WEST VIRGINIA
SECRETARY OF STATE
BETTY IRELAND
ADMINISTRATIVE LAW DIVISION

Form #3

Do Not Mark In This Box

FILED

2006 JUL 28 P 3:26

OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Department of Health and Human Resources Human Services TITLE NUMBER: 78

CITE AUTHORITY: WV Code 49-2B-4.et.seq.

AMENDMENT TO AN EXISTING RULE: YES X NO ____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 3

TITLE OF RULE BEING AMENDED: "Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia"

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Martha Yeager Walker
Authorized Signature

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Minimum Licensing Requirements to Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia

Type of Rule: x Legislative _____ Interpretive _____ Procedural

Agency: **HEALTH AND HUMAN RESOURCES**

Address: **Capitol Complex, Building 3, Room 206**

Charleston, WV 25305

Phone Number: **558-0684** Email: jeansheppard@wvdhhr.org

Fiscal Note Summary

Summarize in a clear and concise manner what effect this measure will have on costs and revenues of state government.

This proposed rule reflects changes to minimum licensing requirements to residential child care and treatment facilities for children and transitioning adults in West Virginia. Calculating the fiscal impact of this proposed rule change is extremely difficult due to the numerous variables used in calculation of rates for child care.

Under the current rules the variables used in calculating rates fluctuate period to period. Every six months rates are calculated which are used to reimburse providers for services. To calculate the rates we use cost reports and census data. Total costs in state dollars for one six month period may not be representative of total state dollars in a future six month period.

A change to the rules adds another factor into cost projections. Total fiscal impact may not be known until after the new rule is implemented and we have 18 to 24 months of cost report history to do projections.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

Effect of Proposal	Fiscal Year		
	2006 Increase/Decrease (use"-")	2007 Increase/Decrease (use"-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	0	0	0
Personal Services			
Current Expenses			
Repairs and Alterations			
Equipment			
Other			
2. Estimated Total Revenues			

3. Explanation of above estimates (including long-range effect):

Please include any increase or decrease in fees in your estimated total revenues.

Memorandum

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

Date	Agency	Authorized Representative
6/27/2006	Department of Health and Human Resources	Martha Yeager Walker Martha Yeager Walker Secretary

Brief Summary

Title 78
Legislative Rule
Department of Health and Human Resources

Series 3

Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia

This proposed rule repeals and replaces the existing rule for regulating residential child care. The rule was developed in collaboration with the West Virginia Child Care Association, the Alliance for Children, the Office for Behavioral Health Services (OBHS), the Office of Health Facilities Licensure and Certification (OHFLAC), the Bureau for Children and Families (BCF) and representative child welfare agencies. Numerous meetings were held over a multi-year period to develop and finalize the rule. The rule will;

- Combine requirements for child welfare agencies and behavioral health centers into a single licensure rule;
- Integrate best practice standards as advanced by the Council on Accreditation (COA) into West Virginia standards;
- Incorporate changes into the rule regarding types of licenses made by House Bill 4790;
- Revise requirements for background checks for employees to be consistent with the current policy of the Department of Health and Human Resources; and,
- Permit residential child care agencies to continue serving foster children past their eighteenth birthday under certain conditions.

Statement of Circumstances

Title 78
Legislative Rule
Department of Health and Human Resources

Series 3

Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia

During the last legislative session, the Legislature passed House Bill 4790, which is effective June 11, 2006, and affects WV Code §49-2B, et seq. This bill revises the types of license which may be issued to agencies and provides for a variable length of time for the license. It also limits provisional licenses to one six month period, which may not be renewed. In addition, House Bill 4790 permits residential child care agencies to serve foster children beyond their eighteenth birthday. In order to comply with the terms of the bill, the Department of Health and Human Resources is required to promulgate emergency rules for group residential programs for children on or before September 1, 2006.

Group residential programs for children that also provide behavioral health services are currently required to be licensed by both the Bureau for Children and Families (BCF) and the Office of Health Facilities Licensure and Certification (OHFLAC). Dual licensure was believed to be an undue burden on residential child care facilities, leading to an initiative to eliminate dual licensure and create a single licensure rule that is acceptable to both entities. A committee was then developed, including representatives of BCF, OHFLAC, the Office of Behavioral Health Services (OBHS), the Alliance for Children, the West Virginia Child Care Association and representative child welfare agencies. Legislation was passed (House Bill 4790) in 2006 which allowed the new draft rule to be promulgated.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period; Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: July 28, 2006

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM:(*Agency Name, Address & Phone No.*) Department of Health and Human Resources
Bureau for Children and Families
350 Capitol Street
Room 691
Charleston, WV 25301
304-558-7980

LEGISLATIVE RULE TITLE: 78CSR3 "Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia"

1. Authorizing statute(s) citation WV Code 49-2B-4 et seq

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

June 26, 2006; appeared in the June 30, 2006 issue of the State Register.

b. What other notice, including advertising, did you give of the hearing?

Notice was sent to DHHR staff, effected licensed residential facilities, the Alliance for Children, the West Virginia Child Care Association, members of the committee that helped draft the rule, and was posted on the DHHR web site.

c. Date of Public Hearing(s) ***or*** Public Comment Period ended:

Public Comment Period ended on July 26, 2006.

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received _____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

July 28, 2006

f. **Name, title, address and <u>phone/fax/e-mail numbers</u>** of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)

Kathie D. King
Department of Health and Human Resources
350 Capitol Street
Room 691
Charleston, WV 25301
304-558-7980 (phone)
304-558-4563 (fax)
kking@wvdhhr.org

g. **<u>IF DIFFERENT</u> FROM ITEM 'f'**, please give **Name, title, address and phone number(s)** of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Same

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

b. Date of hearing or comment period:

_____

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

_____

d. Attach findings and determinations and reasons:

Attached _____

SUMMARY OF RESPONSES TO COMMENTS

Title 78
Legislative Rule
Department of Health and Human Resources
Series 3
Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia

Comment # 1: The "Authority" cited for CSR 78-3 Rulemaking is WV Code, 49-2B-4 et. seq. WV Code, 49-2B authorizes the regulation of (and rulemaking for) out-of-home professional CHILD CARE settings in WV. The Code specifically excludes hospital/inpatient settings from this rule-making authorization. The Proposed Rule attempts to include rules/rulemaking for these (hospital/inpatient) settings.

Response # 1: WV Code 49-2B-4(a) states "the Secretary shall promulgate rules in accordance with the provision of chapter twenty-nine-a of this code regarding the licensure, approval, certification and registration of child care facilities and the implementation of the provisions of this article...". §49-2B-2(g) defines child care as "responsibilities assumed and services performed in relation to a child's physical, emotional, psychological, social and personal needs and the consideration of child's rights and entitlements, but does not include secure detention or incarceration under the jurisdiction of the Division of Juvenile Services..." §49-2B-2(m) defines facility as a "place or residence, including personnel, structures, grounds and equipment, used for the care of a child or children on a residential or other basis for any number of hours a day in any shelter or structure maintained for that purpose...".

The proposed rule (78-3-2.1.c.) applies to:

- Psychiatric residential treatment facilities for persons under age twenty-one;
- Residential crisis support/Emergency shelter care;
- Residential maternity and parenting facilities;
- Group residential child care settings;
- Outdoor therapeutic educational facilities;
- Intermediate care facilities for persons with mental retardation; and,
- Therapeutic residential schools.

All of the above fall within the code definitions of child care and facility.

WV Code 49-2B-3(e)(4) states the code does not apply to "hospital or other medical facilities which are primarily used for temporary residential care of children for treatment, convalescence or testing". The proposed rule (78-3-2.3.a.6.) exempts "hospitals or other medical facilities which are primarily used for temporary residential care of children for treatment, convalescence or testing".

The proposed rule does not attempt to include rules/rulemaking for hospital/inpatient settings and is congruent with WV Code 49-2B.

Comment # 2: Change 3.7 to read loss of "Human Rights" instead of privileges. Loss of privileges is a normal consequence of negative behavior.
Response # 2: The rule will not be modified. Loss of privileges is a type of aversive procedure which must be reviewed as part of the continuous quality improvement process in order to assure that it is being applied appropriately.

Comment # 3: Standards 4.5.d and 4.5.f. are repetitive.
Response # 3: The correction was made.

Comment # 4: Does 4.11 and 4.11.a. refer simply to time cards to prove quantification of staff supervision or will this be interpreted to mean that we be expected to conduct time studies regarding the quantification of staff supervision time upon request of the DHHR? If the latter is the case, will there be specific DHHR time study procedures/forms will we be expected to follow and use?
Comment # 4: Time studies regarding the quantification of staff supervision time, using DHHR procedures and forms may be requested for the purpose of documenting use of federal funds.

Comment # 5: 6.2.a.1 refers to "time out" as a restrictive technique, but the definition of time out does not infer that it is a restrictive technique.
Response # 5: The correction was made.

Comment # 6: The concern with 10.2.e. has to do with the issues involving staffing patterns and staff assignments that exist with youth in a program prior to turning 18, the possibility of having to change them because the youth simply turned age 18. Does this mean that all staff assigned to a cottage must be age 25 if one of the youth in the youth in that cottage has turned 18? We recommend the elimination of the rule or language that clarifies it in a manner that is not so limiting.
Response # 6 : The intent of the provisions for minimum age of employment for persons working in residential child care facilities is to assure that employees responsible for the care, supervision and well being of the residents are sufficiently mature to be able to handle such responsibilities. Having employees who are of the same or approximate age of the residents for which they are responsible can and has been problematic. The rule has been clarified in a way that still addresses the intent, but is less limiting to facilities.

Comment # 7: 10.2.j. and 16.1 are duplicative.
Response # 7: The correction was made.

Comment # 8: Does 13.1.a. mean we have to send a copy to each individual member of the MDT or only to the chairperson of the MDT who would then be responsible for disseminating it?
Response # 8: The designated "chair" of the MDT should be provided copies of assessments and care plans.

Comment # 9: Does 14.12.b.1. indicate that facilities may care for children under the age of 6 (six)?
Response # 9 : That was not the intent and a clarification has been added.

Comment # 10: 14.15.b expects residents to be supervised at all times unless resident is engaged in activity away from supervision authorized by the clinical team. In context of how incidents would be classified (e.g. critical, mandatory) at the time the incident occurred or will it be interpreted as having direct eye contact of each and every child. If interpreted using the latter, this would require an agency in essence to have 1:1 supervision of youth at all times.
Response # 10: The term "supervision" will be interpreted as defined in 3.83 of the rule: "the observation, oversight, and guidance of the resident or group of residents by the staff member(s) assigned to their care". This is the minimal standard for supervision that residential child care facilities must meet. The employee assigned to the care of a group of 6 (six) residents must be actively engaged in the observation, oversight and guidance of the group. An incident of lack of supervision may or may not rise to the level of child abuse or neglect as defined in code, depending upon the circumstances.

Comment # 11: 17.2.a.2. cites that in calculating staff to consumer ratios, if a staff member has any other job responsibility beyond that of providing child care, treatment or supervision, is excluded from the ratio. Does this mean responsibilities at the specific time that the child care, treatment or supervision is being conducted, or does it mean any other job responsibility in the employee's job description. How will this be interpreted? Does this mean a cook, or administrative personnel may not be counted in the ratio, even if they help, at any given moment, in providing care, treatment or supervision. In small agencies it is not unusual for any staff (be it the Director, Office Manager, et.al.) to be involved in the care treatment or supervision of youth at a given moment, and we all work with the youth. Depending on how this is interpreted, an administrative person on-call could be called in due to a crisis or emergency but not be counted in the ratio, thus putting us in violation of this standard. The position is that if ALL staff required to receive ALL the licensing required training (as outline in standard section 11.2), what would be the rational for then excluding them from being allowed to be counted in the ratio at any given time. As another example, what about an overnight emergency in which the supervisory/administrative on-call person is called in and fills in for a regular staff member who may be ill. Would this standard then be interpreted that the supervisory/administrative on-call person is not counted in the ratio?
Response # 11: The intent of section 17.2 is to assure that residents receive adequate supervision. At a minimum, a staff person must be on duty and assigned to direct care of the residents at a ratio of 1 staff for every 6 residents. At the time they are assigned to providing care and supervision of the residents, they must be observing, overseeing and guiding the resident or group of residents. An employee may have more than 1 job function, but at the time he/she is assigned to the resident or group of residents to provide direct care and supervision, he/she may not also be engaged in another job function at the same time. For example, if a cook also performed direct care as part of her employment, she may not be in the kitchen, away from the residents, preparing meals while she is also assigned to direct care of the residents. She would be unable to perform observation, oversight and guidance of the residents if she was in another part of the facility. If however, once the meal preparation was over, she was assigned to provide direct care to the residents, she could do so. There is nothing that would preclude

administrative staff from filling in for direct service staff and be counted as part of the ratio at any given time.

Comment # 12: In 17.2.c.1 and 17.2.c.3, the ratio requirement states that a staff to consumer minimum of 1:6 is required. How is "present" going to be interpreted? Ratio of 1:12 during sleeping hours with at least one staff member awake. Is the interpretation of this standard mean physically present in the building where a consumer is located? What if we have two staff present, and one is with our youth in the cottage with some youth and the other is in another non residential living unit building (e.g. recreation building) with some youth. Would we be cited in such an occurrence? The interpretation of this is critical.
Response # 12: "Present" will be interpreted to mean physically located within the site/cottage/living unit. The number of staff required in the situation described, would depend on the number of residents involved. For example, if there are 11 residents of the cottage and 6 remain in the cottage while 5 go to the recreation building, there would need to be (minimally)1 staff in the cottage and 1 in the recreation building.

Comment # 13: It is acceptable to give breast milk that has been in the refrigerator for 48 (not 24 as your rule says) hours or the refrigerator freezer for 2 weeks (your rule says this correctly) AND it is good for 3 MONTHS if stored in a deep freeze.
Response # 13: The rule was modified.

Comment # 14: The rule as currently drafted omits the definition of "transitioning adult" as found in HB 4790 in §49-2B-2(x). The absence of a definition for a "transitioning adult" within the rule could lead to varying interpretations of its scope and intent. Further, it results in a reading of the rule that violates the stated legislative purpose of Article 2B as written in §49-2B-1(e)4 that persons and entities offering child care are not unduly burdened by licensure and registration requirements. The rule addresses licensing for facilities providing services to both children and transitioning adults but the rule only elects to define "child" and omits the definition of transitioning adult. This contributes to additional confusion within the rule. Northwood Health Systems requests that the agency clarify 78CSR 3 by adding the definition of transitioning adult as defined in §49-2B-2(x) to the body of the rule. Additionally, Northwood continues to evaluate to determine if it is in full compliance with State Code and the expressed policy and purpose contained in §49-2B-1.
Response # 14: The definition of transitioning adult was added to the rule.

Comment # 15: Regarding 17.2.c.1, must staff be present in living units when residents are not present?
Response # 15: No. The rule was modified.

Comment # 16: 72 hours seems like a long time to wait to notify parents or guardians of their child's admission to emergency shelter.
Response # 16: 18.2.e.6. was modified to shorten the time frame.

Comment # 17: There is no standard addressing dangerous areas or highways.
Response # 17: The rule was modified to include 12.8.c.

Comment # 18: There is not a requirement for insect screening.
Response #18: The rule was modified to include 12.9.y.

Comment # 19: A requirement to repair or replace broken furnishings is missing.
Response # 19: The rule was modified to include 12.1.b.1 and 12.1.b.2.

Comment # 20: Requirements pertaining to clothing, personal hygiene, personal belongings and religion are missing.
Response # 20: The rule was modified and those requirements were included in 14.18,14.19, 14.20 and 14.21.

Comment # 21: WV Code, 49-2B identifies specific "PURPOSES" of the Legislation. Two PRIMARY "purposes" (intents) are identified:

a. To assure the HEALTH, SAFETY AND WELL-BEING of all WV children Receiving out-of-home, professional CHILD CARE

b. To assure that professional Child Care providers are not overly "encumbered" with (unnecessary and/or excessive) regulation

Clearly the Legislative intent was/is to assure a balance between the protection of the vulnerable population of children in out-of-home child care settings and the legitimate business interests of the professional child care providers. The Proposed Rule, CSR 78-3, does not "balance" these interests. Instead, it supports (real and perceived) Provider interests at the expense of CHILD "health, safety and well-being".
Response # 21: Specific examples of standards that support provider interests at the expense of child health, safety and well-being would have to be cited in order to respond.

Comment # 22: In drafting National Child Care Standards and in individual State Rulemaking/Rule-Revision, the issue of STAFF-CHILD RATIO is identified as one of the most critical factors in assuring child "health, safety and well-being". The National/Professional trend {Child Welfare League of America (CWLA), National Association of Regulatory Administration (NARA)}and "best-practice" is to RAISE the Staff-Child Ratio whenever possible and wherever, economically feasible. The Proposed Rule, CSR 78-3, LOWERS WV's Staff-Child Ratio in Group Residential settings. The current Rule requires TWO staff whenever (even only) ONE child is present. The Proposed Rule would require ONE staff, "on the UNIT". (At Crittenton, compliance with this proposed "requirement" would mean that ONE staff person could -merely- be on the Residential floor while all the Residential Girls could be out, on their own, on National Road.) "Unit" is not a Child Care but a Medical/Inpatient term.

Aside from the obvious, dramatic and extremely harmful impact such a staff-child ratio would have on child health, safety and well-being, this is an (unfortunate) example of Providers buying into and supporting a Proposed

Rule which, to them, appears to be a money-saver. In fact, such a staffing requirement (one staff per "Unit") will also, most certainly, negatively impact them because of WV's cost-based reimbursement formula.

Finally, the Bureau for Children and Families will be held totally responsible (and liable) for the inevitable harm, injury and/or damage which kids will incur who are living on the "one staff per unit" because the Provider will be in full COMPLIANCE with the (Proposed) Rule.

Response # 22: There are multiple sections of the proposed rule which address minimal requirements for staffing and supervision, including;

3.83. Supervision -- The observation, oversight, and guidance of the resident or group of residents by the staff member(s) assigned to their care.

14.15. Staff Supervision

14.15.a. At all times, the organization shall have sufficient staff to allow the number of children being served to be adequately supervised, taking into consideration the level of severity and need of the children involved. The organization must consider appointments requiring staff supervision, staff leave, possible illness of children and any other relevant factor when scheduling staff and child activities.

14.15.b. Residents are expected to be supervised at all times unless the resident is engaged in an activity away from supervision authorized by the clinical team (e.g., home visit, public school, employment, recreation, etc.).

14.15.c. The organization shall have a policy regarding ratios of staff to children specific for each of the various program settings and activities.

14.15.d. The organization shall have a policy regarding staff supervision which shall ensure the safety, supervision and security of children who are acutely disturbed and/or suicidal.

14.15.e. The organization shall have a policy regarding supervision of children/youth in off grounds activities which shall maximize the supervision and safety of children/youth participating.

14.15.f. The organization shall ensure that when children or youths leave a facility for overnight visits, there is a procedure for signing or being checked in and out of the program. The checklist or sign-in sheet shall be dated and shall include time in/out, person responsible for the child/youth, as appropriate, and the location at which the child/youth may be contacted if necessary.

17.2. Staff Ratios and Training

17.2.a. Staff, for the purposes of this section, is defined as those individuals who are:

17.2.a.1. Fully oriented and trained according to organizational policy; and

17.2.a.2. Have job responsibilities which pertain only to the provision of child care, treatment and supervision.

17.2.b. The group residential program shall have a policy regarding care and supervision of residents that ensures that:

17.2.b.1. Children receive adequate supervision for their age, developmental functioning and emotional and behavioral needs; and

17.2.b.2. The care plan as developed by the interdisciplinary team is implemented as written for each child.

17.2.c. Children/youth shall be cared for and supervised at the following levels, with clinically justified modifications when house parents are employed:

17.2.c.1. Minimum of staff to resident ratio of 1:6 during waking hours when residents are on grounds with a minimum of one staff present per residential living unit at all times when residents are present in the living unit;

17.2.c.2. Availability of additional or back-up care personnel for emergency situations or to meet special needs presented by the persons in care (e.g., physician's appointments, behavioral outbursts, acute suicidal, etc.); and

17.2.c.3. Staff to resident ratio of 1:12 during sleeping hours with a minimum, of at least one staff per residential living unit to be awake at all times when residents are present in the living unit.

17.2.d. The organization shall have a policy regarding supervision of children/youth in off-grounds activities which shall ensure that children are adequately supervised at all times.

17.2.e. As appropriate to the ages and needs of persons in care, the organization shall ensure that one or more trained professional staff members is on duty or available via an on-call system on a 24-hour basis to provide continuous supervision to each residential living unit within a residential program.

17.2.f. The organization which utilizes a house parent model shall have a policy that ensures the safety and supervision of children at night.

In addition, there are other supervision and staffing standards which apply to program specific populations in emergency shelter care, maternity and parenting facilities, outdoor therapeutic educational programs, psychiatric residential treatment facilities, intermediate care facilities and therapeutic residential schools.

The intent of the proposed rules are not to lower the number of staff required, but to allow facilities the flexibility to deploy those staff more effectively where they are most needed, based upon the age, developmental and treatment needs of the residents.

The proposed rule would not permit one staff person to be on the residential floor while all the residential girls could be out on National Road.

"Living Unit" is a term that is used and defined in the existing 78CSR3 rule, "Minimum Licensing Requirements for Group Residential Facilities in West Virginia" promulgated by the legislature in 1982.

Comment # 23: The Proposed Rule, CSR 78-3, was withdrawn from the normal Rulemaking process because of numerous, identified (and unidentified) deficiencies. Instead of addressing and correcting these deficiencies, the Rule was (with only minor and non-substantive revisions) resubmitted to the process as an "EMERGENCY" Rule.

The current Rule (which regulates Group Residential Child Care settings in WV)has protected vulnerable children in out-of-home residential settings since 1982 with no major nor minor revisions. This Rule has effectively and consistently assured the "health, safety and well-being" of our kids residing in Group Residential settings.

The recent Sago Mine Disaster NECESSITATED the EMERGENCY promulgation of new, more effective Mine Safety Rules in WV. No such tragedy or harm in Group Residential Child Care justifies the promulgation or attempted promulgation of Proposed Rule, CSR 78-3, on an EMERGENCY basis (thank you, God!)

The "EMERGENCY" promulgation of CSR 78-3 is an attempt to circumvent the (stringent and prescribed) Rulemaking process in WV and to adopt a Rule which is full of deficiencies and which DOES NOT ASSURE CHILD HEALTH, SAFETY AND WELL-BEING. The Proposed Rule, if promulgated, will be unenforceable because of these many, serious technical and substantive deficiencies.

I urge the WVDHHR and, especially, the Bureau for Children and Families, to:

+Withdraw the Proposed "Emergency" Rule, CSR 78-3 from the Rulemaking process

+Research current National Standards and individual State Rules pertaining to Group Residential Facilities for children and include in this research Rules pertaining specifically to Detention Facilities for Juveniles

+Consult with the CWLA and NARA regarding National trends, Standards and Regulation pertaining to Group Residential Facilities for children, paying particular attention to Standards, Regulations and "best practice" relating to Staff-Child Ratios in these settings.

+Redraft this Rule (CSR 78-3) so that we all, but especially our KIDS in out-of-home care, CAN "LIVE" WITH IT

A QUALITY draft/redraft WILL FLY through the Rulemaking process!

Response # 23: The proposed rule was not withdrawn from the normal rulemaking process. This public comment period is part of the normal rule making process. The proposed rule was filed both as an emergency rule and a proposed rule and will continue through the entire legislative rule making process.

The current rule is an adequate rule, with some needed revisions to update it with current existing conditions and to strengthen some areas of requirements.

The proposed rule has been in development since early 2002, subsequent to the Legislature's instruction to the Department to identify a way to eliminate duplicative licensing by the Bureau of Children and Families (BCF) and the Office of Health Facilities Licensure and Certification (OHFLAC). A committee of various representatives from BCF, OHFLAC, the Bureau for Behavioral Health Services (BHS), legislative staff , child welfare and behavioral health agencies met multiple times to draft the rule. The proposed rule was sent to the committee, to effected licensees and DHHR staff multiple times for review and comment before the filing. Numerous revisions have been made based upon input from others.

Part of the development of the proposed rule included review of the Council on Accreditation (COA) standards for group care residential services, Child Welfare League of America (CWLA) standards on restrictive behavior management, state rules from Pennsylvania, Tennessee, New Jersey, Ohio, North Carolina and Virginia and West Virginia state rules for Juvenile Detention and Correctional Facilities, Behavioral Health Centers and Day Care Centers.

Specifically, the requirements for staff/resident ratio in the proposed rule either meet or exceed the standards for all 6 states reviewed, the COA standards, and the West Virginia state rules for Behavioral Health Centers and Juvenile Detention and Correctional Facilities. A check with the National Association of Regulatory Administrators (NARA) indicated they do not have a formal position on recommended staff/resident ratios in child welfare facilities.

