ×ęĽΦl ýÇŢŵńŢĽő ÇĚl’Í ÇŢ¯ ąĎÇņdőŢĘ’ ČĘÇ ×ęĽŔ ńŇźĞńŇźą ő½ěð ęŔŢŃěő Ŕ¾ŔĘő ŗŢĽÇęő¾źőĽźl ĞĽ Ğ¬Ę 1-757-923-5542 (TTY: 7-1-1) ýĎěőÞ ęĘő’ ņdőĘĞő’l’ ńőŢĎĞĎő ěĽŘl

IHE: Ọ bụrụ na ị na-asụ Ibo, ọrụ enyemaka asụsụ efu dị gị. Enyemaka na ọrụ kwesịrị ekwesị iji nye ozi n'ụdị enwere ike dịkwa n'efu. Kpọọ 1-757-923-5542 (TTY: 7-1-1) ma ọ bụ gwa onye na-eweta gị okwu.

AKIYESI: Ti o ba sọ Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-757-923-5542 (TTY: 7-1-1) tabi sọrọ si olupese rẹ.