The proposed rule is partly modeled after and congruent with the COA standards for group residential services.

The proposed rule does not include licensure for juvenile detention or correctional facilities, as WV Code exempts them from DHHR licensure, so there is no need to further explore rules specifically pertaining to detention facilities for juveniles.

The citation of specific deficiencies in the standards would be more helpful in responding to requests for changes.

From: Kathie King
To: Peggy Cartus
Date: 07/31/2006 4:15:49 PM
Subject: Re: Comments Pertaining to PROPOSED RULE CSR 78-3-Group Residential Facilities

Thank you for taking the time and interest to comment. It was difficult to respond to some of the comments as there were no specific examples or regulations cited. A summary of all of the comments and response is attached for your information.

Kathie D. King
Program Manager
Residential Child Care Licensing and Institutional Investigative Unit (IIU)

>>> "Peggy Cartus" <intake@crittentonservices.com> 07/25/2006 9:56:02 AM >>>
Hi, Kathie!

I would like to make the following comments pertaining to CSR 78-3 "Minimum Licensing Requirements for Group Residential Facilities in West Virginia".

1. The "Authority" cited for CSR 78-3 Rulemaking is WV Code, 49-2B-4 et. seq. WV Code, 49-2B authorizes the Regulation of (and Rulemaking for) out-of-home, professional CHILD CARE settings in WV. The Code specifically excludes hospital/inpatient settings from this Rulemaking authorization. The Proposed Rule attempts to include rules/rulemaking for these (hospital/inpatient) settings.

2. WV Code, 49-2B identifies specific "PURPOSES" of the Legislation. Two PRIMARY "purposes" (intents) are identified:
   a. To assure the HEALTH, SAFETY AND WELL-BEING of all WV children receiving out-of-home,
      professional CHILD CARE
   b. To assure that professional Child Care providers are not overly "encumbered" with
      (unnecessary and/or excessive) regulation
Clearly the Legislative intent was/is to assure a balance between the protection of the vulnerable population of children in out-of-home child care settings and the legitimate business interests of the professional child care providers. The Proposed Rule, CSR 78-3, does not "balance" these interests. Instead, it supports (real and perceived) Provider interests at the expense of CHILD "health, safety and well-being".

3. In drafting National Child Care Standards and in individual State

Rulemaking/Rule-Revision, the issue of STAFF-CHILD RATIO is identified as one of the most critical factors in assuring child "health, safety and well-being". The National/Professional trend {Child Welfare League of America (CWLA), National Association of Regulatory Administration (NARA)}and "best-practice" is to RAISE the Staff-Child Ratio whenever possible and wherever, economically feasible. The Proposed Rule, CSR 78-3, LOWERS WV's Staff-Child Ratio in Group Residential settings. The current Rule requires TWO staff whenever (even only) ONE child is present. The Proposed Rule would require ONE staff, "on the UNIT". (At Crittenton, compliance with this proposed "requirement" would mean that ONE staff person could -merely- be on the Residential floor while all the Residential Girls could be out, on their own, on National Road.) "Unit" is not a Child Care but a Medical/Inpatient term.

Aside from the obvious, dramatic and extremely harmful impact such a staff-child ratio would have on child health, safety and well-being, this is an (unfortunate) example of Providers buying into and supporting a Proposed Rule which, to them, appears to be a money-saver. In fact, such a staffing requirement (one staff per "Unit") will also, most certainly, negatively impact them because of WV's cost-based reimbursement formula.

Finally, the Bureau for Children and Families will be held totally responsible (and liable) for the inevitable harm, injury and/or damage which kids will incur who are living on the "one staff per unit" because the Provider will be in full COMPLIANCE with the (Proposed) Rule.

4. The Proposed Rule, CSR 78-3, was withdrawn from the normal Rulemaking process because of numerous, identified (and unidentified) deficiencies. Instead of addressing and correcting these deficiencies, the Rule was (with only minor and non-substantive revisions) resubmitted to the process as an "EMERGENCY" Rule.

The current Rule (which regulates Group Residential Child Care settings in WV)has protected vulnerable children in out-of-home residential settings since 1982 with no major nor minor revisions. This Rule has effectively and consistently assured the "health, safety and well-being" of our kids residing in Group Residential settings.

The recent Sago Mine Disaster NECESSITATED the EMERGENCY promulgation of new, more effective Mine Safety Rules in WV. No such tragedy or harm in Group Residential Child Care justifies the promulgation or attempted promulgation of Proposed Rule, CSR 78-3, on an EMERGENCY basis (thank you, God!)

The "EMERGENCY" promulgation of CSR 78-3 is an attempt to circumvent the (stringent and prescribed) Rulemaking process in WV and to adopt a Rule which is full of deficiencies and which DOES NOT ASSURE CHILD HEALTH, SAFETY AND WELL-BEING. The Proposed Rule, if promulgated, will be unenforceable because of these many, serious technical and substantive deficiencies.

I urge the WVDHHR and, especially, the Bureau for Children and Families, to:

+Withdraw the Proposed "Emergency" Rule, CSR 78-3 from the Rulemaking process

+Research current National Standards and individual State Rules pertaining to Group Residential Facilities for children and include in this research Rules pertaining specifically to Detention Facilities for Juveniles

+Consult with the CWLA and NARA regarding National trends, Standards and Regulation pertaining to Group Residential Facilities for children, paying particular attention to Standards, Regulations and "best practice" relating to Staff-Child Ratios in these settings.

+Redraft this Rule (CSR 78-3) so that we all, but especially our KIDS in out-of-home care, CAN "LIVE" WITH IT

A QUALITY draft/redraft WILL FLY through the Rulemaking process!

Thank you for the opportunity to present these comments to your consideration.
Peg

Peggy Cartus MA, LCSW, LPC
Coordinator of Intake Services
Crittenton Services, Inc.
304-242-7060 ext. 168

Please visit our new website:
www.florencecrittenton.net

CC: Kathy Szafran; Tracee Chambers

From: Kathie King
To: Scott Boileau
Date: 07/31/2006 4:08:40 PM
Subject: Re: Comment on Draft Licensing Regulations

Thank you for taking the time and interest to comment on the proposed residential child care rule. We did revise reg 10.2.e. as a result of your comment. A summary of all comments and responses is attached.

Kathie D. King
Program Manager
Residential Child Care Licensing and Institutional Investigative Unit (IIU)

>>> "Scott Boileau" <sboileau@alliance4children.org> 07/25/2006 5:13:41 PM >>>
Kathie,

On behalf of the newly formed WV Residential Care Providers Network we would like to submit the following comments regarding the draft residential child care regulations.

We recognize that these regulations have been developed over time with the input of many and commend that effort. In fact we believe that the result of that process is a contributing reason to why we little or no additional comments to make at this stage of the process. We certainly appreciate the opportunity to participate, and comment while acknowledging the work that has gone into the draft regulations.

We have one comment. Under the section for Personnel Practices, regulation 10.2.e - If a program serves transitioning adults up to age 21, the age of the staff must be at least 25.

Our concern has to do with the issues involving staffing patterns and staff assignments that exist with a youth in a program prior to turning 18 the possibly having to change them because the youth simply turned age 18. Does this mean that all staff assigned to a cottage must be age 25 if one of the youth in that cottage has turned 18?

We recommend the elimination of the rule or language that clarifies it in a manner that is not so limiting.

Thank you for the opportunity to comment and if you have any questions please do not hesitate to contact me.

Scott Boileau.

CC: Andi Bennett (Alliance); Arlene Glover; Carolyn Yokum (Elkins Mountain School); Doug Huntt; Mark Spangler; sheila@bumfs.org; Susanne Cole (Pressley Ridge); Tony Warnick (Cammack Children's Center)

From: Kathie King
To: Dr. Mary Boyd
Date: 07/31/2006 4:42:30 PM
Subject: Re: Breastmilk storage in Child Care regs

Thank you for taking the time and interest to comment on the proposed rule. As a result of your comment, a revision to the regulation regarding the storage of breast milk was made. A copy of a summary of all comments and responses is attached for your information.

Kathie D. King
Program Manager
Residential Child Care Licensing and Institutional Investigative Unit (IIU)

>>> "Dr. Mary Boyd" <mboydmd@ccbridge.net> 07/24/2006 2:07:49 PM >>>
Dear Kathie:
I am commenting on your rules r.e. breastmilk storage. It is acceptable to give milk that has been in the refrigerator for 48 (not 24 as your rule says) hours or the regrigerator freezer for 2 weeks (your rule says this correctly), AND it is good for 3 MONTHS if stored in a deep freeze. If you need some proof of these comments, I can get it for you.

Dr. Mary S. Boyd,
Breastfeeding Coordinator, WV-AAP

From: "Dr. Mary Boyd" <mboydmd@cebridge.net>
To: <kking@wvdhhr.org>
Date: 07/24/2006 2:13:45 PM
Subject: CDC table for child care regs

Kathie: Here is a table from the CDC, which is originally prepared by the Academy of Breastfeeding Medicine:

Breastfeeding: Recommendations: Proper Handling and Storage of Human Milk

By following safe preparation and storage techniques, nursing mothers and caretakers of breastfed infants and children can maintain the high quality of expressed breast milk and the health of the baby.

Safely Preparing And Storing Expressed Breast Milk

a.. Be sure to wash your hands before expressing or handling breast milk.
b.. When collecting milk, be sure to store it in clean containers, such as screw cap bottles, hard plastic cups with tight caps, or heavy-duty bags that fit directly into nursery bottles. Avoid using ordinary plastic storage bags or formula bottle bags, as these could easily leak or spill.
c.. If delivering breast milk to a child care provider, clearly label the container with the child's name and date.
d.. Clearly label the milk with the date it was expressed to facilitate using the oldest milk first.
e.. Do not add fresh milk to already frozen milk within a storage container. It is best not to mix the two.
f.. Do not save milk from a used bottle for use at another feeding.

Safely Thawing Breast Milk

a.. As time permits, thaw frozen breast milk by transferring it to the refrigerator for thawing or by swirling it in a bowl of warm water.
b.. Avoid using a microwave oven to thaw or heat bottles of breast milk
  a.. Microwave ovens do not heat liquids evenly. Uneven heating could easily scald a baby or damage the milk
  b.. Bottles may explode if left in the microwave too long.
  c.. Excess heat can destroy the nutrient quality of the expressed milk.
c.. Do not re-freeze breast milk once it has been thawed.

Source: American Academy of Pediatrics.*

Storage Duration of Fresh Human Milk for Use with Healthy Full Term Infants

Location Temperature Duration Comments

Countertop, table Room temperature (up to 77°F or 25°C) 6-8 hours Containers should be covered and kept as cool as possible; covering the container with a cool towel may keep milk cooler.

Insulated cooler bag 5-39°F or -15-4°C 24 hours Keep ice packs in contact with milk containers at all times, limit opening cooler bag.

Refrigerator 39°F or 4°C 5 days Store milk in the back of the main body of the refrigerator.

Freezer Store milk toward the back of the freezer, where temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower

quality.

Freezer compartment of a refrigerator 5°F or -15°C 2 weeks

Freezer compartment of refrigerator with separate doors 0°F or -18°C 3-6 months

Chest or upright deep freezer -4°F or -20°C 6-12 months

Reference: Academy of Breastfeeding Medicine. (2004) Clinical Protocol Number #8: Human Milk Storage Information for Home Use for Healthy Full Term Infants. *(PDF - 125K) Princeton Junction, New Jersey: Academy of Breastfeeding Medicine. Available

---

This site contains documents available in

From: Kathie King
To: Kathy Szafran
Date: 07/31/2006 4:11:34 PM
Subject: Re: WVCCA comments on Title 78 of Legislative Rule

Thank you for taking the time and interest to comment on the proposed rule for residential child care. All of your comments were considered and some revisions have occurred as a result of your input. A summary of all comments and responses is attached for your information.
>>> "Kathy Szafran" <kszafran@comcast.net> 07/25/2006 1:23:14 PM >>>

Dear Kathie,
Please find attached the accumulative comments of the WVCCA regarding the proposed Legislative Rule Title 78. We thank you allowing the providers to be an active participant in this lengthy process of the rule revisions. We appreciated being at the table and feel as if we truly did partner on this project. Thank you!

Kathy Szafran, MA, LPC
Vice President of the WVCCA
President and CEO
Crittenton Services, Inc.
Florence Crittenton Services, Inc.
2606 National Road
Wheeling, WV 26003
(304) 242-7060 Phone
(304) 242-7076 Fax

Visit our web site www.florencecrittenton.net

Make a referral or donation on line...

Transforming lives one child, girl or family at a time.

Kathie D. King
Program Manager
Residential Child Care Licensing and Institutional Investigative Unit (IIU)

message is legally privileged and confidential under applicable law and is intended only for the use of the individual or entity named above. If the recipient of this message is not the above-named intended recipient, you are hereby notified that any dissemination, copy or disclosure of this communication is strictly prohibited.

CC: Brian Hall; Carl White; Dennis Pease; Heather Gallagher; Joanne Dobrzanski; Renee Harrison; Steven W. Fairley; Terry McCormick

DRAFT LICENSING REGULATIONS
TITLE 78
WVCCA COMMENTS
July 25, 2006

SECTION	STANDARD	PAGE	COMMENT
78-3-4	4.5.d 4.5.f	13	These standards read exactly the same and are repetitive.
78-3-4	4.11 4.11.a	17	Does this standard refer simply to time cards to prove quantification of staff supervision or will this be interpreted to mean that we be expected to conduct time studies regarding the quantification of staff supervision time upon request of the DHHR. If the latter is the case, will there be specific DHHR time study procedures/forms/ we will be expected to follow and use.
78-3-13	13.1.a	53	Does this mean we have to send a copy to each individual member of the MDT or only to the chairperson of the MDT who would then be responsible for disseminating it.
78-3-14	14.15.b	73	Residents are expected to be supervised at all times unless resident is engaged in activity away from supervision authorized by the clinical team. In context of how incidents would be classified (e.g. critical, mandatory) how will "supervised" be interpreted. Will it be interpreted based on having the licensing required supervision level (i.e. 1:6) at the time the incident occurred or will it be interpreted as having direct eye contact of each of every child. If interpreted using the latter, this would require an agency in essence to have 1:1 supervision of youth at all times.
78-3-17	17.2.a.2	86	This standard cites that in calculating staff to consumer ratios, if a staff member has any other job responsibility beyond that of providing child care, treatment or supervision, is excluded from the ratio. Does this mean responsibilities at the specific time that the child care, treatment or supervision is being conducted, or does it mean any other job responsibility in the employee's job description. How will this be interpreted. Does this mean a cook, or administrative personnel may not be counted in the ratio, even if they help, at any given moment, in providing care, treatment or supervision. In small agencies it is not unusual for any staff (be it the

			Director, Office Manager, et.al.) to be involved in the care, treatment or supervision of youth at a given moment, and we all work with the youth. Depending on how this is interpreted, an administrative person on-call could be called in due to a crisis or emergency but not be counted in the ratio, thus putting us in violation of this standard. The position is that if ALL staff are required to receive ALL the licensing required training (as outlined in standard section 11.2), what would be the rationale for then excluding them from being allowed to be counted in the ratio at any given time. As another example, what about an overnight emergency in which the supervisory/administrative on-call person is called in and fills in for a regular staff member who may be ill. Would this standard then be interpreted that the supervisory/administrative on-call person is not counted in the ratio.
78-3-17	17.2.c.1	87	The ratio requirement states that a staff to consumer minimum of 1:6 is required . How is "present" going to be interpreted.
	17.2.c.3	87	Ratio of 1:12 during sleeping hours with at least one staff member awake. Is the interpretation of this standard mean physically present in the building where a consumer is located. What if we have two staff present, and one is with our youth in the cottage with some youth and the other is in another non residential living unit building (e.g recreation building) with some youth. Would we be cited in such an occurrence? The interpretation of this is critical.
78-3-3	3.7 Definitions		Would it be better to read loss of "Human Rights" instead of privileges? Loss of privileges is a normal consequence of negative behavior.
78-3-6	6.2.a.1		Refers to "time out" as a restrictive technique, but the definition of time out does not infer that it is a restrictive technique. As a matter of fact, it is pretty much the opposite whereas it cannot be coerced in any way and is used as a "cooling off" period.

From: Kathie King
To: joan phillips; Joan Skaggs
Date: 07/31/2006 4:06:26 PM
Subject: Re: Child Care Regs

Thank you for your comment. We have made the change you suggested regarding storage of breast milk.

Kathie D. King
Program Manager
Residential Child Care Licensing and Institutional Investigative Unit (IIU)

>>> joan phillips <jphill324@yahoo.com> 07/26/2006 9:15:39 AM >>>
Dear Kathy,

In response to change in Child Care regulation 15.4.h.7, I support the amendment to the regulation on the administration of Over the Counter medication (OTC). The "three days within 30 day" clause is a good safety factor for children. Pediatricians appreciate not having to write an order for every OTC given in child care centers.

In Section 16.11.e.12.D, I suggest changing the storage of breastmilk in the refrigerator to 48 hours instead of discarding in 24 hours. Dr Mary Boyd has sent to you literature documentation for this recommendation.
Joan Phillips MD FAAP
President WV Chapter

Comments from Cora Childers
Licensing Specialist, Bureau for Children and Families
July 21, 2006

14.12. b.1. indicates that children under the age of six may be admitted to group residential facilities.

72 hours seems like a long time to wait to notify parents or guardians of their child's admission to emergency shelter.

There is no standard addressing dangerous areas or highways.

Must staff be present in living units when residents are not present (17.2.c.1)?

There is no requirement for insect screening.

There is no requirement for repair or replacement of broken furnishings.

Requirements pertaining to clothing, person hygiene, personal belongings and religion are missing.

TITLE 78
LEGISLATIVE RULE
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SERIES 3
MINIMUM LICENSING REQUIREMENTS FOR RESIDENTIAL CHILD CARE AND TREATMENT FACILITIES FOR CHILDREN AND TRANSITIONING ADULTS IN WEST VIRGINIA

§78-3-1. General

1.1. Scope -- This rule establishes standards and procedures for the licensure of residential child care and treatment facilities under the provisions of W. Va. Code §§49-2B-1 et seq., 27-17-1 et seq., and related federal and state codes except as provided in §78-3-2.3. (relating to exemptions). The W. Va. Code is available in public libraries and on the Legislature's web page, http://www.legis.state.wv.us/. This rule should be read in conjunction with the provisions of W.Va. Code §§49-2B-1 et seq., 27-9-1, and 27-17-1 et seq.

1.2. Authority -- W.Va. Code §§49-2B, 27-17-3, 27-1A-4(g), 27-1A-6(6) and 27-1A-7.

1.3. Filing Date –

1.4. Effective Date. –

1.5. Repeal and Replacement of Former Rule -- This legislative rule repeals and replaces "Minimum Licensing Requirements for Group Residential Facilities in West Virginia," 78CSR3, effective June 1, 1982. These organizations shall be exempt from the requirements for "Licensure of Behavioral Health Centers," 64CSR11, effective July 1, 2000.

1.6. Purpose -- These standards are the basis for the licensing and approval of residential child care and treatment facilities in West Virginia. Licenses or certificates of approval are issued if the standards and applicable rules and regulations are met. The purpose is to protect the health, safety and well-being of children receiving care in residential facilities and to regulate the provision of out of home behavioral health treatment for children with behavioral, emotional and/or developmental challenges, placed in congregate treatment settings, through the formulation, application and enforcement of minimum licensing requirements. Nothing in these standards are intended to interfere with any requirements relating to funding streams.

§78-3-2. Application and Enforcement

2.1. The core rules (Sections 78-3-1 through 78-3-16.4.a) apply to all residential child care settings and congregate treatment settings, both public and private, that offer residential services to children and transitioning adults who have been separated from their family for the purpose of care and/or behavioral health treatment, except where otherwise indicated within this

rule. Organizations classified as foster family care by the Department of Health and Human Resources shall be exempt from this rule and shall be governed by the "Child Placing Agencies Licensure" (78 CSR 1, effective July 1, 2001). Each organization included in this rule shall comply with core requirements in addition to specialized modules as applicable to program provision.

2.1.a. This rule contains the minimum requirements that shall be met to obtain a license or certificate of approval to provide residential child care and treatment for children in West Virginia.

2.1.b. This rule applies equally to profit, nonprofit, publicly funded and privately funded facilities.

2.1.c. This rule applies to the following congregate living facilities serving children and transitioning adults:

2.1.c.1. Psychiatric residential treatment facilities for persons under age twenty-one;

2.1.c.2. Residential crisis support/Emergency shelter care;

2.1.c.3. Residential maternity and parenting facilities;

2.1.c.4. Group residential child care settings;

2.1.c.5. Outdoor therapeutic educational programs;

2.1.c.6. Intermediate care facilities for persons with mental retardation; and,

2.1.c.7. Therapeutic residential schools

2.2. Enforcement

2.2.a. This rule is enforced by the Secretary of the Department of Health and Human Resources.

2.3. Exemptions

2.3.a. This rule does not apply to the following:

2.3.a.1. A program exempted by the state or federal statute;

2.3.a.2. A program providing solely academic services accredited or operated by the state Department of Education;

2.3.a.3. Seasonal camps operated for children with a primary purpose of recreation, in which children are attending sessions for periods not exceeding thirty days;

2.3.a.4. Juvenile detention centers or juvenile correction facilities operated or contracted through the Department of Military Affairs and Public Safety;

2.3.a.5. Adoption and foster family care facilities recognized as such by the Department of Health and Human Resources; and,

2.3.a.6. Hospitals or other medical facilities which are primarily used for temporary residential care of children for treatment, convalescence or testing.

§78-3-3. Definitions

3.1. Administrator -- The designated person responsible for carrying out the governing body's policies and the day-to-day operation of the organization.

3.2. Advisory Council -- An association of persons that makes recommendations regarding the policies and procedures of an organization to the governing body of that organization, but having no proprietary interest in the organization or actual management or administrative authority.

3.3. Advocate -- A person or agency acting in the best interest of the child to establish, expand, protect and enforce the child's human, legal and civil rights.

3.4. Aftercare -- Services to be provided subsequent to a child's or youth's discharge from placement as identified in the discharge plan.

3.5. Appropriate State or Governmental Authority -- A state or local agency that has responsibility for or authority over an aspect of the operation of an organization.

3.6. Aversive Conditioning -- The application of startling, painful or noxious stimuli to a resident for the purpose of behavior management.

3.7. Aversive Procedures -- Restrictive procedures that impose undesirable consequences for inappropriate behaviors. Aversive procedures include, but are not limited to, physical restraint, chemical restraint, seclusion, fines or loss of privileges.

3.8. Behavior Support Plan. -- A written plan designed to teach adaptive behaviors and reduce or eliminate maladaptive behaviors.

3.9. Behavioral Health Services and Treatment -- Services designed to improve the adaptive functioning (including but not limited to emotional, behavioral, interpersonal, and age-appropriate independent functioning) of children or youth with mental illness; developmental disabilities; behavioral challenges; traumatic brain injuries expressed as emotional or behavioral difficulties; or substance abuse.

3.10. Care Plan/Plan of Care -- A document describing the services to be provided to a child/youth while in residential care and treatment. The plan of care shall describe the purpose and objectives of each service provided and shall address the needs of the child and family, as appropriate and as identified in the initial assessment and subsequent assessments. Synonymous with treatment plan.

3.11. Case Record/Clinical Record -- A comprehensive collection of information about a child or youth in the care of an organization providing residential treatment. A unified description and documentation of the evaluation, present and prospective services and treatment provided for the child while in the care of the organization.

3.12. Case Record Review -- The review of case records for accuracy, consistency, quality and compliance by an individual or group of individuals.

3.13. Child -- Any person under eighteen years of age or is a transitioning adult. (W.Va. Code §49-2B-2(e))

3.14. Child Abuse -- The threat to a child's health or welfare by a person who knowingly or intentionally inflicts, attempts to inflict or knowingly allows another person to inflict physical injury or mental or emotional injury upon the child; or sexual abuse or sexual exploitation (W.Va. Code §49-1-3).

3.15. Child Neglect -- The failure to provide adequate nutrition, clothing, shelter, supervision, medical care or education; or abandonment.

3.16. Child's Case Plan -- A comprehensive document prepared by the Department pursuant to the requirements of W. Va. Code §49-6-5 following an adjudication by the court that the child is an abused and/or neglected child, that directs the provision of services, including the services provided to the child and the provision of a permanent placement for the child.

3.17. Child-Specific Training -- Training provided to respond to the specialized needs of a particular child.

3.18. Civil Rights -- The rights of personal liberty guaranteed by the Constitutions of the United States and the State of West Virginia, by federal, and state laws.

3.19. Consequences—Logical and natural consequences are part of a disciplinary or educational plan to teach residents appropriate behavior and the effects of their behavior. Logical consequences are intentionally planned and designed to be similar to what would happen to an

adult in a similar situation. Natural consequences are outcomes that happen as a result of behaviors that are not planned or controlled. Consequences are relevant to the infraction, respectful and reasonable.

3.20. Continuous Quality Improvement -- A well defined process for assessing and improving the overall performance of the organization by identifying standards that will promote quality outcomes for persons served and modifying the organization's practices and services to meet those outcomes.

3.21. Corporal Punishment -- The intentional inflicting of pain or discomfort to the body through actions such as, but not limited to, striking or hitting with any part of the body or with an implement, or pinching, pulling or shaking.

3.22. Corrective Action Plan -- A written agreement between the Department and an agency, approved prior to implementation, that outlines the steps an agency shall take to correct non compliances identified by the Department through an inspection or the investigation of a complaint.

3.23. Criminal Identification Bureau (CIB) Record Check -- A fingerprinting process that identifies a person who has been arrested or convicted of criminal behavior.

3.24. Crisis Intervention Skills and Techniques -- Methods used to de-escalate situations that could result in harm to persons or property.

3.25. Critical Incident -- The alleged, suspected, or actual occurrence, including but not limited to any of the following involving a child in residential treatment: abuse, neglect, death due to any cause, attempted suicide, behavior that will likely lead to serious injury or significant property damage, fire resulting in injury, relocation or an interruption of services, any major involvement with law enforcement authorities, injury that requires hospitalization or results in permanent physical damage, life-threatening reaction because of a drug or food, a serious consequence resulting from an apparent error in medication or dietary administration, extended and unauthorized absence of a child that exceeds his or her plan of care provision for community access, or the unplanned removal of a child from either residential or program services.

3.26. Department -- The West Virginia Department of Health and Human Resources.

3.27. Detoxification -- The process of eliminating the toxic effects of drugs and alcohol from the body.

3.28. Direct Service Worker -- Any employee of an organization who works directly with children as a major function of his/her job.

3.29. Discharge -- The termination of a child's affiliation with an organization.

3.30. Discharge Planning -- The organized process of identifying the approximate length of stay and the criteria for exit of a child from the current service, and less restrictive alternatives for a later date. Discharge planning begins upon admission and includes provision for appropriate follow-up services.

3.31. Discipline -- A system of rules governing conduct in an organization which usually prescribes consequences for the violation of particular rules.

3.32. Documentation -- A record in compliance with this rule.

3.33. Family -- A group of one (1) or more adults and one or more children. The adults shall have a long-term commitment to caring for and rearing children.

3.34. Goal -- An expected result or condition that takes time to achieve, is specified in a statement of relatively broad scope, and provides guidance in establishing intermediate objectives directed toward its attainment.

3.35. Governing Body -- A person or persons with the administrative control and legal authority to set policy and oversee operations of an agency.

3.36. Human Resources -- All persons providing services within an organization including all employees, volunteers, student interns and consulting professionals.

3.37. Incident -- An act or series of acts which violates reasonable expectations for behavior and has the potential to place a child or others at risk.

3.38. Individualized Education Program -- An individualized education program required by Federal and State law for educationally handicapped children; the plan for such a program.

3.39. Informed Consent -- Written verification that a child and his or her parent or guardian have been informed of the nature of the treatment provided to the child and that they agree to the proposed treatment.

3.40. Institutional Investigative Unit -- A unit of the Department authorized by the Secretary to investigate complaints of child abuse or neglect..

3.41. Interdisciplinary Team -- A group including a child, legal representatives, and representatives from the organization whose responsibility is to design and review a child's plan of care.

3.42. Intermediate Care Facility for Persons with Mental Retardation -- A facility which provides appropriate supervision, medical and habilitation services for individuals with mental retardation and/or developmental disabilities as defined in 42 CFR §440.150.

3.43. Intervention -- The action(s) of the health care/organizational staff designed to help the resident complete the objectives contained within his/her care plan.

3.44. Life Skills -- Tasks, abilities, or knowledge required to perform the activities of daily living.

3.45. Medication Error - The failure to administer a drug ordered by a physician, or the administration of a drug without a physician's order, in the wrong dosage, in the incorrect form, by the incorrect method, or that is incorrect itself.

3.46. Multidisciplinary Treatment Team -- A legally identified team as defined in §49-1-3-(g), designated to review and approve the child's placement and plan of care as appropriate. The team shall consist of the child's custodial parent or parents, guardian or guardians, other immediate family members, the attorney or attorneys representing the child, the parent or parents of the child, the child's attorney, the guardian ad litem, if any, the prosecuting attorney or his or her designee and where appropriate to the particular case under consideration and available, a court-appointed special advocate, an appropriate school official and any other person or an agency representative who may assist in providing recommendations for the particular needs of the child and family.

3.47. Objective -- Desired measurable outcome(s) related to a goal stated in terms understandable to the child/youth and his/her parent or guardian and agreed upon by the interdisciplinary team.

3.48. On-ground Educational Program -- An educational program conducted on the property of an organization.

3.49. Organization -- A facility or other entity which provides residential services on a twenty-four (24) hour per day basis and may provide therapeutic treatment program for children or transitioning adults.

3.50. Outdoor Therapeutic Educational Program -- Any entity that provides care, supervision and treatment for older children and transitioning adults aged 12 to 21 in an outdoor setting where routine and specially planned activities are provided in an outdoor milieu and designed to improve the youth's social, emotional, behavioral and educational functioning.

3.51. Parent(s) or Guardian -- A person or persons with an ongoing, legally identified and recognized responsibility for caring for a child; usually the child's mother and/or father, the Department, or the Division of Juvenile Services.

3.52. Physical Escort -- The temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a resident who is acting out to walk to a safe location.

3.53. Placement -- A change of living arrangement, or the ongoing care of a child in an

adoptive or foster home, group facility, or other approved living situation.

3.54. Placement Agreement -- A written document signed by the child's parent or guardian and a representative of the agency, which specifies the terms of the child's placement.

3.55. Placing Agency -- An organization either publicly or privately operated, legally authorized to place a child or transitioning adult in the care of an organization.

3.56. Policy -- A statement of the principles that guide and govern the activities, procedures and operations of a program.

3.57. Procedures -- The specific methods by which policies are implemented.

3.58. Program -- A system of services provided to those persons who are clients of an agency.

3.59. Protective Device -- Any appliance, such as a brace, pad, helmet, covering, or bandage, that is used to aid in the healing of an injury or to prevent injury to the child.

3.60. Protective Services Check -- A review of Adult and Child Protective Services records maintained by the Department of Health and Human Resource to determine whether a person has a documented history of abusing or neglecting vulnerable adults or children.

3.61. Punishment—The infliction of a negative penalty for wrongdoing, which may decrease the future rate and/or probability of the behavior.

3.62 Psychiatric Emergency -- An incident during which a child loses control and behaves in a manner that poses substantial likelihood of physical harm to himself or herself, or to others.

3.63. Psychiatric Residential Treatment Facility for Persons under Twenty-One -- A free-standing program or physically distinct part of a psychiatric inpatient facility that provides intensive, coordinated, and medically supervised behavioral health services in a residential setting to children and adolescents that do not need acute care as defined in 42 CFR §483.350 and §441.151.

3.64. Psychotropic Medication -- Drugs designed to affect the mind, mood, behavior, or other mental processes.

3.65. Public Funds -- Money provided to an organization by any governmental body.

3.66. Quality Committee/Officer -- An individual or group of individuals whose responsibility shall be to develop and implement quality control processes which monitor programmatic and clinical efforts of the organization and identifies methods to improve services and resolve problems.

3.67. Regulatory Body -- A governmental agency with the ongoing responsibility for the formal authorization and oversight of the operation of an organization.

3.68. Requirement -- The specific minimal condition or standard that must be met by an organization as a condition of licensure and/or approval to operate.

3.69. Residential Child Care and Treatment Facility -- A congregate program providing room, board, supervision and may provide behavioral health treatment to children or transitioning adults with behavioral, developmental and/or psychiatric challenges.

3.70. Residential Crisis Support/Shelter Care -- A form of short-term residential care for children or youth which temporarily provides food, shelter, clothing and other necessary crisis intervention and stabilization services for children or youth experiencing emotional, familial or behavioral crises.

3.71. Residential Maternity and Parenting Facilities. -- A facility that primarily offers care and behavioral health services to young women who are either pregnant or parenting and their children.

3.72. Respite Care -- Alternative short-term care.

3.73. Restraints – (1) Any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or any other methods that involves the physical holding of a resident for the purpose of conducting routine physical examinations or tests or to protect the resident from falling out of bed or to permit the resident to participate in activities without the risk of physical harm to the resident (such term does not include a physical escort); and (2) a drug or medication that is used as a restraint to control behavior or restrict the resident's freedom of movement that is not a standard treatment for the resident's medical or psychiatric condition.

3.74. Responsible Agency -- An agency with continuing overall responsibility for the child during placement.

3.75 Residential Living Unit— Living quarters utilized by a particular group of residents in care, consisting of separate cottages or units in a residential building, and include a common room, dining or snack area, facilities for bathing, toileting and personal hygiene and bedrooms.

3.76. Rules -- A set of requirements issued by the Secretary describing a standard/set of standards of care to apply in the oversight of an organization.

3.77. Safety Committee/Officer -- An individual or group of individuals whose responsibility is to review service modalities or other organizational practices that limit freedom

of choice or involve risk. The Committee/Officer also reviews the organization facilities/buildings on a quarterly basis for safety, cleanliness and proper maintenance.

3.78. Seclusion -- A behavioral control technique involving locked isolation or the isolation of a child in an isolated physical space from which he/she is prevented from leaving. Such term does not include a time out.

3.79. Secretary -- The Secretary of the Department of Health and Human Resources or his or her designee.

3.80. Secure Care -- A form of residential treatment which employs, on a regular basis, locked doors or any other physical means to prevent children in care from leaving the facility.

3.81. Service -- A functional division of a program or the delivery of care.

3.82. Standards -- A measure of comparison for qualitative value.

3.83. Supervision -- The observation, oversight, and guidance of the resident or group of residents by the staff member(s) assigned to their care.

3.84. Therapeutic Residential School – A long term residential, educational facility providing post-secondary education preparation, room, board, and supervision while providing a structured environment and therapeutic support to older children and transitioning adults who may need emotional, behavioral, familial, social, intellectual, and/or academic development.

3.85. Time-Out -- A behavior management technique that is part of an approved treatment program and may involve the separation of the resident from the group, in a non-locked setting, for the purpose of calming. Time out is not seclusion and is not physically enforced or coerced in any way.

3.86 Transitioning Adult -- An individual with a transfer plan to move to an adult setting who meets one of the following conditions:

(1) Is eighteen years of age but under twenty-one years of age, was in departmental custody upon reaching eighteen years of age, remains under the jurisdiction of the juvenile court, and requires supervision and care to complete an education and or treatment program which was initiated prior to the eighteenth birthday;

(2) Is eighteen years of age but under twenty-one years of age, was adjudicated abused, neglected, or in departmental custody upon reaching eighteen years of age and enters into a contract with the Department to continue in an educational, training, or treatment program which was initiated prior to the eighteenth birthday.

3.87. Treatment -- A broad range of planned habilitative and/or rehabilitative services, including diagnostic evaluation, counseling, medical, psychiatric, psychological, training and social service care, that are provided to enable a child to meet identified goals and objectives. This definition does not supercede definitions related to funding streams.

3.88. Treatment Strategy -- An orientation or set of clinical techniques used in a particular therapeutic model to meet a diagnosed need of a child in care over and above the provision of basic care.

3.89. Universal Precautions -- A collection of medically related behaviors, procedures, and protocols designed to minimize the risk of disease transmission and contamination.

3.90. Variance -- A written declaration by the Secretary that a certain requirement of this rule may be satisfied in a manner different from the manner set forth in the rule.

3.91. Volunteer - A person who provides services without direct financial remuneration, and who meets the organization's employment qualifications for health, safety and training.

3.92. Waiver -- A written declaration by the Secretary that a certain requirement may be treated as inapplicable in a particular circumstance.

§78-3-4. State Administrative Procedures

4.1. General Licensure Provisions

4.1.a.. Before establishing, operating, maintaining or advertising a residential child care and treatment program within the State of West Virginia, an organization shall first obtain from the Secretary a license authorizing the operation.

4.1.b. A license is valid for the organization named in the application and is not transferable.

4.1.c. An invalid license shall be surrendered to the Secretary on written demand.

4.1.d. Applications for licenses or approvals shall be made on forms prescribed by the Secretary.

4.1.e When the ownership of an agency changes, the new owner shall apply for a license and shall not operate until a license is issued.

4.1.f An agency must demonstrate a need for the proposed service by obtaining a current certificate of need from the Health Care Authority.

4.1.g. The Secretary shall make a decision on each application within sixty days of its receipt and shall provide to unsuccessful applicants written reasons for the decision.

4.1.h. An on-site inspection is required prior to issuing initial, renewal or provisional licenses.

4.2 License Application

4.2.a The organization shall submit an application for license or certificate of approval when any of the following conditions apply:

4.2.a.1 Establishment of a new facility;
4.2.a.2 Change in location;
4.2.a.3 Change in ownership;

4.2.a.4 Change in the population served, including but not limited to gender, age and capacity.

4.2.a.5 Expiration of existing license.

4.2.b. A completed application shall be submitted by the organization at least 60 days in advance of the planned opening date, change of location, change of ownership, change in program or expiration of existing license.

4.2.c. Application forms shall be completed with all information required or the application will be invalid.

4.2.d. The application must be accompanied by supporting documentation.

4.2.e. The application must be signed by a member of the governing body and the chief executive officer.

4.2.f. The application must be accompanied by a current fire inspection report by the State Fire Marshal's Office and a current food service and environmental inspection by the Health Department.

4.2.g. The governing body or its designated authority shall ensure adequate resources to support the agency's services. If a new agency or an expansion of an existing agency, the governing body must demonstrate sufficient operating funds for at least six months. Such demonstration may include reserves, lines of credit or history of adequate cash flow from an existing program to support a new program for six months.

4.2.h. Existing organizations must demonstrate financial stability. This shall include a statement from an independent certified public accountant (CPA) that proper accounting procedures, including an annual audit from a CPA, are in place for the agency.

4.3. Types of Licenses

4.3.a. Following application review, on-site inspection and approved corrective action, if necessary, the Secretary shall issue a license in one of three categories, if there is compliance with these regulations. A license may be amended at any time during the cycle to reflect changes in the program, structure or population.

4.3.b. An initial license shall be issued to facilities establishing a new service found to be in compliance with regard to policy, procedure, organization and record keeping regulations. It shall expire not more than six months from date of issuance and may not be re-issued.

4.3.c. A provisional license shall be issued when an agency seeks a renewal license and is not in compliance with this rule, but does not pose a significant risk to the rights, well-being, health and safety of a consumer. It shall expire not more than six months from date of issuance and may not be re-issued.

4.3.d. A regular license shall be issued for up to two years, when a facility is in compliance with this rule.

4.4 Construction and Renovation

4.4.a Before construction or extensive renovation begins, an applicant shall submit to the Secretary for approval a copy of the site drawings and specifications for the architectural structure and mechanical work.

4.4.b. All extensively renovated and new structures shall meet current Americans with Disabilities Act (ADA) standards.

4.4.c. The Secretary may provide consultation and technical assistance in obtaining compliance with this rule.

4.5 Inspections

4.5.a. An organization shall permit the Secretary unrestricted access to the facility to conduct announced and unannounced inspections of all aspects of its operation and premises.

4.5.b. An organization shall permit review of an agency's case records, corporate and financial records, board minutes and employment records as desired by the Secretary.

4.5.c. An organization shall permit access to employees, members of the governing board and residents receiving services from the organization as desired by the Secretary.

4.5.d. If an organization is accredited by an accreditation body, it shall supply copies of all relevant accreditation reports to the regulatory body within ten days of receipt.

4.5.e. A licensed organization shall be inspected from thirty to ninety days prior to the expiration of its license, at a minimum.

4.5.f. Within ten working days of completion of an inspection, the Secretary shall issue a report.

4.6. Complaint Investigation

4.6.a. Any person may file a complaint with the Secretary alleging violation of applicable laws or rules by an organization. A complaint shall state the nature of the complaint and the organization by name.

4.6.b. The Secretary may conduct unannounced inspections of organizations involved in a complaint and any other investigations necessary to determine the validity of a complaint.

4.6.c. At the time of the investigation, the investigator shall notify the administrative officer of the alleged reason for the complaint.

4.6.d. The Secretary shall provide to the organization a written report of the results of the investigation along with any violations.

4.6.e. The Secretary may provide to the complainant a description of the corrective action the organization is required to take and of any disciplinary action the Secretary will take.

4.6.f. The names of a complainant and of any resident involved in the complaint or investigation, and any information that could reasonably lead to their identification, shall be kept confidential and shall not be disclosed without their written consent, and before disclosure of investigative information to the public, such identifying information shall be deleted.

4.6.g. If a complaint becomes the subject of a judicial proceeding, nothing in this rule prohibits the disclosure of information that would otherwise be disclosed in judicial proceedings.

4.6.h. The organization shall not discharge or discriminate in any way against a resident, guardian, or employee who has been a complainant, on whose behalf a complaint has been submitted, or who has participated in an investigation process.

4.7. Reports and Records

4.7.a. The Secretary shall keep on file a report of any inspection or investigation.

4.7.b. A report shall specify the non compliance and the provision of the rule it violates, and describe the precise data, observation or interview to support such deficiency.

4.7.c. Information in reports or records is available to the public except:

4.7.c.1. As specified in this section regarding complaint investigations;

4.7.c.2. Information of a personal nature from a resident or personnel file; and

4.7.c.3. Information required to be kept confidential by state or federal law.

4.7.d. A report shall not be made public until the organization has the opportunity to review the Statement of Non Compliance and a Corrective Action Plan has been submitted to and approved by the Secretary.

4.8. Corrective Action Plans

4.8.a. Within ten working days after receipt of the licensing report, the organization shall submit to the Secretary for approval a written plan to correct all non compliances that are in violation of this rule, unless a variance is requested by the organization and granted by the Secretary. The plan shall specify:

4.8.a.1. Action taken or procedures proposed to correct the non compliances and prevent their reoccurrence;

4.8.a.2. Date or projected date of completion of each action taken or to be taken; and

4.8.a.3. Signature of the chief executive officer or his/her designee.

4.8.b. The Secretary shall approve, modify or reject the proposed Corrective Action Plan in writing. Modifications may be made by the organization in conjunction with the Secretary.

4.8.c. The Secretary shall state the reasons for rejection or modification of any Corrective Action Plan.

4.8.d. When the Secretary rejects a Corrective Action Plan, a revised plan shall be submitted within ten working days upon receipt of the rejection.

4.8.e. The organization shall immediately correct a non compliance that risks the health or safety of resident or other persons.

4.8.f. The Secretary may determine if corrections have been made.

4.9. Waivers and Variances

4.9.a. An organization shall comply with all relevant requirements unless a waiver or variance for specific requirement has been granted through a prior written agreement with the regulatory body. This agreement shall specify the particular requirement to be waived, the duration of the waiver, and the terms under which waiver is granted.

4.9.b. Waiver of specific requirements shall be granted only when the organization has documented and demonstrated that it complies with the intent of the particular requirement in a manner not permitted by the requirement.

4.9.c. The waiver shall contain provisions for a regular review of the waiver.

4.9.d. When an organization fails to comply with the waiver agreement, the agreement shall be subject to immediate cancellation.

4.10. Penalties

4.10.a. The Secretary may deny the organization's application for licensure or licensure renewal; revoke or modify a license; and/or prohibit admissions ban or reduce resident census for one or more of the following reasons:

4.10.a.1. The Secretary makes a determination that fraud or other illegal action has been committed;

4.10.a.2. The organization violates federal, state, or local law relating to building, health, fire protection, safety, sanitation or zoning, payment of worker's compensation or employment security taxes.

4.10.a.3. The organization conducts practices that jeopardize the health, safety, well-being or clinical treatment of a resident;

4.10.a.4. The organization fails or refuses to submit reports or make records available as requested by the Secretary; or

4.10.a.5. An organization refuses to provide access to its location or records as requested by the Secretary.

4.10.b. Where a violation of this rule may result in serious harm to children under care, the Secretary may seek injunctive relief against any person, corporation, child welfare agency or government official through proceedings instituted by the attorney general, or the appropriate county prosecuting attorney, in the circuit court of Kanawha County, or in the circuit court of any county where the children are residing or may be found.

4.10.c Where the operation of a residential child care and treatment facility constitutes an immediate danger of serious harm to children served by the facility, the Secretary shall issue an order of closure terminating operation of the facility. A facility closed by the Secretary may not operate pending administrative or judicial review without court order.

4.11. Annual Time Study

4.11.a. The organization shall be subject to an annual time study regarding the quantification of staff supervision time upon the request of the Department.

4.12 Administrative and Judicial Review

4.12.a. Any person, corporation, governmental official or child welfare agency, aggrieved by a decision of the Secretary made pursuant to this rule may contest the decision upon making a request for a hearing by the Secretary within thirty days of receipt of notice of the decision. Administrative and judicial review shall be made in accordance with the provisions of article five, chapter twenty-nine-a of the State Code of West Virginia. Any decision issued by the Secretary may be made effective from the date of issuance. Immediate relief therefrom may be obtained upon a showing of good cause made by a verified petition to the circuit court of Kanawha County or the circuit court of any county where the affected organization of child welfare agency may be located. The pendency of administrative or judicial review shall not prevent the Secretary from obtaining injunctive relief as provided for in 4.10.b.

§78-3-5. Ethical Practice, Rights and Responsibilities

5.1. Rights and Responsibilities

5.1.a. The organization shall inform all residents and their family and/or guardians of their rights and responsibilities. Information on rights and responsibilities shall be tailored for each of the organization's services as appropriate, and must reflect the consequences of non-compliance with programmatic rules, as well as limitation on individual rights occasioned by involuntary placement or court orders.

5.1.b. All persons served and/or their guardians as appropriate shall receive information about their rights and responsibilities that is:

5.1.b.1. Posted in a public area (as appropriate);

5.1.b.2. Provided in writing;

5.1.b.3. Distributed during their initial contact; and

5.1.b.4. Effectively and appropriately communicated to persons with special needs and/or in an age-appropriate manner.

5.1.c. Each resident's record shall contain documentation that the individual received an explanation of his/her rights and responsibilities, initialed by the resident and/or parent or guardian.

5.1.d. Written rights must include, but are not limited to:

5.1.d.1. Rules and behavioral expectations;

5.1.d.2 Factors that could result in discharge and termination unless clinically contra-indicated;

5.1.d.3. Basic information about how to file complaints, grievances or appeals.

5.1.d.4. Rights of persons in residential child care and treatment facilities as specified in subsection 5.4 of this rule.

5.1.e. The organization's policy and procedures shall ensure that:

5.1.e.1. The parent or guardian may refuse any service, treatment or medication unless mandated by law or court order;

5.1.e.2. If the parent or guardian or older child refuses a recommended service, treatment or medication the organization informs the person of the consequences of such refusal, which may include termination or discharge.

5.2. Access and Eligibility

5.2.a. The organization shall define its service population and the eligibility criteria for each of its services.

5.2.b. Organizational policy must state that the organization does not discriminate by race, color, age, national origin or disability unless it is part of an individualized determination that the facts and circumstances of a particular case require the consideration of race, color, age, national origin or disability in order to advance the best interests of the resident.

5.2.c. The organization shall have in place a policy detailing admissions procedures for each service and such procedures shall:

5.2.c.1. Minimize barriers to timely initiation of services;

5.2.c.2. Provide for initial screening or placement on a waiting list;

5.2.c.3. Allow the organization to give priority to children and families with urgent needs or in emergency situations as appropriate; and

5.2.c.4. Ensure that all persons are treated equitably.

5.3. Culturally Competent Practice

5.3.a. The organization's policies, procedures and practices shall recognize, respect and respond to the unique, culturally defined needs of persons and families within its service population.

5.4. Rights of Persons in Residential Child Care and Treatment Facilities

5.4.a. A child or transitioning adult receiving services from the organization shall have basic rights including, but not limited to:

5.4.a.1. Adequate food, clothing and shelter;

5.4.a.2. Adult guidance, support and supervision;

5.4.a.3. Freedom from abuse, neglect, corporal punishment and exploitation;

5.4.a.4. Education;

5.4.a.5. Services necessary to promote safety, permanency and well-being;

5.4.a.6. Clean and safe surroundings;

5.4.a.7. Adequate medical care;

5.4.a.8. Visitation with family and significant others as specified in the plan of care and/or child's case plan, unless clinically contra-indicated or otherwise described in policy;

5.4.a.9. Communication with family and significant others by telephone or other means of communication as specified in the plan of care and/or child's case plan or under conditions described in policy;

5.4.a.10. Uncensored mail, unless there is reason to suspect it may contain unauthorized, dangerous or illegal substances or materials or is clinically contra-indicated, or unless consent has been given by parent or guardian to inspect mail;

5.4.a.11. Freedom of thought, conscience and religion;

5.4.a.12. Reasonable access to a legal representative, clergy or spiritual advisor and representative of the placing agency, if applicable;

5.4.a.13. Reasonable access to personal funds, if managed by the organization, unless clinically contra-indicated;

5.4.a.14. Privacy, as reasonable for the resident's age and functioning, unless clinically contra-indicated; and,

5.4.a.15. Participation in decisions regarding the services provided, unless clinically contra-indicated.

5.5. Confidentiality and Privacy Protections

5.5.a. The organization shall conform to all federal and state requirements with regard to confidentiality of children and families served (42 CFR Part 2, Public Law 104-191, Health Insurance Portability and Accountability Act of 1996 and W.Va. Code §49-7-1).

5.5.b. The organization shall have clearly stated procedures regarding the disclosure of information about children served that are in compliance with state and federal code. Policy shall include procedures for instances in which the child may be dangerous to him/herself and/or others.

5.5.c. The organization shall assure that a release of information is completed in full, prior to signature, for it to be valid. A copy of the signed form shall be placed in the case record..

5.5.d. The organization shall have a written policy regarding searches of resident rooms or property which shall be respectful of privacy rights. The organization shall document any such search carefully.

5.5.e. Employees shall be required to make every effort to preserve the child's right to privacy and personal dignity according to the age and functioning of the child;

5.5.f. Surveillance cameras or listening devices shall not be used for routine observation of residents in their rooms unless required by judicial order or contract;

5.5.g. The organization shall provide a secure area or locker for a resident's possessions if the resident so desires; and

5.5.h. The organization shall prohibit:

5.5.h.1. Involuntary participation of children served in public performances without the informed consent of the parent or legal guardian;

5.5.h.2. Required or coerced use of public statements by persons served that express gratitude to the organization; and

5.5.h.3. Use of photographs, videotapes, audio-taped interviews, artwork or creative writing for public relations or fund raising purposes without the informed consent of the parent or guardian or the child if he/she has reached majority or has been adjudicated an emancipated adult.

5.6. Access to Case Records and Information Management

5.6.a. Children, their attorney or their parent or guardian shall have access to their case records to the extent permitted by state and federal law (Public Law 104-191 and W.Va. Code §49-7-1).

5.6.b. The organization may require that sensitive psychological, psychiatric or other information be reviewed with the support of clinical personnel. The organization shall document the reason for such a requirement.

5.6.c. The organization shall have policy and procedures that protect electronically maintained data in compliance with federal standards (Public Law 104-191)

5.7. Research Protections

5.7.a. The organization shall have written policies regarding the participation of children and transitioning adults in research projects

5.7.b. Organizational policy shall clearly state whether or not the organization conducts, participates in, or permits research involving persons served.

5.7.c. If an organization does research, it must have a human subjects committee or an internal review board that reports to the chief executive officer or a designated authority with policymaking functions; and:

5.7.c.1. Reviews research proposals that involve persons served;

5.7.c.2. Makes recommendations regarding the ethics of proposed or existing research;

5.7.c.3. Makes recommendations as to whether or not to approve research

proposals; and

5.7.c.4. Establishes a minimum frequency for monitoring of ongoing research activities.

5.7.d. Participation in research is voluntary. The organization may not threaten to withdraw services or otherwise coerce persons or their guardians into participating and shall prohibit the use of financial incentives for recruiting research participants.

5.7.e. Each research participant or when appropriate his/her parent or guardian shall sign a consent form that includes:

5.7.e.1. A statement that s/he voluntarily agrees to participate;

5.7.e.2. A statement that the organization will continue to provide services whether or not s/he agrees to participate;

5.7.e.3. An explanation of the nature and purpose of the research;

5.7.e.4. A clear description of possible risks or discomfort;

5.7.e.5. A guarantee of confidentiality; and,

5.7.e.6. The signature of the parent or guardian .

5.7.f. The organization shall safeguard the identity and privacy of persons served in all phases of research conducted by or with the cooperation of the organization.

5.8. Grievance Procedures

5.8.a. Written policy and procedures shall provide persons requesting or receiving services with a formal mechanism for expressing and resolving complaints and grievances. These procedures shall be explained and distributed. The recipient shall acknowledge receipt in writing. The procedures:

5.8.a.1. Shall be given to all persons served, their parent or guardian upon intake into service, and thereafter upon request or at the initiation of a grievance;

5.8.a.2. Shall include an internal appeal procedure and options for external appeal which shall include the regulatory body and/or the Federal Office of Civil Rights;

5.8.a.3. Shall provide for a timely resolution of the matter and require a written response to the aggrieved that includes documentation of the response in the case record; and administrative file;

5.8.a.4. Shall indicate that grievances may be filed either orally or in writing and that all staff of the organization shall be responsible for assisting any person who wishes to file a grievance.

5.9. Ethical Conduct

5.9.a The organization shall develop and implement written standards of ethical conduct for its governing board and its employees.

5.9.b The organization shall not misrepresent or operate a service or program in any way that is misleading, deceptive or illegal.

5.9.c. The organization shall require its personnel to know and comply with policies and procedures established by the organization.

5.9.d. When a resident's third party benefits or payments end or a child reaches his/her majority while in service, the organization must have a procedure to discontinue services to the resident and family in an orderly, ethical fashion.

5.10. Protection of Health and Safety

5.10.a. In its daily operations, the organization must protect the health and safety of the recipient of service in its care.

§78-3-6. Continuous Quality Improvement

6.1. The organization shall describe in policy and procedure a well-defined process for assessing and improving its overall performance and shall identify standards that will promote quality outcomes for persons served.

6.1.a. The policy or procedure shall:

6.1.a.1. Describe the organization's continuous quality improvement activities;

6.1.a.2. Assign responsibility for conducting and coordinating continuous quality improvement activities;

6.1.a.3. Specify time frames;

6.1.a.4. Define methods for monitoring and reporting results; and

6.1.a.5. Describe feedback mechanisms and corrective action.

6.1.b. The continuous quality improvement procedure shall be annually reviewed and updated by senior management and the governing body.

6.1.c. The continuous quality improvement process shall include at a minimum three basic components:

6.1.c.1. Safety ;

6.1.c.2. Case review and compliance; and,

6.1.c.3. Quality .

6.1.d. Organizations have the latitude to designate committees and/or individuals to carry out the continuous quality improvement process.

6.2. Safety

6.2.a. The organization shall conduct a quarterly review of the use of service modalities or other organizational practices that involve risk or limit freedom of choice including but not limited to:

6.2.a.1. The use of restrictive behavior management interventions such as restraints (physical, mechanical or chemical) and seclusion to manage inappropriate and/or aggressive behavior;

6.2.a.2. Aversive procedures used by the organization to consequate inappropriate behavior;

6.2.a.3. Critical incidents;

6.2.a.4. Reports/allegations of neglect and/or abuse, both internal and external;

6.2.a.5. Restrictions of privacy including mail, phone and visitation restrictions;

6.2.a.6. Internal investigations; and

6.2.a.7. Grievances

6.2.b. The organization shall conduct a documented, quarterly safety review of all facilities/buildings to ensure the safety, cleanliness and appropriateness of each service environment. Outdoor facilities shall have a monitoring procedure which shall review at least quarterly all program environments and processes for safety and sanitation.

6.3. Case Review

6.3.a. The organization shall conduct a quarterly case review consisting of at least 10% of all open cases and of cases closed that quarter, chosen using a generally accepted standardized sampling methodology. Records from all program or unit sites must be sampled.

6.3.b. Personnel who conduct case reviews shall evaluate quality and the presence or absence of required documents, and the clarity and continuity of such documents, which shall include but not be limited to:

6.3.c.1. Assessments;

6.3.c.2. Care plans;

6.3.c.3. Appropriate consents;

6.3.c.4. Custody or guardianship documents;

6.3.c.5. Individualized educational plans as appropriate;

6.3.c.6. Progress notes, case notes and summaries;

6.3.c.7. Relevant signatures; and

6.3.c.8. Aftercare/discharge/transition plans.

6.3.d. Written procedures for case review shall ensure that workers do not review cases in which they have been directly involved.

6.3.e. The case record review shall result in a document summarizing case record non-compliances. Management shall be responsible for documenting follow-up on case record non-compliances.

6.3.f. The organization shall document efforts to remediate identified patterns of non- compliance through re-training or increased supervision efforts.

6.4. Quality

6.4.a. The organization shall have a process that establishes standards and measures outcomes relative to those standards for each of its facilities on an ongoing basis.

6.4.b. The organization shall analyze outcome data at least annually as part of a self-assessment in order to determine program effectiveness. Results of findings shall be presented to the governing body.

6.4.c. The organization shall have a systematic, documented method of assessing

resident satisfaction.

6.5. Feedback Mechanisms

6.5.a. The organization shall submit annual summary results of the safety, case review and quality evaluation processes to the governing body and any advisory councils

6.5.b. Results of all reviews including annual financial audits, accreditation reviews and licensing reviews shall be provided to the governing body annually.

6.5.c. The organization shall use the findings of its continuous quality improvement processes to:

6.5.c.1. Identify problems or service deficits;

6.5.c.2. Determine possible causes when data reveal issues of concern;

6.5.c.3. Problem solve and develop plans to correct areas of concern or deficit;

6.5.c.4. Implement and monitor the effectiveness of corrective plans; and

6.5.c.5. Modify the corrective plans as necessary.

§78-3-7. Governing Body and Organization

7.1. The organization shall have a clearly identified group of people (or person or partnership when applicable) which exercises authority over and has responsibility for its operation, policies and practices.

7.1. a. The governing body shall be one of the following:

7.1. a.1. A Board of Directors in the case of a non-profit or for-profit corporation; or

7.1.a.2. Appointed officials of a governmental unit; or

7.1.a.3. A proprietor in case of a sole proprietorship; or

7.1.a.4. Partners, in case of a partnership; or,

7.1.a.5. Meets the criteria of the Secretary of State.

7.2 The governing body of the organization shall be composed of no fewer than six

members to include men and women with varying abilities, experiences, and cultural backgrounds representative of the community, or may establish an advisory council to the governing body composed of such members.

7.3. An advisory council shall provide feedback, information and recommendations to the governing body on program policy and procedures, incident reports and quality assurance data.

7.4. No employee or member of the immediate family of an employee of any public agency which regulates or purchases or arranges the services of a privately run organization shall be a member of the governing body of the organization.

7.5 All members of the governing body or advisory council must be provided:

7.5. a. A formal orientation to the organization and responsibilities of membership of the governing body or advisory council, which shall be documented;

7.5. b. Written information that specifies the member's fiduciary and/or other responsibilities of the organization;

7.5. c. Annual reports of the activities of the organization; and

7.5.d. Reports from all regulatory bodies.

7.6 The Governing Body shall:

7.6.a. Identify in writing the mission of the organization and develop a plan to meet that mission;

7.6.b. Ensure that all planned or provided services are consistent with the organization's mission and plan;

7.6.c. Oversee the organization's operations and services;

7.6.d. Determine whether services are within the organization's capabilities and resources;

7.6.e. Adopt administrative, personnel, and program policies which are reviewed at least every two years;

7.6.f. Review and approve a budget prior to the beginning of the fiscal year;

7.6.g. Annually review and formally accept the financial audit;

7.6.h. Employ a chief executive officer and delegate authority to that person to employ and dismiss staff, implement board policies, and manage day-to-day operation of the organization;

7.6.i. Permit the chief executive office or designee to attend all meetings of the governing body and committee, with the exception of those held for the purpose of reviewing the performance, status or compensation of the chief executive officer.

7.6.j. Annually evaluate and document the chief executive officer's performance through specific criteria and objectives;

7.6.k. Initiate a Continuous Quality Improvement Program and direct needed changes based on the results;

7.6.l. Annually review facility needs related to risk management;

7.6.m. Maintain a long range plan and review annually;

7.6.n. Maintain minutes and records generated from all meetings, including members who were present or absent;

7.6.o. Annually visit each organizational site;

7.6.p. Annually review facility needs related to capital improvements; and

7.6.q. Meet at least twice annually.

7.7. Chief Executive Officer

7.7.a. The chief executive officer shall be responsible for the organization's daily operations.

7.7.b. The chief executive officer shall:

7.7.b.1. Plan and coordinate the development of policies governing the organization's program of services with the governing body;

7.7.b.2. Work with the governing body to develop and implement facilities which serve to meet the mission of the organization;

7.7.b.3. Provide written comprehensive reports to the governing body at least annually regarding the operation of present facilities and their compliance with organizational policy;

7.7.b.4. Provide written reports on the organization's finances to the

governing body at least annually regarding present financial status, anticipated problems, financial planning and funding alternatives; and

7.7.b.5. Ensure that human resources management complies with federal and state employment law.

7.8. Conflicts of Interest

7.8.a. The organization shall have a policy which defines and limits conflicts of interest.

7.8.b. Personnel, governing body, advisory council members and consultants shall follow the policy.

7.9. Administrative File for the Organization

7.9.a. An organization shall assemble an administrative file, which shall be made available upon request of the appropriate governmental agency. It shall contain the following information and documents:

7.9.a.1. Governing structure including the charter and articles of incorporation as appropriate;

7.9.a.2. Mission statement and long term plan;

7.9.a.3. Most recent audit/financial statement;

7.9.a.4. By-laws or other legal basis for its existence;

7.9.a.5. Organizational structure and the overall administrative lines of authority and organization staff by site;

7.9.a.6. Name and position of persons authorized to sign agreements and submit official documentation to the appropriate government agency;

7.9.a.7. Governing body structure and composition with names and addresses and terms of membership as appropriate;

7.9.a.8. Existing purchase of service agreements;

7.9.a.9. Insurance coverage (all types) including bonding documents if appropriate;

7.9.a.10. Master list of all clinical and social service professionals used by

the organization, either as employees or contractors, and;

7.9.a.11. Description and membership of any advisory councils.

§78-3-8. Risk Management

8.1. The organization shall purchase appropriate types of insurance including as appropriate, but not limited to: general liability, worker's compensation, disability, fire and theft, medical, indemnification, professional liability, officer's or director's liability, automobile liability and malpractice.

8.2. The organization shall ensure that all personnel who sign checks, handle cash or contributions or manage funds, including resident funds, are bonded at the organization's expense or the organization maintains appropriate insurance coverage to cover potential losses.

8.3. An organization that provides transportation for persons served as part of a service shall maintain adequate insurance coverage. Personnel transporting residents in their own vehicles as part of their duties shall provide the organization with evidence that they are properly insured in case of automobile accident. That evidence shall be updated annually. Copies of the individual's license to drive shall be maintained in the personnel file and shall be updated at an interval to be specified in organizational policy.

8.4. All insurance policies shall be at a financial level adequate to cover the organization in case of accident or suit. All bonding policies shall be adequate to replace the aggregate of funds managed by the organization.

8.5. Legal Compliance

8.5.a. The organization shall comply with all applicable federal, state, and local laws and regulations associated with all aspects of service delivery and operations and shall possess all relevant and appropriate licenses.

8.6. Security of Information

8.6.a. The organization shall have policies and procedures regulating access to records of staff and persons served which are in compliance with all federal (Public Law 104-191 and 42 CFR Part 2) and state requirements. Regulatory agencies shall be allowed access to all information as necessary to fulfill their statutory duties.

8.6.b. The organization shall ensure that records, whether paper or electronic, can be located at any time.

8.6.c. The organization has procedures to protect service and organizational records, whether in electronic or paper form, from destruction by fire, water, loss or other damage and from other unauthorized access, which include:

8.6.c.1. Daily backup of all electronic records; and

8.6.c.2. Storage of paper records and preserved data in locked cabinets and in a secure area.

8.6.d. Written operational procedures shall govern the retention, maintenance and destruction of records of former service recipients.

8.6.e. Resident records shall be retained for a minimum of five years following discharge except in the case of minors in which case, records shall be retained until five years after the resident's eighteenth birthday.

8.6.f. The organization shall have a policy regarding disposal of records which respects confidentiality and security of resident information.

8.6.g. The organization shall ensure that all computers have up-to-date anti-virus protection and procedures for protecting the confidentiality and integrity of internal databases and sensitive information.

8.6.h. The format of electronically transmitted data shall comply with legal standards and requirements (Public Law 104-191).

8.7. Contractual Relationships

8.7.a. The organization shall use written purchase of service agreements or written contracts with both general contractors or vendors and professional contractors of clinical services.

8.7.b. Purchase of non-clinical service or material contracts shall describe all significant terms and conditions including as appropriate:

8.7.b.1. Roles and responsibilities of participants;

8.7.b.2. Services to be provided;

8.7.b.3. Provisions for training and technical support as necessary;

8.7.b.4. Duration of contract, including delineation of follow up services;

8.7.b.5. Methods for resolving disputes;

8.7.b.6. A plan and procedure for timely payment;

8.7.b.7. Consequences for failure to pay;

8.7.b.8. Documentation necessary for, and means of reporting to, funding or oversight bodies;

8.7.b.9. Conditions for termination; and

8.7.b.10. Expected outcomes as appropriate.

8.7.c. If the organization arranges externally or contractually for the provision of clinical services, the agency shall have a written agreement which specifies:

8.7.c.1. Roles and responsibilities of the organization and the contracting party;

8.7.c.2. Documentation required of the contracting individual or service with time lines for provision of such documentation;

8.7.c.3. Services to be provided;

8.7.c.4. Provision of appropriate liability or malpractice insurance either by the contractor or contracting party;

8.7.c.5. Procedures for exchange of information;

8.7.c.6. Definition of the clients to be served and the services to be provided;

8.7.c.7. Time lines for provision of service;

8.7.c.8. Terms of payment;

8.7.c.9. Assurances that the contracting party shall adhere to state and federal requirements of confidentiality; and

8.7.c.10. Arrangements for at least annual documented management reviews of quality of service provided, using continuous quality improvement data as appropriate.

8.7.d. The organization shall ensure a complete personnel file on each contracted clinical employee/consultant who provides direct services to children on site, including:

8.7.d.1. Evidence of clinical training;

8.7.d.2. Evidence of appropriate licensure/certification;

8.7.d.3. Evidence of malpractice/liability insurance as specified in contract;

8.7.d.4. Evidence of a license to operate a business in the state of West Virginia;

8.7.d.5. References and other initial information as required for full-time employees;

8.7.d.6. Evidence of a criminal background check;

8.7.d.7. Initial health screening for Tuberculosis, and;

8.7.d.8. Evidence of other agency training required of full-time staff (e.g., physical restraint, CPR, first aid, etc.) or documentation of a lack of need for such training.

8.7.d.9. At least annual performance evaluation/review as described above.

8.7.e. If the organization contracts for professional services with a licensed practitioner who serves children in his/her own location, the organization shall have a personnel file containing the following:

8.7.e.1. Evidence of clinical training;

8.7.e.2. Evidence of licensure;

8.7.e.3. Evidence of malpractice/liability insurance;

8.7.e.4. Evidence of a license to operate a business in the state of West Virginia; or

8.7.e.5. Evidence that the practitioner is the employee of a licensed behavioral health center and therefore in compliance with regulatory requirements.

8.7.f. The organization shall ensure that contractual vendors are oriented to and adhere to the organization's policies and procedures regarding professional practices and confidentiality.

§78-3-9. Financial Management System

9.1. The organization shall have a written budget, approved by the governing body,

that shall serve as a plan for managing its financial resources for the fiscal year.

9.2. The organization shall have established financial management policies and procedures that follow generally accepted accounting principles (GAAP).

9.3. The organization shall have annual financial statements shall be prepared in accordance with generally accepted accounting principles (GAAP).

9.4. Financial Accountability

9.4.a. The organization shall make available an annual report of fiscal, statistical and service data that includes summary information regarding its financial position.

9.4.b. The organization shall ensure that an administratively independent auditor conducts an annual audit.

9.4.c. An organization that assumes fiduciary responsibility for client funds or disburses other resident funds, such as maintenance or allowance funds, shall have written operational procedures that ensure:

9.4.c.1. Separate individual accounting of funds with monthly statements to the resident and his/her guardian. Funds managed on behalf of clients shall not be commingled with organizational funds;

9.4.c.2. Protection of resident assets, including a bond sufficient to cover all resident accounts, unless the aggregate value of the resident accounts is less than $500; and

9.4.c.3. Compliance with applicable legislative, judicial and governmental requirements, including those applying to payment of benefits allotted by the state or federal government.

§78-3-10. Management of Human Resources

10.1. Deployment of Staff

10.1.a. The organization shall retain sufficient numbers of qualified individuals to:

10.1.a.1. Efficiently and effectively meet the demand for all services it provides; and

10.1.a.2. Provide and coordinate the services that are within the organization's scope and mission.

10.1.b. The organization shall ensure that sufficient, licensed or certified

professional clinical staff are employed or available on a consistent basis to provide, at a minimum, that:

10.1.b.1. All intakes and diagnostic assessments are completed by suitably trained and experienced professional staff;

10.1.b.2. Professional staff is available and mandated to provide direct supervision and consultation to direct care staff, professional supervises/interns and paraprofessionals at a ratio appropriate to the number of employees or interns supervised and the demands of the population served;

10.1.b.3. Professional staff or staff under supervision for licensure or certification according to state law is available and mandated to provide direct service to children and transitioning adults for those organizations providing therapy services (individual, group and family) and/or medical services; and

10.1.b.4. Staff is available in sufficient quantity and with sufficient credentials to address the needs of the child or youth as identified by the assessment and interdisciplinary team process.

10.1.c. The organization shall identify an individual at each program site responsible for overall administration of the program at that site.

10.2. Personnel Practices

10.2.a. Upon employment, the organization shall provide employees with written policies and procedures regarding wages, benefits, promotions, insurance protections, personnel training and development opportunities as appropriate.

10.2.b. The organization shall have policies which are compliant with federal and state statutes and regulations regarding employment practices.

10.2.c. The minimum age of employment for organizations serving children aged 13 and greater shall be 20 years of age.

10.2.d. If the age of the population served is uniformly 12 and down, the age of the staff serving the population must be a minimum of 18.

10.2.e. If the program serves transitioning adults up to age 21, the ages of the staff providing direct care must be at least 3 (three) years older than the age of the eldest resident.

10.2.f. The organization shall interview each qualified applicant personally prior to employment. The organization shall document contact with at least three unrelated references by telephone, in writing or in person for each person being actively considered for employment.

If the person has never been employed, school references may be used.

10.2.g. The organization shall review with the applicant a comprehensive job description at the time of the interview and provide a copy of a detailed written job description upon employment and upon significant changes in job assignment or responsibilities.

10.2.h. A Criminal Identification Bureau (CIB) records check and a Protective Services records check shall be submitted to the Department of Health and Human Resources on each potential employee prior to working with children. An organization may submit CIB records check directly to the West Virginia State Police. The organization must document that it has pursued the completion of the records check vigorously. The organization shall be responsible for following policies and procedures with regard to researching possible criminal and protective services backgrounds as established and disseminated by the Secretary.

10.2.h.1. The organization may utilize applicants for employment prior to receiving the result of the CIB records check under the following conditions;

10.2.h.1.a A delay in offering or beginning an applicant's employment would seriously disrupt staff scheduling and/or impact staff/resident ratios.

10.2.h.1.b The applicant's fingerprints have been submitted.

10.2.h.1.c The employee is informed in writing that final approval for employment is contingent upon the receipt of a clear CIB check.

10.2.h.1.d. A safety plan is implemented which ensures that the newly hired staff works under direct supervision and is not left alone with a resident until the CIB record check results are received.

10.2.i. Organizational policy shall prohibit employment of either personnel or contractors who have a history of convictions for;

10.2.i.1 Abduction;

10.2.i.2 Any violent felony crime included by not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery;

10.2.i.3 Child/Adult abuse or neglect;

10.2.i.4 Crimes which involve the exploitation of a child or an incapacitated adult;

10.2.i.5 Domestic battery or domestic assault;

10.2.i.6 Felony arson;

10.2.i.7 Felony or misdemeanor crime against a child or incapacitated adult which causes harm;

10.2.i.8 Felony drug related offenses within the last ten (10)years;

10.2.i.9 Felony DUI within the last ten (10) years.

10.2.i.10 Hate crimes;

10.2.i.11 Kidnapping;

10.2.i.12 Murder/homicide;

10.2.i.13 Neglect or abuse by a caregiver;

10.2.i.14 Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct.

10.2.i.15 Purchase or sale of a child;

10.2.i.16 Sexual offenses but not limited to incest, sexual abuse, or indecent exposure.

10.2.j. The organization shall have a policy and mandatory training process for all employees for compliance with mandatory reporting requirements regarding allegations of abuse or neglect of children as described in §49-6A-1 et seq.

10.2.k. The organization shall have a written job description and selection criteria for each position or group of similar positions that includes the qualifications, expectations and responsibilities required of personnel. Job descriptions shall be readily available to staff.

10.2.l. The job description shall detail the supervisory chain of command for each position.

10.2.m. The organization shall designate a supervisor for each separate service or program.

10.2.n. The organization shall employ persons who are qualified according to the job description and selection criteria for the positions they occupy. An organization employing any person who does not possess usual qualifications for the position in which he/she is

employed shall have a written statement justifying reasons for employing this person. Licensure/certification requirements for a position may only be waived or altered by the Secretary.

10.2.o. The organization verifies the credentials of all agency staff and individuals, who are contract employees of the agency, including:

10.2.o.1. Education and training;

10.2.o.2. Relevant experience; and

10.2.o.3. State licensing or certification requirements for their respective disciplines, if any.

10.2.p. If the job description allows less than full licensure for individuals eligible for professional licensure or certification, the organization shall demonstrate that:

10.2.p.1. A person with requisite credentials provides appropriate supervision to such personnel; and

10.2.p.2. Personnel are actively working toward licensure and/or certification.

10.2.p. 3. This requirement shall not be construed to apply to individuals performing job duties which would not normally require licensure or certification.

10.3. Volunteers

10.3.a. Volunteers included in this rule are defined as those individuals involved in direct contact with the organization's residents on a regular basis.

10.3.b. The organization shall have a policy which specifies the roles and responsibilities that volunteers may assume.

10.3.c. The organization shall ensure that volunteers receive regular supervision to provide assistance, directions for activity and support.

10.3.d. Any documentation provided by volunteers to be placed in a clinical record shall include the date and signature of the volunteer's on-site supervisor prior to being placed in the record.

10.3.e. The organization shall ensure that volunteers understand the responsibilities of the position and the time commitments required prior to formal assignment.

10.3.f. The organization shall formally train volunteers in confidentiality prior to onset of their activities and shall maintain documentation of such training.

10.3.g. The organization shall have a policy requiring volunteer screening, which shall include criminal and protective services background checks on all volunteers, as required by Department policy.

10.4. Students and Student Interns/Residents

10.4.a. Students covered by this rule shall be those individuals serving an academic placement of more than thirty hours on site per three month quarter. Students serving less than thirty hours per quarter shall be continually supervised by staff and may not work alone with children/youth.

10.4.b. The organization shall have a policy which specifies the roles and responsibilities that students may assume.

10.4.c. The organization shall ensure that students receive regular documented supervision to provide assistance, directions for activity and support.

10.4.d. Any documentation provided by students to be placed in a clinical record shall include the date and signature of the student's on-site supervisor prior to being placed in the record.

10.4.e. The organization shall formally train students in confidentiality prior to onset of their activities and shall maintain documentation of such training.

10.5. Employee, Volunteer, and Student Records

10.5.a. The organization must maintain personnel records for all employees, contracted clinical employees, students and volunteers. These records shall be reviewed annually and updated as necessary, and contain, as appropriate:

10.5.a.1. Identifying information and emergency contacts;

10.5.a.2. Application for employment, volunteer or student service or resume (excepting contracted clinical employees);

10.5.a.3. Job description or contract;

10.5.a.4. Reference verification;

10.5.a.5. Documentation of education and/or licensure/certification;

10.5.a.6. Documentation of relevant training as appropriate;

10.5.a.7. Documentation of employee orientation including training in confidentiality;

10.5.a.8. Documentation of criminal and protective services background checks ; and

10.5.a.9. Performance evaluations (except contracted clinical employees, students and volunteers) and documentation relating to performance, including disciplinary actions and termination summaries, as appropriate.

10.5.b. Each employee shall have a record, stored separately, containing the employee's medical information to include:

10.5.b.1. Initial tuberculosis screening and annual screening thereafter;

10.5.b.2. Physician's statement of lack of a communicable disease; and

10.5.b.3. Results of random drug screens if required by organization policy.

10.5.c. Such files shall be secured in a confidential manner with limited access.

10.6. Performance Review

10.6.a. The organization shall conduct annual performance reviews between each employee and the supervisor/person to whom s/he is accountable.

10.6.b. The organization shall develop performance expectations for each position which are discussed with each employee.

10.6.c. Personnel are given the opportunity to sign the written performance review and provide written comments before the report is entered into their personnel record.

10.6.d. The organization shall have a policy which clearly delineates procedures governing disciplinary actions and non-voluntary termination of personnel.

§78-3-11. Training and Supervision of Staff

11.1. Orientation of New Personnel

11.1.a. The organization shall ensure that all new personnel, volunteers, students and contracted clinical personnel receive an orientation within the first ten days of employment and that orientation shall be documented in the individual's personnel record.

11.1.b. The organization shall orient all new personnel, volunteers, students and contracted clinical personnel to:

11.1.b.1. Its mission, philosophy and goals;

11.1.b.2. Its services, policies and procedures;

11.1.b.3. An organizational chart that delineates lines of accountability and authority at all levels of the organization;

11.1.b.4. The objectives and process of the organization's continuous quality improvement program;

11.1.b.5. The organization's policies and procedures on confidentiality and disclosure of information on; persons served, including penalties for violation of these policies and procedures and an orientation to HIPAA requirements as they apply to the organization;

11.1.b.6. The legal rights of persons served;

11.1.b.7. Mandatory reporting procedures for suspected abuse and neglect;

11.1.b.8. Appropriate identification and documentation of incidents;

11.1.b.9. The responsibility to abide by organizational and professional ethics;

11.1.b.10. Fire drills; and

11.1.b.11. Procedures regarding medical emergencies.

11.1.c. Additionally, program personnel (those with direct care responsibilities) shall be trained as soon as possible upon:

11.1.c.1. The establishment of rapport and responsive behaviors with persons served;

11.1.c.2. Sensitivity to differences in cultural norms and values as appropriate;

11.1.c.3. Family dynamics, including human growth and development;

11.1.c.4. Proper documentation techniques;

11.1.c.5. Psychiatric emergency procedures and management; and

11.1.c.6. Basic therapeutic/behavior management techniques that may include principles of behavior modification and analysis, including antecedents and consequences, functionality of behavior, principles of reinforcements and alternative methods of reducing/replacing inappropriate behaviors.

11.1.d. Until such training is completed, the staff person may not work unless accompanied at all times by a staff member who is experienced and knowledgeable in these areas.

11.2. Personnel Training and Content

11.2.a. The organization must provide training to clinical and direct care personnel in the following health related topics within thirty days of employment:

11.2.a.1. Basic medical needs and problems of the population served;

11.2.a.2. Basic first aid (completed according to OSHA-approved pediatric first aid requirements and adult requirements as appropriate) and medication reactions (including desired and undesired effects), updated at least every three years;

11.2.a.3. Adult and infant cardiopulmonary resuscitation(CPR) , updated every two years;

11.2.a.4. Supervision of self-administration of medication as applicable including typical medications prescribed, appropriate dosages and schedules and common side effects, updated annually;

11.2.a.5. Basic de-escalation techniques and passive restraints , updated annually;

11.2.a.6. The organization's protocols for universal disease precautions and providing services to children with contagious and infectious diseases including positive HIV, AIDS, hepatitis, tuberculosis, or other air and blood borne pathogens, updated annually;

11.2.a.7. Recognizing the symptoms of common medical problems such as asthma and diabetes;

11.2.a.8. The organization's procedures regarding the duty to warn others of impending harm by a resident;

11.2.a.9. Appropriate management of suicidal threats/behaviors;

11.2.a.10. Appropriate management of aggressive or out of control behavior;

11.2.a.11. Procedures for notifying family members, parent or legal guardians or other contacts in the case of emergencies;

11.2.a.12. Management of children attempting to escape supervision;

11.2.a.13. Food handlers certification as necessary and appropriate; and

11.2.a.14. Heimlich's maneuver.

11.2.b. The organization must provide a minimum of twelve hours of annual internal continuing education for all program personnel (those providing direct services to children and transitioning adults). Objectives for internal continuing education should be based on required items as listed within this rule and an analysis of systemic weaknesses as identified by the continuous quality improvement process.

11.2.c. The organization must inform all personnel in writing of its policy defining and prohibiting corporal and degrading punishment.

11.2.d. The organization shall train appropriate personnel on procedures for maintaining a safe, hygienic, and sanitary environment. Procedures shall address:

11.2.d.1. Steps to retard the spread of infection in bathrooms, bedding and food;

11.2.d.2. Proper storage of cleaning supplies and hazardous materials; and

11.2.d.3. Handling of sick residents.

11.2.e. Staff must be trained at the time of admission to serve any children or youth with special needs such as dietary restrictions, use of epipen injections, rescue inhalers, diabetic monitoring mechanisms, etc.

11.2.f The organization must document all staff training provided to employees.

11.3. Supervision

11.3.a. The organization shall have a system of personnel supervision that is tailored to the organization's model of service delivery and uses individual and/or group supervision on a regularly scheduled basis.

11.3.b. Supervisory ratios for program personnel shall be adequate and adjusted according to the following criteria:

11.3.b.1. Educational background and skill level of those supervised;

11.3.b.2. Skills of the supervisor;

11.3.b.3. Workload size and complexity;

11.3.b.4. Newness of the assignment;

11.3.b.5. Variance due to turnover, vacation and other factors; and

11.3.b.6. Mode of supervision (group, individual, on-going, scheduled, etc.).

11.3.c. The organization must ensure that supervisory personnel have sufficient time to hold supervisory conferences and conduct evaluation and training activities.

11.3.d. Supervisory assignments, frequency and duration shall be adjusted in response to the findings and recommendations of the continuous quality improvement processes.

§78-3-12. Service Environment

12.1. Environmental Quality

12.1.a. The organization shall provide services in an environment (buildings, grounds and equipment) that meets all applicable federal, state and local health, building, safety and fire codes.

12.1.b. All structures on the grounds and equipment of the organization shall be maintained in good repair and free from danger to health and safety.

12.1.b.1. Broken, rundown or defective furnishings and equipment shall be replaced or repaired promptly.

12.1.b.2. Outside doors, windows and other features of the structure necessary for security from weather shall be repaired within 24 (twenty-four) hours of being found to be in a state of disrepair.

12.1.c. The organization shall operate facilities in an environment that is safe, accessible, and appropriate for the needs of the residents.

12.1.d. The organization shall provide adequate housekeeping, laundry, maintenance, storage and other administrative support functions required to carry out its services.

12.1.e. The organization shall post by the telephone in all direct care and

residential service locations, emergency telephone numbers for the fire department, poison control hotline, local police, child abuse hot line and on-call staff. Each child capable of using them shall be oriented to their presence and use of the telephone system in emergencies.

12.1.f. Buildings owned or leased by the organization shall be in compliance with Title III of the Americans with Disabilities Act. Existing organizations shall make any modifications readily achievable within the resources of the organization. Where the building's age or excessive cost prevents change to the facility or grounds, the organization shall have on file a plan that can be readily implemented to accommodate the needs of persons with physical disabilities when served. The organization may be compliant with the requirements of this section by adapting its program to serve individuals with disabilities in other equally effective ways.

12.1.g. All residential buildings shall conform to the current Life Safety Code of the National Fire Protection Association, unless exempted by the State Fire Marshal.

12.1.h. The organization shall have documentation that the facilities owned or leased by the organization and used for services are in full compliance with the State Fire Code. That evidence shall be renewed as required by the State Fire Marshal.

12.1.i .All water supply systems in buildings owned or leased by the organization shall comply with applicable Public Health rules.

12.1.j. All drinking water facilities in buildings shall be sanitary and accessible.

12.1.k.All buildings owned or leased by the organization shall be served by an approved public sewage system or by a sewage disposal system that has been approved by the Secretary.

12.1.l. All rooms in buildings used by the organization shall provide adequate heating, illumination and ventilation. The following shall be prohibited:

12.1.l.1. Unvented, fume-producing heating devices; and

12.1.l.2. Unprotected open heaters.

12.1.m. The organization shall have appropriate and as necessary, secure storage areas for items such as food, utensils, work materials, cleaning supplies, clothing, linens, medicines and toxic materials. Food and medicines shall be stored separately from all other materials and from each other.

12.1.n. Poisons and other potentially hazardous items shall be kept in a locked place.

12.1.o. Solid waste storage shall be sufficient to contain all solid waste in a safe

and sanitary manner.

12.1.p. Garbage and rubbish which is stored outside shall be stored securely in non-combustible, covered containers and shall be removed on a regular basis not less than once every week. Garbage containers shall be watertight and vermin proof, kept clean and stored on a concrete or metal platform. Trash collection receptacles and incinerators shall be separate from play areas and be so located as to avoid being a nuisance to neighbors.

12.1.q All plumbing in buildings owned or leased by the organization shall meet the requirements of local plumbing codes or the National Plumbing Code if no local codes apply.

12.1.r. Structures shall be maintained free of insects and rodents of public health significance.

12.1.s. A routine maintenance and cleaning program shall be maintained by the organization in all areas of the facility, including interior and exterior spaces.

12.2. Food Services

12.2.a. Food shall be stored, prepared and served in a sanitary manner.

12.2.b. Food services must:

12.2.b.1. Meet or exceed national nutritional standards;

12.2.b.2. Be planned with the documented assistance of a dietitian; and

12.2.b.3. Meet general and prescribed dietary needs of persons served.

12.2.c. Use of paper and/or throw-away plates, beverage containers and utensils are to be limited and not used in day-to-day meal service. Outdoor therapeutic educational programs shall be exempt from this requirement when operating in the field.

12.3. Compliance with Legal, Health and Regulatory Requirements

12.3.a. The organization shall have current authorization or licensure for facilities that require authorization or licensure.

12.3.b. Current licenses or certificates shall be prominently displayed in an area visible to the public.

12.3.c. The organization shall maintain in the administrative file reports regarding:

12.3.c.1. Certification of occupancy requirements;

12.3.c.2. Zoning and building codes;

12.3.c.3. Occupational safety and health administration codes;

12.3.c.4. Health, sanitation and fire codes;

12.3.c.5. Records of maintenance and safety inspections performed internally (e.g., by the Safety Committee/Officer of the continuous quality improvement process);

12.3.c.6. All other applicable safety codes; and

12.3.c.7. Any and all corrective action plans or citations for any of the above.

12.4. Transportation

12.4.a. An organization that provides transportation in its vehicles for children as part of a service shall have procedures for ensuring:

12.4.a.1. The use of age-appropriate passenger restraint systems;

12.4.a.2. Adequate passenger supervision relative to the ages, sexes, behavioral challenges and disabilities of the children;

12.4.a.3. Proper and timely licensure and inspection of the vehicle(s);

12.4.a.4. First aid kits in each organizational vehicle;

12.4.a.5. Proper and timely maintenance of vehicles;

12.4.a.6. That the number of persons in any vehicle used to transport children shall not exceed the number of available safety restraint systems;

12.4.a.7. Sufficient liability insurance;

12.4.a.8. Adequate aisle space in vans transporting wheelchair-bound children;

12.4.a.9. Secure anchoring for wheelchairs except in automobiles; and

12.4.a.10. Annual validation of driver licenses.

12.4.b. An organization that permits the transportation of persons served in vehicles that belong to staff shall require:

12.4.b.1. Passenger insurance coverage either through the organization's insurance or the driver's automobile liability insurance;

12.4.b.2. Proof of insurance;

12.4.b.3. Age-appropriate passenger restraints for all passengers;

12.4.b.4. Annual validation of driver's license; and

12.4.b.5. Current registration and inspection validated annually.

12.5. Organization Safety and Security

12.5.a. The organization shall have a schedule of regular inspection and maintenance activity to ensure the safety of premises, equipment and fixtures.

12.5.b. The organization shall have fire extinguishers reviewed by a qualified professional annually.

12.5.c. The organization shall not maintain any firearm or chemical weapon on the grounds or within the structures of the facility.

12.5.d. All power driven equipment used by a facility shall be kept in safe and good repair. Such equipment shall be used by residents only under the supervision of a staff member and according to state code. Lawn mowers shall be stored in areas separated with one hour fire rated material.

12.5.e. The organization shall have a Safety Committee or designated safety and maintenance officer whose function shall be to perform regular documented inspections for identification of potentially hazardous conditions (e.g., harmful water temperatures, improper use of small appliances, stairs without handrails, etc.) and items in need of repair or maintenance. At no time shall those inspections be less than quarterly.

12.6. Emergency Response

12.6.a. The organization shall have procedures in place for responding to accidents, serious illness, fire, medical emergencies, floods, natural disasters and other life threatening situations that:

12.6.a.1. Address the needs of any special population served by the

organization;

12.6.a.2. Specify evacuation procedures including evacuation site, parties to notify, emergency items to take when evacuation;

12.6.a.3. Describe relocation plans for the service/program if such should become necessary;

12.6.a.4. Specify appropriate responses to medical emergencies; and

12.6.a.5. Require notification of the resident's parent or guardian and other appropriate authorities at the earliest opportunity.

12.6.b. Residential facilities shall conduct monthly fire drills rotating all shifts at least once per quarter and shall meet legal requirements for fire drills as specified by the State Fire Marshal. Participation shall be mandatory for all staff and residents. Organizations which do not operate by shifts (e.g., outdoor therapeutic educational programs) shall have monthly fire drills at various times of the day and night.

12.6.c. The organization shall have procedures for dealing with injuries, accidents and illnesses. The organization shall ensure that a communication device and first aid supplies are readily available in all agency buildings.

12.6.d.The organization shall have procedures in place for dealing with:

12.6.d.1. Persons who are injured, lost or absent from care without permission; and

12.6.d.2. Persons who threaten violence or harm to themselves or personnel providing care/supervision.

12.6.e. The organization shall assign a staff member to orient each newly arrived child to organization emergency procedures and the location of emergency exits as appropriate during the first full day of the child's stay at the organization. The staff member shall file a written confirmation in the child's case record that such orientation has taken place.

12.6.f. The organization shall ensure that all staff have immediate access to current poison control information or procedures for referral for emergency medical attention.

12.7. Contagious and Infectious Diseases

12.7.a. The organization shall have a procedure in place for minimizing the risk of exposure to airborne and blood-borne pathogens. Procedures shall comply with related standards of the Centers for Disease Control and the Occupational Safety and Health Administration.

12.7.b. The organization shall develop policies and procedures to prevent and control the spread of HIV/AIDS, hepatitis, tuberculosis, and other contagious or infectious diseases and shall review and update those policies as necessary or every two years at a minimum.

12.7.c. The organization shall have policies which ensure that personnel with direct contact with residents:

12.7.c.1. Receive a tuberculosis risk assessment or test prior to initial assignment and at least annually thereafter, as well as after incidents of exposure or manifestation of symptoms of TB; and

12.7.c.2. Demonstrate completion of an approved treatment when test results are positive.

12.7.d. The organization that provides/prepares food for residents shall have policies and procedures to ensure clean and safe food preparation and prevent the exchange of communicable diseases. Such procedures:

12.7.d.1. Require that food service personnel do not prepare and/or serve food if they have symptoms of acute illness or an open, untreated wound;

12.7.d.2. Set forth minimum dishwashing and laundry water temperatures to kill bacteria; and

12.7.d.3. Conform with the requirements for food service as specified by the Bureau for Public Health (64CSR17), including as appropriate, current food handler's cards.

12.7.e. No child or employee, while affected with any disease in a communicable form, or while a carrier of such disease, or while affected with infected wounds, sores or a respiratory infection shall work in any capacity in which there is a likelihood of such person transmitting disease to other persons.

12.7.f. The organization shall immediately notify the health officer of the county in which it is located of any known or suspected cases of unusual communicable disease, as required by law.

12.8. Building Exteriors and Grounds

12.8.a. An organization shall ensure that buildings, grounds and recreational areas owned or leased by the organization shall be maintained in good repair and free from reasonable danger to health or safety.

12.8.b. Children and transitioning adults shall have access to outdoor recreational space and suitable recreational equipment that is in good repair and free from defects.

12.8.c. Areas determined to be unsafe, including steep grades, cliffs, open pits, swimming pools, high voltage boosters, high speed roads, or elevated walkways or stairs, shall be fenced off or have natural barriers to protect residents.

12.9. Interior Space

12.9.a. Each living unit of an organization shall contain space for the free and informal use of children in care.

12.9.b. Dining areas shall be arranged so as to allow children, staff and guests to eat together in small groups.

12.9.c. Dining areas shall be well-lighted, ventilated and appropriately furnished.

12.9.d. There shall be a minimum of sixty square feet per occupant in bedrooms (exception: outdoor therapeutic educational programs). Bedrooms for single occupants shall have a minimum of eighty square feet.

12.9.e. No more than four children may occupy a designated bedroom space.

12.9.f. The bedroom space must have a direct source of natural light.

12.9.g. Each child/youth shall have his/her own bed with sufficient linens and covers (Exception: outdoor therapeutic educational programs). Linen shall be changed at least weekly, but more frequently if necessary. Cots or other portable beds are not to be used on a routine basis. The uppermost mattress of any bunk bed in use shall be far enough from the ceiling to allow the occupant to sit up in bed.

12.9.h. Each child shall have his or her own dresser or other storage space for private use, and/or a designated space for hanging clothes and placing possessions.

12.9.i. Bathrooms and plumbing fixtures shall be kept clean and maintained in good repair.

12.9.j. Water temperatures in sinks and showers/bathtubs shall not exceed one hundred twenty (120) degrees Fahrenheit. There shall be a safe and adequate supply of hot and cold running water which shall be potable. Water from any source other than a public water supply must be tested annually by the appropriate state or local authority in accordance with state or local law.

12.9.k. Fixtures in bathrooms shall be situated so as to be accessible to the average sized resident of the household. If the organization serves individuals with physical

challenges, accessible and/or adapted equipment shall be provided and there shall be sufficient space in the bathroom to permit staff assistance if necessary.

12.9.l. A facility shall have one toilet, one lavatory and one bathtub or shower for every six residents.

12.9.1.a. Bathrooms shall be clean and maintained in good repair.

12.9.1.b. Bathroom floors and walls shall be moisture resistant and non-absorbent.

12.9.l. There shall be no open flame heaters in any facility operated by the organization and used by children/youth.

12.9.m. Bathroom and bedroom facilities shall allow individual privacy unless there is a clear, clinical justification otherwise, which must be documented on the plan of care. There shall be doors on sleeping areas and bathrooms that can be readily opened from both sides.

12.9.n. Kitchens used for meal preparation shall be provided with the necessary equipment for the preparation, storage, serving and cleanup of all meals for all the children and staff regularly served by the kitchen. All equipment shall be maintained in working order. Living quarters serving more than eleven residents shall meet all applicable provisions of the Bureau for Public Health Food Service Sanitation regulations (64CSR17). Those less than twelve may utilize a family-type kitchen provided that:

12.9.n.1. Food is protected from contamination during storage, preparation and service;

12.9.n.2. Food contact utensils and equipment are of appropriate material, easily cleaned and maintained in good repair;

12.9.n.3. Refrigeration equipment assures the maintenance of food at or below 45 degrees Fahrenheit; and

12.9.n.4. Kitchen sinks shall have at least two bowls. If a dishwasher is used, the temperature must reach a level sufficient to sanitize dishes. If no dishwasher is used, proper sanitation treatments in the washing process must be utilized.

12.9.o. An organization utilizing live-in staff/house parents shall provide adequate, separate living space for these staff.

12.9.o.1. A bed shall be provided in staff quarters for live-in staff/house parents.

12.9.o.2 Staff shall not share bedrooms with residents.

12.9.p. Furniture provided for children/youth shall be appropriately designed to meet the size and capabilities of the children. Furnishings shall be maintained in good repair.

12.9.q. An organization shall have securely locked storage spaces for all potentially harmful materials. Poisonous or toxic materials shall be stored in locked storage spaces not used for any other purpose.

12.9.r. Drugs, personnel files and case records are to be kept in locked storage spaces with authorized access only.

12.9.s. Any room, corridor or stairway within a facility shall be sufficiently illuminated. Corridors in sleeping areas shall be illuminated at night.

12.9.t. Each separate living unit within an organization shall have telephone service.

12.9.u. Every access and exit to the building shall be continuously maintained free of all obstruction or impediments to immediate use.

12.9.v. The use of candles shall not be allowed.

12.9.w. Children shall swim only in areas which are supervised by a certified individual. A certified individual has a current water safety instructor certificate or senior lifesaving certificate from the Red Cross.

12.9.x. On grounds pools shall be in a secured area and shall comply with Public Health requirements regarding swimming pools (64CSR16).

12.9.y. Windows shall have insect screening unless the facility is centrally air-conditioned. The screening should be readily removable in emergencies and shall be in good repair. All exterior doors shall be close fitting and self closing.

§78-3-13. Initial Assessment and Plan of care

13.1. Multidisciplinary Team

13.1.a. In all instances in which there is a legally designated Multidisciplinary Team (MDT), the organization's assessments and care plans shall be copied to the designated "chair" or DHHR representative of the MDT for the purpose of maintaining consistency in assessment, treatment and placement planning. The MDT is responsible by statute for overseeing the assessment and case planning process for all children who are in the custody of the Department. The organization shall supply a representative to the MDT who is familiar with the

child, their current status and their progress in treatment. The Department of Health and Human Resources designee assigned as the child's representative to the MDT shall be responsible for approving plans of care designed by the organization. This approval shall include permissions for treatment including permission to administer specific medications.

13.2. Initial Assessment

13.2.a. Each child or transitioning adult that enters residential treatment shall have a thorough assessment and a subsequent plan of care, if deemed appropriate by a health care professional.

13.2.a.1. For children and transitioning adults who have comprehensive assessments completed within six months prior to admission, further assessments are not required, unless circumstances have significantly changed or the assessments are incomplete.

13.2.b. The organization shall have a comprehensive assessment procedure for children entering the organization's care. Assessments shall be completed by an appropriately licensed or certified clinical professional or an individual under supervision for such licensure or supervision. The assessment shall be completed prior to the development of the plan of care and shall include as appropriate and available:

13.2.b.1. Demographic information including custody status;

13.2.b.2. Presenting problems/reason for referral;

13.2.b.3. History of treatment;

13.2.b.4. Medical history;

13.2.b.5. Social history;

13.2.b.6. Developmental history;

13.2.b.7. Educational/vocational history;

13.2.b.8. Legal history;

13.2.b.9. Substance abuse history;

13.2.b.10. Mental status examination;

13.2.b.11. Assessment of independent living/adaptive living skills;

13.2.b.12. Summary of resident strengths;

13.2.b.13. Summary of family strengths and weaknesses, and;

13.2.b.14. Summary of presenting problems/potential foci for treatment as identified through the assessment.

13.2.c. When appropriate to the needs of the person served, the assessment shall include:

13.2.c.1. A review of adaptive behavior and/or a functional assessment.

13.2.c.2. A review of the need for assistive technology, auxiliary aids and services and other special accommodations;

13.2.c.3. Nutritional and dietary needs;

13.2.c.4. Special/unique behavioral issues, and;

13.2.c.5. Academic, cognitive and/or vocational testing/assessment(s).

13.2.d. Each assessment shall consider any unique aspects of the person's racial, ethnic and cultural background, and the need for any special service approaches resulting from that assessment.

13.2.e. The assessment shall result in a written integrated summary of findings and recommendations which shall guide the organization's treatment efforts. The integrated summary of findings shall include:

13.2.e.1. Recommendations for dental, visual and other health screenings or treatment;

13.2.e.2. A diagnosis, stated in terms approved by the American Psychiatric Association, if applicable;

13.2.e.3. Recommendations for further assessment as appropriate;

13.2.e.4. Recommendations for clinical behavioral health treatment, if applicable;

13.2.e.5. Recommendations for interventions to be made in the home environment, as necessary and appropriate;

13.2.e.6. Preliminary recommendations for placement and aftercare upon discharge;

13.2.e.7. Recommendations for family visitation unless contraindicated clinically or legally, and;

13.2.e.8. Any recommendations for rights restrictions

13.2.f. The organization shall have a policy establishing time lines for completion of a full assessment which shall take into account urgency of resident need, expected duration of treatment, and time lines for plan of care. The time lines shall facilitate provision of an appropriate range of services at the earliest opportunity depending on the unique needs of the individual and the expected duration of services. Exceptions to those time lines shall be fully documented and justified in the clinical record.

13.2.g. When the organization is required to accept assessments from another organization or subcontracting entity, it shall review each assessment for sufficiency and conduct additional assessments if the product does not meet the above standard.

13.2.h. The organization shall have a policy that addresses the need to incorporate families into the assessment and service-planning process unless clinically or legally contra-indicated.

13.3. Initial Plan of Care

13.3.a. Short term/initial planning; within 72 hours of placement, the organization shall develop a short term or initial plan of care that includes the following:

13.3.a.1. Justification for continuation of medications prescribed prior to admission and continued until the assessment process is completed or justification for medications prescribed by the admitting physician;

13.3.a.2. Summary of assessments needed for the development of a full diagnostic and treatment perspective and recommendations;

13.3.a.3. Description of specific, short-term individual or group interventions to be provided prior to discharge or the development of a plan of care, if any;

13.3.a..4. Description of educational services to be provided prior to the development of an extended plan of care, if any;

13.3.a.5. Description of any behavioral interventions or protocols deemed likely to be necessary prior to the completion of the full assessment process and;

13.3.a.6. Description of any acute or chronic medical problems that may require treatment prior to the completion of the assessment process.

13.3.a.7. The short term or initial plan of care shall be developed whenever possible by a team representative of the professionals performing the assessments, the

child (if cognitively capable of participating), the guardian, and the parent(s) of the child if practicable and not forbidden by the court. The plan shall include a written description of the services to be provided as enumerated above. The short term or initial plan of care shall be approved in writing by the parent or legal guardian and the individual served, if that individual is considered sufficiently mature to understand the document. The organization shall document every effort to obtain guardian consent for treatment if the guardian is not present for the development of the initial or short term plan of care.

13.3.b. If the expected length of stay is thirty (30) days or less, the short term plan of care shall guide the team's efforts throughout the child's stay with the organization and shall be modified as necessary and appropriate. If, however, the expected length of stay is to be greater than 30 days, the team will meet prior to the end of that time period to develop an extended plan of care.

13.3.c. Prior to discharge the team shall meet to review and document the child's progress in treatment, describe continuing problems and issues and develop specific recommendations for aftercare and follow-up. The aftercare and follow-up plans and/or recommendations shall be provided to the resident and his/her parent and guardian upon discharge.

13.3.d. If a child/youth should require a specific therapeutic support plan or a protocol for staff to use in dealing with an inappropriate behavior, the plan or protocol shall be in writing , shall be in terms which make it clear to direct care staff and shall have the consent of the parent or guardian:

13.3.d.1. the behaviors to be monitored/modified;

13.3.d.2. the precise action to be taken by staff should the behavior occur;

and

13.3.d.3. documentation staff shall be responsible for supplying, if any.

13.4. Plan of Care

13.4.a. The plan of care planning and review team shall be an interdisciplinary team consisting of the staff involved in providing services to the resident (including at a minimum a licensed or certified master's level practitioner/professional), the parents, the guardian (if other than parent), and the resident him or herself, if the resident is of sufficient developmental age to appreciate the content of the review. Unless clinically or legally contraindicated in writing, both parents shall be considered members of the care planning team regardless of the identification of a guardian. The resident or guardian may request the presence of any other individuals they feel may add to the process however the organization will not be responsible for bearing any costs related to the presence of other resources. Teachers or other

external providers of service while the resident is receiving services from the organization should be invited to team meetings and considered part of the team. The organization is responsible for ensuring that all members of the team receive adequate notification of team meetings, both by telephone, if possible, and in writing. The organization shall document its efforts to obtain participation by team members and any lack of attendance. The organization shall also document efforts to obtain informed consent for treatment from the parent or legal guardian if the guardian does not attend the team meeting.

13.4.b. The plan of care shall:

13.4.b.1. Utilize the summary and recommendations of the assessment process;

13.4.b.2. Contain plans for maintaining or strengthening the relationship between the person served and his/her family if clinically and legally appropriate;

13.4.b.3. Identify the ultimate goal of services (e.g., return to home, foster care, independent living, post secondary education, etc.);

13.4.b.4. Identify the services the organization intends to provide to meet the needs of the resident and resident's family as revealed by the comprehensive assessment, including:

13.4.b.4.A. A list of general goals tied to the problems identified in the assessment; and desired measurable objectives for each goal stated in terms that are understandable to the resident and guardian;

13..4.b.5. A description of the interventions to be provided in order to achieve the stated objectives, including:

13.4.b.5.A. Medications prescribed by the organization or a contracted agency/physician associated with the organization; and

13.4.b.5.B. A description of therapeutic interventions intended to achieve the outcomes to include behavior support plans and/or therapy plans as necessary and appropriate;

13.4.b.6. Identification of the person(s) responsible for providing each intervention;

13.4.b.7. The frequency of the intervention;

13.4.b.8. Identification of any outside providers such as therapists which the agency has arranged to treat the child/youth and the goals of such interventions;

13.4.b.9. Educational, vocational, and health services, including dietary, provided to the client. Medications may be altered by the physician or qualified medical practitioner during the interval between development and review of the care plan without modification of the care plan itself, however, notes made and signed by the physician or qualified medical practitioner must be present in the record to document what changes were made and why within one week of alteration of a medication regimen; and

13.4.b.10 Proposed discharge plan.

13.5. Review of Plan of Care

13.5.a. The organization shall have a policy regarding regular review of the plan of care. The policy shall dictate schedules of review of the plan depending on the average or projected length of stay for the resident. At no time shall the schedule allow a period of review to extend more than ninety days except as permitted in subrules for each provider type.

13.5.b. Reviews shall always be performed prior to discharge and at critical treatment junctures.

13.5.c. The review shall be the result of a conference of all members of the child's care team including the guardian. Participation by team members and guardians may be telephonic or, when appropriate, submitted in writing and included in the progress summary (e.g., by educational staff). The organization shall be responsible for documenting efforts to notify each team member in a timely fashion of the review.

13.5.d. Changes to the plan of care shall be the result of recommendations by the review team and shall be dated and approved in writing by the members of the team including the resident (as developmentally appropriate) and his/her guardian.

13.5.e. Reviews shall be conducted by the interdisciplinary team and shall be in writing. They shall consist of:

13.5.e.1. Review of each outcome objective and its current status;

13.5.e.2. Identification of problems which are preventing progression;

13.5.e.3. Suggestions for dealing with those problems;

13.5.e.4. Modifications and/or additions to be made to the care plan;

13.5.e.5. Review of any therapeutic service provided by an outside provider, to include a written report from that provider if he/she is not present for the review meeting;

13.5.e.6 Summary of all interventions provided to date;

13.5.e.6. Review of any incidents in which the recipient of service may have been involved since the prior review;

13.5.e.7. Review of discharge plan and permanency plan and;

13.5.e.8. Review of the effectiveness of each psychotropic medication the child is taking at the time of the review.

13.6. Permanency Plans

13.6.a. The organization shall assist the MDT in the development of a permanency plan for each recipient of service, when required by statute.

§78-3-14. Service Delivery

14.1. Program Description

14.1.a. Each organization shall develop a written description of each service/program that shall be available to the public and potential residents. The description shall include:

14.1.a.1. The goals of the program;

14.1.a.2. The expected outcomes of the program;

14.1.a.3. The services provided by the program;

14.1.a.4. The usual staffing of the program including ratios and overall credentialing;

14.1.a.5. Characteristics of residents appropriately served by the program; and

14.1.a.6. Restrictions in access to the program, if any.

14.2. Involvement of Families and Guardians

14.2.a. The organization shall document efforts to involve families of biological origin and foster and adoptive families in developing, modifying and reviewing plans of care unless contraindicated by the court or unless clinically contraindicated in writing in the resident record, regardless of custody.

14.2.b. When residential or other out-of-home services cannot be provided close

to a child or youth's home, the organization shall document efforts to maintain family ties and involve the family in plan of care and delivery.

14.2.c. The organization shall be responsible for notifying parents and guardians of:

14.2.c.1. Interdisciplinary team meetings;

14.2.c.2. Changes in the plan of care; and

14.2.c.3. Critical incidents and significant changes in resident condition.

14.2.d. Such notification shall be completed within one working day after the event and documented.

14.2.e. If the organization cannot obtain guardian or parental participation and permission for treatment after documented efforts to do so, it shall not be held in violation of regulatory standards regarding permission and participation, however the organization must continue to document on-going efforts to include parents and guardians in the treatment process.

14.3. Behavioral and Therapeutic Interventions

14.3.a. An organization that uses therapeutic interventions shall:

14.3.a.1. Use positive approaches whenever possible to teach pro-social adaptive behavior and to modify behaviors that may be socially or personally maladaptive;

14.3.a.2. Identify antecedent conditions that may trigger inappropriate behavior and determine the most appropriate intervention;

14.3.a.3. Apply interventions in a caring and humane manner; and

14.3.a.4. Carefully describe and document interventions in the client record and in the plan of care.

14.4. Discipline

14.4.a. The organization shall follow a policy that outlines its practices regarding punishment or discipline of persons served and this policy shall prohibit the following:

14.4.a.1. Corporal punishment (physical hitting or physical punishment inflicted in any manner upon the body);

14.4.a.2. Physical exercises such as running laps or pushups when used solely as a means of punishment;

14.4.a.3. Requiring or forcing the child to take an uncomfortable position for an extended period of time or forcing the child to repeat physical movements when used solely as a means of punishment;

14.4.a.4. The use of aversive conditioning such as electric shock devices, sound, heat, cold, light, water, noise, hot pepper, pepper sauce, pepper spray or ammonia;

14.4.a.5. Interventions that involve withholding nutrition, sleep, or hydration;

14.4.a.6. Punitive work assignments;

14.4.a.7. Sanctioning by peers, except as part of an organized therapeutic self-government program that is conducted in accordance with written policy and is supervised directly by staff;

14.4.a.8. Punishment of the group for an individual child's behavior except as it involves a brief delay to initiation of the next activity or to ensure safety of the staff and residents or as part of a therapeutic program using logical and natural consequences as a means of discipline;

14.4.a.9. Punishment which subjects the child to verbal abuse, ridicule or humiliation;

14.4.a.10. Excessive denial of on-grounds program services or denial of any essential program service solely for disciplinary purposes;

14.4.a.11. Denial of visiting or communication privileges with family solely as a means of punishment;

14.4.a.12. Enforced silence for long periods of time;

14.4.a.13. Exclusion of the resident from entry to the residence;

14.4.a.14. Assignment of unduly physically strenuous or harsh work;

14.4.a.15. Use of physical restraint involving peers;

14.4.a.16. Use of physical restraint outside commonly accepted systematic methods of passive physical control applied in an appropriately de-escalating fashion;

14.4.a.17. Use of any technique of manual/physical restraint as an ongoing intervention for inappropriate or undesired behavior except in situations involving significant risk of harm to self or others if the restraint is not used.

14.4.b. The organization shall discontinue use of any intervention if it:

14.4.b.1 Produces adverse side effects such as illness, physical damage or injury; and/or

14.4.b.2. Is ineffectual or detrimental to meeting service goals and objectives.

14.5. Medication Control and Administration

14.5.a. Medication shall be prescribed and monitored by a licensed physician, dentist or physician's assistant or nurse practitioner operating within their scope of practice. The organization is responsible for physicians and other medical staff contracted for service just as it is responsible for physicians considered to be employees. Such physicians and other staff shall have personnel files containing the materials/information specified in "Management of Human Resources".

14.5.b. Organizations that administer medication using approved medication assistive personnel must be in compliance with regulations regarding medication administration by unlicensed personnel (64CSR60).

14.5.c. A child entering a facility with properly bottled and labeled medications may be continued on those medications with appropriate consents, until such time as the organization can obtain current physician's orders, either from the organization physician or the child's physician, to continue the medications. At no time shall that period of administration exceed two week days. Physician's orders may be verbal or faxed from the office of the treating physician. If verbal, they must be confirmed in writing within one week. If the orders are given by a physician unfamiliar with the child, the organization shall obtain face to face physician contact for the child within one week of admission, if that child is prescribed medications of any type.

14.5.d. When medication is prescribed and/or administered, the organization:

14.5.d.1. Obtains the written consent of the parent or legal guardian and the child over age 12 unless the child is incapable of supplying informed consent or there are compelling and documented clinical or legal reasons to overlook the child's lack of consent. If reasons for continued medication administration are clinical, the organization shall obtain court ordered permission to treat the child against his will within the shortest period possible;

14.5.d.1.a. When the medication is a psychotropic, the following information must be provided to the parent or guardian;

14..5.d.1.a.1. Specification of condition(s) the medication is to address, such as mood swings, irritability, etc.;

14.5.d.1.a.2 Efforts to address condition without medication;

14.5.d.1.a.3 Expected length of time on medication;

14.5.d.1.a.4. Necessary medical testing needed to determine proper usage of the medication; and,

14.5.d.1.a.5 How often symptoms will be evaluated to determine effectiveness of the medication.

14.5.d.2. Fully explains the benefits and possible side effects of the proposed medication (except in cases of routine refill, changes within a class of medications or dosage changes); and

14.5.d.3. Obtains approval from parent or legal guardians in advance to dispense medication unless there is documented inability to reach the guardian within a reasonable period of time relative to the urgency of the need for the medication, which must be documented.

14.5.e. The organization shall have a written procedure directing the administration and storage of prescribed and over-the-counter medications to include:

14.5.e.1. An individual record for those who receive medications to include:

14.5.e.1.A. Medications administered;

14.5.e.1.B. Date medications were administered;

14.5.e.1.C. Time of administration (medications are to be administered within one hour of prescribed time unless otherwise allowed by physician's order);

14.5.e.1.D. Individual administering;

14.5.e.2. A record of all appointments for medication management including unscheduled or canceled visits;

14.5.e.3. A record of missed medications and the reason;

14.5.e.4. Protocols for the administration of over-the-counter medications which includes individualized approval by a physician or qualified medical practitioner; and

14.5.e.5. Prescription medications are properly labeled and packaged and include:

14.5.e.5.A. The name of the person served;

14.5.e.5.B. Dosage and name of medication;

14.5.e.5.C. Name of the prescribing physician; and

14.5.e.5.D. Expiration date.

14.5.f. The organization shall have written procedures that govern:

14.5.f.1. The safe disposal of discontinued, out-of-date or unused medications, syringes, medical waste or medication prescribed to former service recipients; and

14.5.f.2. Provision for locked, supervised storage of medications with access limited to authorized personnel.

14.5.g. Only licensed nursing staff may accept verbal orders for changes in medication regimens. These must be signed by the prescribing physician within one week.

14.5.h. Organizations must have, at a minimum, a consulting registered or practical nurse whose responsibilities shall include as necessary:

14.5.h.1. Generating and reviewing monthly Medication Administration Records;

14.5.h.2. Matching physician's orders to the medication administration records;

14.5.h.3. Observing staff supervising self-administration of medications at least quarterly;

14.5.h.4. Assisting interdisciplinary teams to develop educational goals for children taking regularly prescribed medications and participating in a supervised self-administration protocol;

14.5.h.5. Instructing staff in dietary or medication administration issues as necessary;

14.5.h.6. Responding to emergency calls from staff on medical issues, and;

14.5.h.7. Assessing resident's health and health habits on an initial and on-going basis.

14.5.i. The nursing staff of the organization must assess each resident for the ability to self-medicate with supervision if the organization allows such administration. No child under the age of 12 shall be considered capable of self-administration of medications, even under supervised conditions. Assessment shall be based on developmental ability to participate in a plan of care as described below. Residents not capable of participating in such a plan shall have medications administered by licensed nursing staff or approved medication assistive personnel (64CSR60).

14.5.j. Medications may be self-administered under supervision of staff under the following conditions:

14.5.j.1. As part of the child's plan of care, he/she is taught to identify his/her medications, recognize possible side effects, describe the purpose for the medication(s) and indicate the time of day and frequency of which he/she is to take the medications;

14.5.j.2. The child/youth is assessed as being cognitively capable of learning these skills and is over the age of 12;

14.5.j.3. Medication is kept in a secure location with limited access to staff only except at dosage times;

14.5.j.4. Staff is fully trained as to the purpose, most common side effects and dangers of each medication youth in the facility are prescribed, and can identify each medication on sight;.

14.5.j.5. Staff is trained in emergency procedures for overdose or abreactions;

14.5.k. All medications will be kept at all times in a locked, secure area accessible only to staff.

14.5.l. The organization must assess the effect of medication on the person served at regular intervals and base its assessment on:

14.5.k.1. Documentation by clinical staff of the person's behavior in the case record;

14.5.k.2. The observations of the resident, staff, and significant others and;

14.5.k.3. Any commonly recommended medical tests necessary to determine the impact and safety of the medication on the persons served (e.g, blood levels, etc.).

14.5.m. Organizations with a length of stay longer than one year shall document attempts to titrate psychotropic medications to the lowest possible level while still achieving

symptom control prior to discharge.

14.6. Medication as Chemical Restraint

14.6.a. No organization shall utilize chemical restraints unless permitted otherwise by its specific rules. If an organization uses medications for the purpose of anger and agitation management on an on-going basis, the medications must be accompanied by specific educational/therapeutic interventions designed to teach the child to modulate and control his or her emotions.

14.7. Case Records

14.7.a. The organization shall maintain a case record for each person served.

14.7.b. Case records are confidential and access to case records is limited to:

14.7.b.1. The resident and/or as appropriate, his/her parent, guardian or attorney, unless legally contraindicated;

14.7.b.2. Personnel authorized to see specific information on a "need-to-know" basis; and

14.7.b.3. Others outside the organization whose access to the information contained in case records is permitted by law.

14.7.c. When not being used by authorized staff, case files should be returned to a secure area.

14.7.d. The case record shall comply with all legal requirements and contain, at a minimum:

14.7.d.1. Biographical or other identifying information;

14.7.d.2. Copies of custody and guardianship papers and court orders if appropriate and possible within the time frame of the program;

14.7.d.3. Reason for referral and admission date;

14.7.d.4. Assessment information;

14.7.d.5. Plan of care including goals and objectives of service;

14.7.c.6. Behavior support plans and/or therapy plans, if any;

14.7.c.7. Reviews of plan of care as appropriate;

14.7.c.8. Reports from outside or contracted providers of service to the resident;

14.7.c.9. Copies of all signed, written consent forms;

14.7.c.10. Routine documentation of ongoing services;

14.7.c.11. Documentation of incidents and/or investigations or reference to a separate incident file for each incident or investigation;

14.7.c.12. Documentation of any therapeutic physical restraints used by the organization with the resident in question;

14.7.c.13. Documentation of medication administration for prior months;

14.7.c.14. Educational records as available considering average program length;

14.7.c.15. Recommendations for ongoing and/or future service needs and assignment of aftercare or follow-up responsibility if needed and appropriate; and

14.7. c.16. A closing summary entered within 30 days of termination or discharge.

14.7.d. The organization shall document reasonable effort to obtain required materials.

14.7.e. When necessary and appropriate, the case record shall also include:

14.7.e.1. Legal evidence of custody;

14.7.e.2. Court ordered restrictions on the rights of persons served;

14.7.e.3. Psychological, medical, toxicological, diagnostic or psychosocial evaluations;

14.7.e.4. Copies of all written orders for medications or special treatment procedures such as diet and physical therapy;

14.7.e.5. Regular reports from contracted service providers serving the child, youth or family;

14.7.e.6. Reports relevant to the plan of care from other providers serving the child/youth/family with appropriate releases of information; and

14.7.e.7. Other information essential for delivering service to the client.

14.7.f. Only authorized personnel may make entries into case records and all entries shall be:

14.7.f.1. Specific, factual and pertinent to the nature of the service and the needs of the persons served; and

14.7.f.2. Completed, signed, or electronically identified and dated by the person who provided the service.

14.7.g. Case records shall be clearly legible, kept up-to-date from intake through termination and contact entries shall be made within 24 hours, or one working day, unless the group is away from the main facility, in which case entries shall be made within 24 hours of return to the main facility or program site.

14.8. Outside Providers of Service

14.8.a. Outside providers of service to children in out of home therapeutic environments shall provide summaries of intervention and progress no less than monthly for the organization's client record unless frequency of contact is less than once per month, in which case, summaries shall be provided quarterly. The organization and the outside provider shall ensure that therapeutic interventions are consistent across settings either by joint development of plans of care or by regular and documented sharing of information. Outside providers of service include physicians, therapists, physical therapists, occupational therapists, and other providers of service relevant to the accomplishment of the goals of the care plan.

14.9. Termination or Discharge

14.9.a. Discharge goals shall be developed with the creation of the plan of care.

14.9.b. Termination or discharge shall occur when:

14.9.b.1. The resident achieves the goals of their plan of care and/or is no longer in need of out-of-home care;

14.9.b.2. The resident has reached maximum benefit or cannot benefit further from services provided by the organization;

14.9.b.3. The guardian terminates treatment;

14.9.b.4. The resident no longer meets eligibility criteria;

14.9.b.5. The resident refuses to meet program standards or requirements;

14.9.b.6. The resident has needs that exceed organizational resources; or

14.9.b.7. The resident completes court-ordered treatment.

14.9.c. The organization and interdisciplinary team, guardian, placement agency (such as the court), multidisciplinary team, and the person or family shall jointly plan for termination or discharge.

14.9.d. A person that is involuntarily discharged shall be linked with appropriate services in another organization or in the community whenever possible.

14.9.e. Upon termination of service or within 30 days of termination or discharge, a closing summary shall be entered into the case record that:

14.9.e.1. Includes recommendations for any needed future services; and

14.9.e.2. Provides a summary of services received while in care and an assessment of service effectiveness.

14.9.f. The organization that has collaborated with other organizations or has shared case management responsibility for the person or family served shall notify those organizations, upon termination of services, with the written consent of the person served or his/her guardian. The person served or his/her guardian shall have the right to refuse such notification, which shall be documented.

14.10. Educational Facilities

14.10.a. The organization shall develop an educational program for each school-age child in care.

14.10.b. All children and transitioning adults in residential treatment must be enrolled in an educational or vocational program (depending on age and the youth's expressed desire) and provided with an educational or vocational plan, as appropriate, that is integrated into his/her plan of care and complies with the requirements set forth by the state department of education. The organization is responsible for ensuring that the child's educational credits are accepted by the child's home school/county.

14.10.c. When appropriate and unless clinically, programmatically or educationally contraindicated, children and transitioning adults shall be enrolled in the public school system. Organization personnel shall maintain regular contact with school personnel at a frequency appropriate for the severity and type of each child or youth's problems and service

needs. The organization shall have a policy describing the method and frequency of contact.

14.10.d. The organization shall collaborate with the public school so that information can be exchanged freely and problem behaviors addressed consistently across all environments. Upon admission, the organization shall be responsible for obtaining parent or guardian permission for information to be exchanged with the public or private school system which the child is expected to attend.

14.11. On-Ground Schools

14.11.a. On-ground schools shall meet the guidelines required by the West Virginia Department of Education. At a minimum, on grounds schools shall attain Exemption A status, be a school operated by Institutional Services of the Department of Education, or be conducted in conjunction with or under the auspices of the local educational authority in the county in which the organization is operating. When possible the school shall be accredited by a state or regional accrediting body. Educational staff shall be certified to teach in the state of West Virginia. Outdoor therapeutic educational programs shall be exempt from this rule and shall comply with the requirements described in the specific sub-section applying to such facilities.

14.11.b. Educational personnel shall:

14.11.b.1. Develop and implement an educational plan for each student to be incorporated into the overall plan of care. The plan shall be appropriate for the student's assessed current level of academic functioning;

14.11.b.2. Integrate educational goals and activities into the overall service program; and

14.11.b.3. Involve children and transitioning adults in community social, athletic and recreational facilities as appropriate to individual need and readiness.

14.11.c. There shall be an adequate educational staff to child ratio for the needs and educational goals of the children/youth.

14.11.d. Special education students shall be identified and managed as required by state and federal law (IDEA Public Law 105-17).

14.11.e. The on-ground school shall request school records upon admission of the resident and provide up to date records to a new school upon request for information by a new school if the child is transferred.

14.11.f. When appropriate, the organization shall assess whether students are ready for placement in an off-campus school setting and make such placements in accord with the goals and timetables of the student's individual educational plans and with the knowledge

and cooperation of the local educational authority.

14.11.g. On-ground educational personnel shall facilitate school transfer and provide consultation as needed and requested to professionals in off-campus educational settings.

14.11.h. Therapeutic support plans developed in the residential setting shall be continued in the on-ground educational setting and vice versa. The educational program and the residential program shall communicate on a regular basis to ensure that this occurs and shall exchange data and information regularly. The organization shall have a policy and an interagency or interoffice agreement specifying how the agencies or offices will interact and the frequency of that interaction.

14.12. Groups and Groupings

14.12.a. The organization shall ensure that therapeutic activities and groups shall be of an appropriate size to promote the success of the activity. Generally, the therapeutic group should consist of no more than 12 children.

14.12.b Groups shall be separated according to developmental functioning, sex, social skills, group dynamics, and other variables if appropriate and necessary. Residents shall have the right to be housed with residents of the same approximate ages, developmental levels and social needs. This separation shall be a matter of organizational policy.

14.12.b.1. No child under six years of age shall be placed in a residential child care facility without prior written approval from the regulatory body.

14.12.b.2. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

14.13. Work Facilities

14.13.a. The organization may involve the child in maintenance of the facility (cleaning bedrooms and bathrooms, working in the kitchens, etc.) so long as those facilities do not replace the organization's need for housekeeping and maintenance staff. Household "chores" may be required as a condition of participation in the program or as a method of moving to a more privileged level of programming. Descriptions of such work facilities should be included in the organization's program descriptions. All work programs must be evaluated for their therapeutic or habilitative value. If there is no therapeutic or habilitative value in the activity, the child must be paid for the activity at a level required by state or federal law and the work activity must be voluntary. Money earned in a work program belongs to the child or youth, although the organization may maintain control of the money until the child's discharge, using an accurate and on-going method of tracking disbursements and deposits, made available to the child or guardian upon request. Work facilities other than household "chores" must be evaluated and approved by the interdisciplinary team.

14.14. Daily Schedules

14.14.a. The interdisciplinary team shall provide each child with a written daily schedule of activities designed to help him/her develop positive personal and interpersonal skills and behaviors by providing activities that are individualized, and:

14.14.a.1. Appropriate to the age, behavioral level, emotional needs, strengths and interests of the child;

14.14.a.2. Specialized to meet the child's identified strengths and needs as described in the assessment and plan of care;

14.14.a.3. Normalizing and integrated into the community to the maximum extent possible given the child's clinical needs and behavioral functioning;

14.14.a.4. Available at all times to the staff and child; and

14.14.a.5. Comprehensive of all waking hours while allowing a reasonable amount of recreational and study/quiet time.

14.15. Staff Supervision

14.15.a. At all times, the organization shall have sufficient staff to allow the number of children being served to be adequately supervised, taking into consideration the level of severity and need of the children involved. The organization must consider appointments requiring staff supervision, staff leave, possible illness of children and any other relevant factor when scheduling staff and child activities.

14.15.b. Residents are expected to be supervised at all times unless the resident is engaged in an activity away from supervision authorized by the clinical team (e.g., home visit, public school, employment, recreation, etc.).

14.15.c. The organization shall have a policy regarding ratios of staff to children specific for each of the various program settings and activities.

14.15.d. The organization shall have a policy regarding staff supervision which shall ensure the safety, supervision and security of children who are acutely disturbed and/or suicidal.

14.15.e. The organization shall have a policy regarding supervision of children/youth in off grounds activities which shall maximize the supervision and safety of children/youth participating.

14.15.f. The organization shall ensure that when children or youths leave a facility for overnight visits, there is a procedure for signing or being checked in and out of the program.

The checklist or sign-in sheet shall be dated and shall include time in/out, person responsible for the child/youth, as appropriate, and the location at which the child/youth may be contacted if necessary.

14.16. Special Services and Populations

14.16.a. If an organization provides specialized services to a unique population (e.g., children with issues of substance abuse, children with developmental disabilities, sexually reactive children) the organization shall ensure that:

14.16.a.1. The service and clinical model reflects knowledge and utilization of the best practices available in the field;

14.16.a.2. Clinical and professional staff are appropriately trained and when possible certified or licensed in the area(s) of service provided;

14.16.a.3. Direct care staff are specially trained to understand issues in clinical treatment of the population and able to use suitable intervention techniques when necessary and appropriate;

14.16.a.4. The environment and milieu of the treatment location is clinically, structurally and developmentally appropriate for the population served and;

14.16.a.5. The facility is suitably secure and staff ratios suitably high to ensure supervision and safety of children served.

14.16.b. If an organization accepts into service a child with unusual clinical and/or programmatic needs, the organization shall be responsible for adapting its routine practices to meet the needs of the child in care to the greatest extent possible. If it becomes evident that the child cannot benefit from the program, even with the adaptations the organization is able to make, the organization shall be responsible for arranging a more suitable placement at the earliest opportunity in conjunction with the guardian and/or multidisciplinary team.

14.16.c. A residential program that specializes in serving children and transitioning adults with developmental disabilities or mental retardation shall ensure that staff are trained to properly provide habilitation services and supervision in the following areas as appropriate for the population served:

14.16.c.1. Feeding;

14.16.c.2. Communication with nonverbal individuals;

14.16.c.3. Use of community recreation options;

14.16.c.4. Management of self-abusive and aggressive behavior;

14.16.c.5. Adaptive living skills;

14.16.c.6. Person first language and attitudes;

14.16.c.7. Therapeutic behavioral supports; and

14.16.c.8. Implementation of the principles of normalization.

14.16.d. When serving individuals with developmental disabilities for more than 30 days, the program provides supportive services to help them fully interact with the community and achieve maximum independence. If the organization provides or contracts for the provision of therapeutic services such as individual therapy, it shall ensure that therapeutic interventions are adapted for the developmental functioning of the child/youth.

14.16.f. An organization that provides services to youth with developmental disabilities adheres to and implements the Principles of Normalization and adapts the organization's therapeutic facilities to meet the developmental needs of the resident with developmental disabilities.

14.16.g. The organization shall provide children and transitioning adults with substance abuse problems with specialized services to meet their needs as identified in the comprehensive assessment. The organization shall arrange for detoxification and inpatient services to meet any emergency needs of residents.

14.16.h. The organization shall ensure that youth are provided with therapeutic and didactic interventions which directly address his/her substance abuse and/or dependence and any deficits in adaptive functioning relating to or concurrent with the abuse of substances.

14.16.i. If the organization specializes in substance abuse treatment, personnel training shall comprehensively address the latest information, theories and techniques in:

14.16.i.1. Identification, diagnosis and treatment of alcohol and drug abuse;

14.16.i.2. The concept of chemical dependency as a disease; and

14.16.i.3. Prevention activities that address both primary and relapse prevention.

14.16.j. When the initial assessment indicates the presence of a sexually sensitive history (either as offender or victim) the organization shall:

14.16.j.1. Obtain either directly or by contract/referral a thorough assessment of the sexual history and functioning of the youth, attending in particular to episodes of victimization or offense;

14.16.j.2. Obtain either directly or by contract/referral specialized treatment interventions as appropriate; and

14.16.j.3. Ensure that the child/youth is appropriately housed and supervised in order to secure their safety or the safety of other youth in the organization.

14.16.k. If the organization specializes in the treatment of sexual offenders:

14.16.k.1. The milieu shall be organized and maintained in such a way as to maximize the safety and supervision of youth at all times;

14.16.k.2. Staff shall be specially trained in the supervision and treatment of sexually reactive youth; and

14.16.k.3. Professional staff shall be trained and certified as appropriate in the treatment of sexually reactive youth, or shall be in the process of obtaining certification and properly supervised by certified staff.

14.16.l. If the organization discovers that resident is pregnant and it is not a Maternity and Parenting Program, it shall provide or make referral for the following health services, at a minimum, until other arrangements are made;

14.16.l.1. Fetal alcohol syndrome screening;

14.16.l.2. Prenatal care;

14.16.l.3. Well-baby care; and

14.16.l.4. Parenting skills instruction.

14.17. Health Services

14.17.a. The organization shall have a procedure in place to ensure emergency medical care for all its residents on a 24 hour basis.

14.17.b. Each resident shall have upon admission or receive within 5 days of admission a current medical screening by a qualified medical practitioner working within the scope of their practice.

14.17.c. In facilities of longer than 30 days duration, appropriate dental assessments shall be conducted at least annually to include provision of any routine dental care as recommended by the evaluating dentist.

14.17.d. Health services shall also include, in facilities of longer than 30 days duration, age appropriate instruction regarding:

14.17.d.1. Pregnancy prevention,

14.17.d.2. AIDS/HIV and STD prevention,

14.17.d.3. Nutrition;

14.17.d.4. Laboratory and/or other diagnostic work as prescribed by physician; and,

14.17.d.5 Other general information about the prevention and treatment of disease.

14.17.e. Educational services shall also be provided regarding psychotropic medications and mental health as age appropriate and necessary. When possible, the family of origin or expected family of projected placement shall be educated as well.

14.18 Clothing

14.18.a The organization shall ensure that each child in care has adequate, clean, well fitting, attractive and seasonable clothing as required for health, comfort and physical well-being and as appropriate to age, sex and individual needs. The resident shall be encouraged to participate in the selection of clothing.

14.18.b. A resident's clothing must be identifiably his/her own and not shared in common.

14.18.c. Clothing shall be kept clean and in good repair. The resident shall be involved in the care and maintenance of his/her clothing. As appropriate, laundering, ironing and sewing facilities shall be accessible to the resident.

14.18.d. When uniforms are required, the resident and parents or guardians shall be advised prior to admission.

14.18.e. The organization shall ensure that discharge plans make provisions for clothing needs at time of discharge. All personal clothing shall go with a resident when he/she is discharged.

14.19 Personal Belongings

14.19.a. The organization shall allow a resident to bring personal belongings to the program and to acquire belongings. However, the organization shall, as necessary, limit or supervise the use of these items. Provisions shall be made for the protection of resident's property.

14.20 Personal Hygiene

14.20.a. Procedures to ensure that residents receive assistance and training in person care, hygiene and grooming appropriate to their age, sex, race and culture shall be established.

14.20.b. The organization shall ensure that children are provided with all necessary toiletry items.

14.20.c. A resident shall be permitted a reasonable degree of freedom in selecting a style of wearing his/her hair and clothing.

14.21 Religion and Culture

14.21.a. Residents shall have the opportunity to participate in religious activities and services in accordance with their own faith. The organization, when necessary, shall arrange transportation.

14.21.b. Residents may not be coerced or required to attend religious activities.

14.21.c. The organization shall involved residents in cultural or ethnic activities, appropriate to their own cultural or ethnic background.

§78-3-15. Restrictive Behavioral Interventions

15.1. Legal Compliance

15.1.a. Restrictive behavior management techniques include: restraint (physical, mechanical or chemical) and seclusion. The organization shall have a policy with specific procedures to govern the use of these techniques. The policy shall delineate the circumstances under which such techniques may be used and shall describe which techniques may be used in precise language. Unless indicated otherwise in this rule, restraints are to be used only in an emergency when there is imminent risk of physical harm to self or others, including staff. Non-physical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response. Restrictive behavior management techniques are not to be used as a part of an approved plan of care.

15.1.b. Group restraints incorporating peers as restrainers or observers are forbidden in any treatment environment.

15.1.c. Seclusion, chemical and mechanical restraints shall be used only in facilities with explicit permission to do so as described in this rule (i.e. psychiatric residential treatment facilities and intermediate care facilities).

15.2. General Guidelines

15.2.a. Restrictive behavior management techniques shall be used only in emergency situations to protect individuals from harming themselves or others and not as part of an on-going plan of care.

15.2.b. Use of the techniques shall conform to federal guidelines when such guidelines exist unless such guidelines are less stringent than those described in this rule.

15.2.c. The organization shall maintain comprehensive data on the use of any restrictive behavior management practices, collected individually for each organization or program it manages, and shall summarize and review that data quarterly. An annual report shall be made to the governing body by the safety committee/officer.

15.2.d. At admission each child/youth shall be assessed for his/her potential need for use of restrictive behavior management interventions. The assessment shall include:

15.2.d.1. The potential for risk of harm to self or others;

15.2.d.2. Antecedents (if known) to out of control behavior;

15.2.d.3. Effectiveness (if known) of previous use of such interventions;

15.2.d.4. Psychological or social factors such as psychosis, claustrophobia or; history of sexual or physical abuse that would influence use of such practices and;

15.2.d.5. Medical factors that might put the person at risk in a restraint.

15.2.e. If the child is judged likely to require the use of restrictive behavior management techniques, staff shall be alerted to any considerations identified in the assessment and trained/oriented appropriately.

15.2.f. The organization shall ensure and document that the parent or legal guardian:

15.2.f.1. Received notification in writing at the time of admission that such interventions are used by the organization;

15.2.f.2. Received a copy of the behavior management protocol; and

15.2.f.3. Was notified immediately if a restraint was used unless the guardian has requested otherwise.

15.2.g. The organization shall prohibit the following:

15.2.g.1. Use of restrictive behavior management techniques in non-crisis or emergency situations, as a form of coercion or discipline, or for the convenience of staff;

15.2.g.2. Excessive or inappropriate use of restrictive behavior management techniques; and

15.2.g.3. The application of restrictive behavior management interventions by other persons served or any person other than trained, qualified staff.

15.2.h. A trained observer should be present whenever possible.

15.2.i. The condition of the restrained or secluded person must be monitored. Consciousness, respiration, agitation, mental status, skin color and skin integrity should be monitored continuously.

15.2.j. Staff members identified as medical resources should have the authority to continue or stop a specific intervention based on health issues.

15.2.k. The organization shall discontinue restrictive behavior management interventions immediately if they produce adverse side effects such as illness, severe emotional or physical stress or physical damage and obtain immediate medical treatment for the resident.

15.3. Training

15.3.a. All personnel shall receive documented training in the organization's restrictive behavior management practices.

15.3.b. All direct care, supervisory and clinical personnel shall receive initial and ongoing competency-based training on the organization's restrictive behavior management policies, procedures and practices appropriate for the type of program.

15.3.c. Such training shall include:

15.3.c.1. Recognizing situations, including medical conditions that may lead to a crisis;

15.3.c.2. Unique situations which preclude the use of restraints (medical issues, sexual reactivity, etc.);

15.3.c.3. Understanding how staff behavior can influence the behavior of persons served; and

15.3.c.4. Using appropriate methods for de-escalating volatile situations, including verbal techniques, mediation, distraction and diversion and other non-restrictive ways of dealing with aggressive or out of control behavior.

15.4. Physical restraint

15.4.a. Written procedures shall govern the use of physical restraint. They shall specify that:

15.4.a.1. Physical restraint is used only in emergency or crisis situations to protect individuals from harming themselves or others;

15.4.a.2. Personnel use the least restrictive, safest and most effective methods generally accepted in the field;

15.4.a.3. Physical restraint is used in each instance only when less restrictive measures have proven to be ineffective or in an immediately dangerous situation which precludes the use of other interventions;

15.4.a.4. The decision to use physical restraint shall take into account an analysis which determines that the risk of the individual's behavior to self or others outweighs the potential risk of the use of physical restraint. This shall be documented as soon as possible after the use of the restraint;

15.4.a.5. Physical restraint is discontinued as soon as possible;

15.4.a.6. All direct service personnel have access to a copy of written policies and procedures regarding the appropriate and limited use of physical restraint;

15.4.a.7. A continuing monitoring system/log shall be kept documenting names of staff restraining, names or identifiers for children restrained, date and time of restraint, other individuals involved, circumstances and reasons for physical restraint, amount of time restrained, and documentation of supervisory review;

15.4.a.8. Use of physical restraint must be documented in the person's case record;

15.4.a.9. Use of a physical restraint shall result in completion of a report;

15.4.a.10. Significant injuries occurring during a physical restraint shall be reported to the Institutional Investigative Unit under mandatory reporting requirements (W.Va. Code 49- 6A- 9); and

15.4.a.11. The organization shall have documentation of notification of parent or guardian unless the parent or guardian indicates in writing that they do not wish such notification or unless parent or guardian has specified parameters for notification (i.e., in case of injury during restraint).

15.4.b. The clinical justification, use, personnel involved, circumstances, efforts to employ less restrictive measures and length of application must be clearly documented for each instance of physical restraint.

15.4.c. Each incident shall be administratively reviewed no later than one working day after its use.

15.4.d. Physical restraint may not be used:

15.4.d.1. To force a youth into compliance;

15.4.d.2. In response to cursing or screaming;

15.4.d.3. For refusal to participate in an activity; and

15.4.d.4. For failure to join a group activity.

15.4.e. The use of physical restraints are discontinued as soon as possible, and shall be limited to the following maximum time per episode:

5.4.e.1. Fifteen minutes for children aged nine and younger; and

15.4.e.2. Thirty minutes for persons aged ten and older.

15.4.e.3. Periodic attempts to free the child must be made, during the period in which restraint is employed.

15.4.f. If the restraint extends longer than recommended guidelines, the organization shall document the reason for the extended restraint and describe action taken to prevent further use of extended physical restraint.

15.4.g. Following each instance of physical restraint, a meeting is held within 24 hours that includes the appropriate personnel (the staff restraining and supervisory staff) and the person restrained (if developmentally and clinically appropriate) to:

15.4.g.1. Evaluate the well-being of the person served and identify the need for counseling or other services related to the incident;

15.4.g.2. Identify antecedent behaviors and modify the care plan as appropriate; and

15.4.g.3. Analyze how the incident was handled.

15.4.h. Staff and designated supervisory staff shall discuss necessary changes to procedures and/or staff training in order to preclude further restraints to the maximum extent possible. Recommendations shall be documented.

§78-3-16. Critical incidents and Crisis Management

16.1. Abuse and neglect

16.1.a. The organization shall have a policy regarding identification and reporting of instances of alleged abuse and/or neglect of residents in its care that shall be in compliance with state law (49 6A 1 et seq).

16.1.b. Definitions of abuse and neglect and procedures regarding reporting of abuse and neglect shall be consistent with those established by State Law.

16.1.c. The staff, volunteers and management of any organization are considered to be mandatory reporters by State Law and are required to report any and all allegations of abuse and neglect to the appropriate state authorities as required in Chapter 49 6A 1 et seq. All allegations of abuse and neglect shall be immediately reported by telephone to the Institutional Investigative Unit of the West Virginia Department of Health and Human Resources via a telephone call to the Child Abuse Hotline. Within forty-eight hours of the incident, the organization shall prepare a written incident report, which shall be available to the Institutional Investigative Unit upon request. The Institutional Investigative Unit shall inform the organization if an investigation of the incident shall be conducted. If the Institutional Investigative Unit indicates that there shall be no Institutional Investigative Unit investigation the allegation shall be downgraded to a critical incident and the organization shall proceed with a full investigation as defined and described herein.

16.1.c.1. The organization shall limit internal assessment of an incident to ensuring the safety of the resident(s) in placement without compromising the Department's subsequent investigation.

16.1.d. All incidents which have harmed or may have represented potential harm to a resident or residents shall result in the completion of an incident form. Incidents suspected of being subject to mandatory reporting requirements as defined by WV State Law shall be reported to the Institutional Investigative Unit according to organization policy and procedures. This shall include medication errors with negative outcome for the resident and any injuries occurring in the course of a restraint.

16.1.e. The organization shall cooperate fully in an investigation of any incident and shall provide all information requested by the Department.

16.1.f. Any investigations completed by the organization shall be maintained in a

central file and made available to the state regulatory agency.

16.1.g. In all cases, the organization shall take the actions necessary to protect the child from further harm until an investigation is completed. An incidents involving the alleged sexual abuse or physical abuse causing a serious physical injury to a child by an employee of the organization requires that the employee be removed from direct service work with children until the investigation is completed. Otherwise, the organization shall have a procedure in place for management of staff alleged to have abused or neglected a child/youth that may include any or all of the following:

16.1.g.1. Removal from duty pending investigation;

16.1.g.2. Increased supervision to ensure child/youth safety;

16.1.g.3. Transfer to a substantially different area of the organization with different residents (higher developmental functioning, different sex, etc.);

16.1.g.4. Transfer to a different more closely supervised shift;

16.1.g.5. Transfer to different job responsibilities that do not include contact with children, and;

16.1.g.6. Other appropriate actions as indicated by the circumstances.

16.2. Critical Incidents

16.2.a. The organization is responsible for monitoring and investigating any incident which may have had the potential for harming a resident or residents emotionally or physically with the exception of those incidents investigated by the Institutional Investigative Unit. Critical incidents include but are not limited to the following:

16.2.a.1. Attempted suicide with some potential for lethality;

16.2.a.2. Behavior likely to lead to serious injury or significant property damage;

16.2.a.3. Fire resulting in injury;

16.2.a.4. Behavior resulting in interruption of services including the necessity for movement to a more intensive level of care;

16.2.a.5. Major involvement with law enforcement authorities;

16.2.a.6. Possession of illicit substances including alcohol;

16.2.a.7. Possession of weapons;

16.2.a.8. Injury resulting in hospitalization or medical treatment;

16.2.a.9. Significant reaction to a medication or food;

16.2.a.10. Medication errors with negative outcome which the Institutional Investigative Unit determines it will not investigate;

16.2.a.11. Dietary errors resulting in negative outcome for the child;

16.2.a.12. Extended and unauthorized absence of a resident that exceeds his/her plan of care provision for community access;

16.2.a.13. Removal of a child or youth from service without his/her consent and that of the interdisciplinary team including the guardian;

16.2.a.14. Significant injuries of unknown origin; and

16.2.a.15. Any other incident judged by staff, management or other individual to be significant and to potentially have a negative impact on the child/youth.

16.2.b. For the purposes of sorting mandatory reporting incidents from other incidents, the issue of lack of appropriate staff oversight must always be considered. If the incident can be attributed to lack of staff oversight, it is upgraded to a mandatory reporting incident. "Lack of staff oversight" shall be defined to mean a violation of organizational policy regarding oversight of a child or group of children.

16.2.c. All critical incidents must be documented, investigated by a committee consisting of at least two members not in direct chain of command for the organization, and shall result in a report which shall be reviewed by the administrator or his/her designee within five working days of the occurrence of the incident or within five days of notification by the Institutional Investigative Unit that it will not investigate. The report must describe the incident, possible antecedents, consequences, witnesses, time of day, length of incident, individuals involved and any other information necessary for quality improvement and/or risk management. Whenever possible, all witnesses should be interviewed and the results of the intake documented.

16.2.d. All facilities will also encounter incidents which are not necessarily critical in nature but which will require investigation. Again, lack of staff oversight must always be evaluated as an issue. If the lack led to negative outcome for the resident, it must be upgraded to mandatory reporting. Injuries of unknown origin must also always be evaluated and considered for potential of abuse in protected populations.

16.2.e. A non-critical incident shall be defined as any unusual event occurring to a resident that needs to be recorded and briefly investigated or reviewed and tracked for risk management or quality improvement purposes. Such incidents would not include behaviors for

which there is a behavior support plan and data tracking mechanism in place. Examples would be assault by another resident with minor or no injury resulting; seizures; minor injuries of unknown origin; brief episodes away from supervision; self-injurious behavior with no significant negative outcome; suicidal threats or minor gestures without significant injury; medication error without negative outcome; unsuccessful fire setting; any other similarly non-critical event. If a pattern of non-critical incidents is identified, the organization shall more carefully and thoroughly investigate incidents typical of the pattern (e.g., medication errors, injuries of unknown origin, etc.)

16.2.f. The organization shall keep a central administrative file of all incident reports and any ensuing investigations.

16.2.g. Incident reports/descriptions must be completed prior to the end of the shift of the reporter/individual involved. The program supervisor must review and sign off on the report within one working day. Reports shall be made by telephone or fax to the Institutional Investigative Unit immediately, when appropriate. Written reports shall follow within 48 hours as appropriate. Internal investigations must be completed within five days of the incident or within five days of notification by the Institutional Investigative Unit that it will not investigate, depending on the nature of the incident.

16.2.h. As a part of the organization's risk management and quality assurance processes, all incident reports shall be submitted either monthly or quarterly (depending on the size of the organization and number of reports) to the organization's safety committee/officer for review. That review shall result in an annual report to the governing body and shall be used to improve quality and safety of care to the children/youth in service.

16.3. Emergency Medical Services

16.3.a. The organization shall have a specific policy and procedures for directing staff in case of medical emergencies.

16.3.b. All staff shall have access to the procedures and to a list of emergency numbers as required by the policy.

16.3.c. All staff shall be trained in emergency medical procedures as specified in policy.

16.3.d. Residential direct care staff shall have at a minimum the availability of telephone contact with supervisory staff on a 24-hour basis. Telephone numbers for supervisory staff and schedules of on-call responsibility shall be readily available to all staff at all times.

16.4. Deaths

16.4.a. All resident deaths shall be reported to the Institutional Investigative Unit, the Office of Health Facility Licensure and Certification, the coroner of the county in which the organization is located, and to other state or federal agencies as required by law within twenty-four

hours.

§78-3-17. Group Residential Treatment

17.1. Definition

17.1.a. Group residential treatment is the provision of supervision, room, board and psychosocial/habilitative treatment for children and transitioning adults who are in need of out-of-home care and may be considered emotionally, developmentally and/or behaviorally challenging. Such definition shall not include any organization more narrowly defined/classified elsewhere in this rule (e.g., Intermediate Care Facilities for the Mentally Retarded, Psychiatric Residential Treatment Facilities, Outdoor Therapeutic Educational Programs), nor shall it include children or youth placed in a private residence classified as a foster family or foster home by the Department of Health and Human Resources.

17.2. Staff Ratios and Training

17.2.a. Staff, for the purposes of this section, is defined as those individuals who are:

17.2.a.1. Fully oriented and trained according to organizational policy; and

17.2.a.2. Have job responsibilities which pertain only to the provision of child care, treatment and supervision.

17.2.b. The group residential program shall have a policy regarding care and supervision of residents that ensures that:

17.2.b.1. Children receive adequate supervision for their age, developmental functioning and emotional and behavioral needs; and

17.2.b.2. The care plan as developed by the interdisciplinary team is implemented as written for each child.

17.2.c. Children/youth shall be cared for and supervised at the following levels, with clinically justified modifications when house parents are employed:

17.2.c.1. Minimum of staff to resident ratio of 1:6 during waking hours when residents are on grounds with a minimum of one staff present per residential living unit at all times when residents are present in the living unit;

17.2.c.2. Availability of additional or back-up care personnel for emergency situations or to meet special needs presented by the persons in care (e.g., physician's appointments, behavioral outbursts, acute suicidality, etc.); and

17.2.c.3. Staff to resident ratio of 1:12 during sleeping hours with a minimum, of at least one staff per residential living unit to be awake at all times when residents are present in the living unit.

17.2.d. The organization shall have a policy regarding supervision of children/youth in off-grounds activities which shall ensure that children are adequately supervised at all times.

17.2.e. As appropriate to the ages and needs of persons in care, the organization shall ensure that one or more trained professional staff members is on duty or available via an on-call system on a 24-hour basis to provide continuous supervision to each residential living unit within a residential program.

17.2.f. The organization which utilizes a house parent model shall have a policy that ensures the safety and supervision of children at night.

17.3. Environmental Issues

17.3.a. To the maximum extent possible, the organization providing group residential services shall be non-institutional in appearance and practices. Each child or transitioning adult shall be permitted to have personal space, personal possessions and a place to store those possessions unless clinically contraindicated. Each resident is expected to assume some responsibility for an aspect of home/facility maintenance (cleaning, cooking, etc.) on an ongoing basis.

17.3.b. The organization shall ensure that residential living units within the milieu consist of no more than 12 children. The size of the groups shall be dictated by their function and some may be smaller than 12 members. Group therapeutic and residential living activities should be conducted in an appropriately sized group format, taking into consideration best practice standards for the sex, developmental status, and diagnosis of the members.

17.3.c. Children/youth shall have clearly identifiable schedules and activities, individualized for their strengths and needs. Each child must have a unique schedule which identifies therapy times, chore or work assignments, school hours, and other activities.

17.3.d. Staff must be available in sufficient quantity and with appropriate credentials to address the needs of the child or youth as identified by the assessment and interdisciplinary team process.

17.3.e. The residential program that permits pets must follow written procedures that address their availability, care, feeding, and maintenance that includes at a minimum, veterinary evaluation and vaccinations as recommended by the veterinarian in writing.

17.3.f. Service elements unique to the population/environment:

17.3.f.1. If the residential program permits residents to operate vehicles while

in placement, it shall do so under the following conditions:

17.3.f.1.A. The resident has a valid West Virginia driver's permit or license;

17.3.f.1.B. The resident's vehicle, if any, is appropriately licensed and insured; and

17.3.f.1.C. The resident receives permission in writing from his guardian/custodian and parent, as appropriate.

17.3.f.2. The organization shall have a written plan of basic daily routines which shall be available to all personnel and updated regularly.

17.3.f.2.A. Residents shall participate in planning daily routines.

17.3.f.2.B. Residents shall have set routines for waking and going to bed.

17.3.f.3. The organization shall encourage and arrange for residents to participate in community, school functions and recreational activities on an individual basis.

§78-3-18. Residential Crisis Support/Emergency Shelter Care

18.1. Definition

18.1.a. Children's emergency shelter care is a form of short-term (typically less than 45 days) residential care for children or transitioning adults or youth that temporarily provides food, clothing, shelter and other necessary crisis support services.

18.2. Service Description

18.2.a. Children's emergency shelter care services are provided to children or transitioning adults or youth in need of room, board and supervision and support during a familial or personal crisis.

18.2.b. Children's emergency shelter care services are provided to all children/youth unless services are limited to a specific target population through a written program description or through contract with the Secretary.

18.2.c. Children's emergency shelter care shall be responsible for making reasonable efforts to assist individuals to find appropriate placement if admission is impossible because of census, program description, or client variables.

18.2.d. When children/youth are provided shelter without permission of parent or

guardian, the organization shall:

18.2.d.1. Establish the youth's legal status;

18.2.d.2. Conduct a brief interview to ascertain the circumstances of the need for admission;

18.2.d.3. Notify the parent/guardian of the admission unless the Shelter documents that the youth;

18.2.d.3.a. Is an emancipated minor;

18.2.d.3.b. Has reached age of majority; or

18.2.d.3.c. Could be endangered as a result of notification.

18.2.d.4. Notify the local representative of the Department of Health and Human Resources; and

18.2.d.5. Obtain authorization to provide care for the youth if appropriate and necessary.

18.2.d.6. The youth shall be informed of the planned notification, which must occur immediately after admission.

18.2.e. Stays in the Shelter are voluntary unless the youth has been ordered into the facility by a legal entity with authority to do so. If a youth voluntarily enrolled as a participant chooses to leave the facility, staff shall document efforts to persuade him/her to remain and/or to arrange safe alternative placement. If in the staff's assessment, the child is not capable of adequate self-protection, the staff will take action as delineated by Department of Health and Human Resources policy.

18.2.f. Youth in Shelter care are expected to be supervised at all times unless the youth is engaged in an activity away from supervision authorized by the clinical team (e.g., home visit, public school, employment, etc.). The shelter shall ensure that when children or youths leave the building, there is a procedure for signing or being checked in and out. The checklist or sign-in sheet shall be dated and shall include time in/out, person responsible for the child/youth, as appropriate, and the location at which the child/youth may be contacted if necessary.

18.2 .g. The Shelter shall have policies and procedures for expelling an individual from a Shelter. Policies and procedures shall be described in an understandable fashion to the individual at admission and he/she shall also receive a copy of policies regarding standards of conduct in the Shelter at that time. Policies and procedures shall:

18.2.g.1. Define the reasons or conditions for which an individual may be expelled;

18.2.g.2. Delineate a clearly defined process for expulsion including timely due process provisions;

18.2.g.3. Describe the conditions or process for re-admission to the Shelter; and

18.2.g.4. Require that all reasonable efforts be made to provide an appropriate alternative placement.

18.2.h. All Shelters provide services that are designed to meet the immediate safety and survival needs of the youth. As such, they shall provide, either directly or by referral, the following:

18.2.h.1. Sleeping accommodations;

18.2.h.2. Food;

18.2.h.3. Clothing;

18.2.h.4. Personal hygiene supplies and facilities;

18.2.h.5. Crisis intervention;

18.2.h.6. Case management and assistance;

18.2.h.7. A mailing address;

18.2.h.8. Information and referral for services;

18.2.h.9. Linkage to medical services;

18.2.h.10. Eyes on supervision;

18.2.h.11. Supportive group counseling;

18.2.h.12. Supportive individual counseling;

18.2.h.13. Access to recreational activities; and

18.2.h.14. Educational assistance, if necessary.

18.2.i. The Shelter shall:

18.2.i.1. Provide prompt admission;

18.2.i.2. Emphasize short term stay by working aggressively to arrange more appropriate alternative placement;

18.2.i.3. Provide an organized written program of daily activities for each youth that includes social, recreational and educational activities;

18.2.i.4. Promote continued contact and communication between parent/guardian and child unless legally or clinically contraindicated; and

18.2.i.5. Assist in developing supportive aftercare or other services to ameliorate the problems that led to the need for Shelter.

18.2.j. Shelters shall be exempt from provision 14.9 (educational programming) of the core rules. Shelters shall:

18.2.j.1. Informally evaluate educational needs upon admission of school-age children/youth;

18.2.j.2. Arrange admission to the public school system;

18.2.j.3. Provide educational activities for each school age child in the Shelter environment as required by the state Department of Education.

18.3. Staff Ratios and Training

18.3.a. The Shelter shall have the following staff:

18.3.a.1. Direct care staff who provide continuous supervision for children/youth 24 hours per day at ratio of not less than 1:5 with one staff present at all times in each residential living unit;

18.3.a.2.Home manager to provide coordination and supervision of staff and operations, possessing a minimum of a bachelor's degree and two year's experience in working either in management or with children and families;

18.3.a.3. Consulting licensed psychologist, available as needed by staff or children;

18.3.a.4. Case manager/service coordinator, to provide case management services and supportive counseling, minimum educational requirements a bachelor's degree and one year experience working with children and families. The case manager must be appropriately

supervised on a regularly documented basis by a qualified behavioral health clinician or social worker;

18.3.a.5. Consulting registered nurse available onsite at least weekly and responsible for:

18.3.a.5.A. Performing nursing assessments on each child/youth within five working days of admission;

18.3.a.5.B. Completing medication administration records for each child/youth, updated as necessary;

18.3.a.5.C. Monitoring medication administration including supervising Approved Medication Assistance Personnel if necessary;

18.3.a.5.D. Assessing residents for ability to self-medicate under supervised conditions and developing appropriate educational materials or facilities for educating residents about their medications or other health conditions;

18.3.a.5.E. Educating staff to meet the demands of residents with unusual health conditions such as diabetes, epilepsy, etc.; and

18.3.a.5.f. Monitoring medication availability, storage, record-keeping, disposal, and medication errors.

18.4. Treatment Teams

18.4.a. Shelter treatment teams shall consist of the child/youth if developmentally appropriate, a direct care staff person, the case manager and the home manager at minimum. The consulting psychologist shall review and approve all activities of the treatment team if he/she was not an active participant. When appropriate for residents with medical issues, the consulting nurse shall also be a member of the team or shall approve the team's activities in writing. Parents/guardians and the child's social worker shall be notified of and participate in team activities unless time lines for team activities prohibit such involvement or parental participation is not clinically or legally appropriate. The social worker shall receive a copy of the team's actions within 24 hours if not a direct participant.

18.5. Care Plans

18.5.a. Shelters shall be exempt from the plan of care sections of the core rule (§78-3-13.2. et seq.) as long as the child is present in the facility less than thirty days. Should the child be present in the facility for thirty or more days, an extended plan of care must be developed as required by the core rules and all other aspects of the rule shall apply with regard to service delivery, plans of care, and reviews of plans of care.

18.5.b. Upon admission, the Shelter shall complete the collection of any background material and history available either from the child, a social worker, or a significant other. From that information, the Shelter shall develop an intake plan which shall describe the following:

18.5.b.1. Further testing, evaluation or collection of information necessary to complete the comprehensive assessment of the child/youth and tentative time lines for completion of that assessment;

18.5.b.2. Safety plans/behavioral protocols, if necessary, to deal with any predictable inappropriate behaviors (e.g., need for eyes on at all times, one to one staffing, likelihood of sexual reactivity, etc.);

18.5.b.3. Plans for linkage/referral for the necessary medical screenings; and

18.5.b.4. Permission to administer properly bottled medications brought in by the child/youth.

18.5.c. The intake plan shall be completed within twenty-four hours and approved by the admitting parent or social worker within seventy-two hours.

18.5.d. Within seven days, the Shelter shall develop a list of problems identified in the assessment. The list may include not only behavioral health problems but also legal, familial, financial, medical and academic problems, among others. The Shelter shall determine through an interdisciplinary team meeting those problems which the Shelter intends to address prior to discharge and those problems which may need to be addressed in an aftercare plan. At all times, consideration will be given to improving the child's/youth's relationship with his family unless clinically or legally contraindicated.

18.5.e. The Shelter shall provide objectives for each problem that it has determined that it shall address prior to discharge.

18.5.f. Objectives shall be stated in simple language, understandable to the child/youth whenever possible.

18.5.g. The intervention to be used in addressing the objective shall be described and the person or persons responsible named, if appropriate.

18.5.h. Should an objective include an individual or group therapy intervention, the intervening agency or provider, whether the Shelter's employee or a contractual or other provider to whom the agency refers, shall be responsible for developing a specific therapy plan that describes the processes the therapist intends to use, in specific language, and the skills to be

learned or behaviors to be increased or reduced by the child/youth. If necessary, a plan or protocol shall be provided to direct care staff to attempt to generalize behaviors discussed in therapy to the shelter environment. Outside providers shall be responsible for providing feedback to the shelter prior to discharge, in writing, regarding progress made in therapy or lack thereof and rationale for lack of progress.

18.5.i. Physicians or qualified medical practitioners providing services to residents in Shelter, whether by contractual or referral relationship, shall be responsible for communicating with the Shelter nurse regarding medication changes, and for providing written records regarding changes in medications and rationale for such changes.

18.6. Behavior Plans/Protocols

18.6.a. If a child/youth should require a specific behavior support plan or a protocol for staff to use in dealing with an inappropriate behavior, the plan or protocol shall be in writing and shall be in terms which make it clear to direct care staff:

18.6.a.1. The behaviors to be monitored/modified;

18.6.a.2. The precise action to be taken by staff should the behavior occur; and

18.6.a.3. Documentation staff shall be responsible for supplying, if any.

18.7. Reviews of Plans of Care

18.7.a. The treatment team shall meet weekly to review progress in implementing the plan of care and to modify it as necessary. The plan of care shall be a flexible document to which may be added additional problems or objectives, as they become identified in the assessment process. Other problems may be resolved and objectives discontinued as they become irrelevant or are achieved. A copy of any revisions to the plan shall be sent to the child/youth's social worker for approval if the social worker is not available for the weekly team meeting. Parents/guardians shall also receive amendments unless clinically or legally contraindicated.

18.8. Planning for Discharge

18.8.a. The treatment team of the Shelter shall begin planning for discharge at admission. When possible, seven days prior to discharge the child/youth, his/her guardian (as appropriate and possible), the child's social worker (if any) and the treatment team shall meet to develop a discharge plan. Issues to consider in developing the plan shall be:

18.8.a.1. Remaining problems to be addressed from the initial problem list and any problems added later during the child's stay;

18.8.a.2. Appropriate placement for the child/youth considering issues of safety, permanency and clinical need;

18.8.a.3. Recommendations for aftercare including recommended behavioral health and medical services; and

18.8.a.4. Any other relevant and compelling information or considerations.

§78-3-19. Program Specific Rules for Maternity and Parenting Facilities

19.1. Definition

19.1.a. An organization shall be licensed as a maternity/parenting facility when it meets the standards of the following section in addition to the core rules. A maternity/parenting organization offers care and behavioral health services to young women ages twelve to eighteen that are either parenting or pregnant.

19.2. Maternity Care

19.2.a. Care to pregnant or parenting adolescent or transitioning adult includes, but is not limited to:

19.2.a.1. Appropriate health care and health education;

19.2.a.2. Education needs specific to the pregnant or parenting young women;

19.2.c.3. Nutritional guidance and support;

19.2.c.4. Counseling services specific to making decisions and planning for their child;

19.2.c.5. Parenting educational services; and

19.2.c.6. Maintenance of an environment conducive to the safety of children (infant through toddler) and pregnant women.

19.3. Appropriate Health Care and Health Education

19.3.a. The organization will provide or arrange for health services to the expectant and parenting teens that includes:

19.3.a.1.A written health summary, including family medical history, immunizations, operations and childhood illnesses;

19.3.a.2. A general medical examination which will occur at the time of admissions, and an obstetrical/gynecological examination for pregnant residents within the first two weeks of admission or sooner if the teen is considered to be high risk;

19.3.a.3. Thorough medical supervision of the pregnancy, including all needed prenatal care; testing and post natal care shall be done by a licensed obstetrical/gynecological specialist; and

19.3.a.4. Direct provision or referral for services to meet the needs of high risk pregnancy or high risk infant care-related issues.

19.3.b. Registered nursing staff with obstetrical/gynecological experience are to be available on grounds at least twelve hours per day, with twenty-four hour availability onsite.

19.3.c. The pregnant or parenting adolescent shall receive ongoing health education with age-appropriate instruction regarding pregnancy prevention, HIV/AIDS prevention, and general information about the prevention and treatment of disease.

19.3.d. The organization shall be located within fifteen minutes of a hospital with maternity care.

19.3.e. Standing medical orders for pregnant teens shall be carefully evaluated and shall take into consideration cautions necessary for pregnant women.

19.3.f. All pregnant or parenting young women shall have access to educational services as appropriate:

19.3.f.1. All pregnant or parenting adolescents, once assessed, will participate in some type of educational service such as GED classes, public school, and/or alternative education;

19.3.f.2. Daycare services will be in close proximity to the education facilities; and

19.3.f.3. Supportive services for child care will be available to assure that the young mother can have necessary study time.

19.4. Nutritional Guidance and Support

19.4.a. All parenting and pregnant adolescents will be assessed at a minimum within the first thirty days of admission by a registered dietitian, unless dietary problems are indicated at admission.

19.4.b. Ongoing dietary support will be encouraged through a nutritional education

program and as indicted individual instruction by the registered dietitian or registered nurse.

19.4.c. All pregnant and parenting adolescents will receive counseling services specific to parenting and alternative choices, on an ongoing basis.

19.4.d. The agency shall have policy and procedures related to the involvement of the putative father of the baby.

19.4.e. Supportive counseling services will be extended to the family of the young woman, the biological father (unless contra-indicated by court order) and the family of the biological father.

19.4.f. The organization will offer an ongoing parent education program with a curriculum that comprehensively addresses at a minimum, the following topics:

19.4.f.1. Personal growth and maturity;

19.4.f.2. Interpersonal relationships;

19.4.f.3. Early childhood development;

19.4.f.4. Infant stimulation and cognitive development;

19.4.f.5. Safety and accident prevention, including First Aid and CPR;

19.4.f.6. Physical care, nutrition, and health of infants and young children;

19.4.f.7. Signs and symptoms of child abuse and neglect;

19.4.f.8. Time, budget, and household management;

19.4.f.9. Community resources that provide assistance;

19.4.f.10. Daycare use and how to choose daycare.

19.4.g. Parenting education may be offered in both a formal and informal setting utilizing classroom instruction, small groups, and individual and experiential teaching methods, based on the needs of the mother.

19.4.h. The organization shall maintain an environment conducive to the safety of a child (infant through toddler) and a pregnant woman.

19.4.i. The facility shall contain at least one area for routine medical examination, counseling and treatment for clients. This area shall be private and in adherence with all universal precautions, Occupational Safety and Health Administration (OSHA)

standards and best medical practice.

19.4.j. All areas shall be child proofed and all infant and child furniture must be maintained in good repair and meet the Resident Product Safety Commission (CPSC) guidelines.

19.4.k. The exposure of the pregnant teen and infant to cleaning supplies and pesticides should be limited. The organization shall be cognizant of the possible side effects of exposure and limit accordingly.

19.5. Baby Care

19.5.a. An organization shall provide a plan of care for babies that includes, but is not limited to the following:

19.5.a.1. Appropriate health care;

19.5.a.2. Appropriate daily care; and

19.5.a.3. Appropriate daily stimulation.

19.5.b. An organization shall also provide:

19.5.b.1. A warm and child friendly environment; and

19.5.b.2. Staff specifically trained to meet the needs of infants through toddlers.

19.5.c. The organization shall document that all babies receive a thorough assessment prior to leaving the hospital or at the time of admission to the organization.

19.5.d. The organization shall assure that all children receive health care according to EPSDT standards of care.

19.5.e. The organization shall have policy and procedures to assure that the health and well-being of the child is protected once he or she leaves the hospital.

19.5.f. The organization shall have policy and procedures to assess and treat infants and children who show signs of illness, which include but are not limited to diarrhea, vomiting, fever, etc.

19.5.g. If at any time the child's mother is unable or refusing to care for her child, the organization shall have policy and procedures to assure that appropriate interventions are utilized to secure the health of the child.

19.5.h. Appropriate daily care:

19.5.h.1. The organization will ensure that all babies have the necessities to meet their basic daily needs, including but not limited to, diapers, clothing, bottles, bedding needs, bathing supplies, car seats, etc.

19.5.h.2. The organization will ensure the basic needs of the infant are consistently met, including but not limited to bathing, bottle-making using sterile bottles, feeding, laundry, baby sitting, diaper changing, and, when appropriate, toilet training;

19.5.h.3. All babies under twelve months will have a feeding/diet plan prescribed by the physician.

19.5.i. The organization shall handle breast milk and formula in the following manner:

19.5.i.1. Prepared bottles are to be capped and clearly labeled with the child's name, contents and the date prepared;

19.5.i.2. Bottles are to be refrigerated in a separate section of the refrigerator, labeled with the child's name and accessible only to staff;

19.5.i.3. Breast milk shall be stored in a hard plastic or glass bottle with tight lids;

19.5.i.4. Breast milk or formula when it remains at a temperature higher than forty-one (41) degrees Fahrenheit for more than one hour shall be discarded;

19.5.i.5. Refrigerated breast milk shall be used within forty-eight hours of receipt, frozen breast milk within two weeks of receipt and deep frozen breast milk within three months;

19.5.i.6. Formula bottles shall be used within twenty-four hours of preparation or discarded; and

19.5.i.7. A microwave oven is not permitted for the heating of breast milk or formula bottles.

19.5.j. Solid food, including cereals are not to be placed in a bottle.

19.5.k. Jar baby food is to be served from a bowl and not from the jar.

19.5.l. Until a child is able to hold a bottle securely, a baby and the bottle shall be held while being fed. At no time is the bottle to be propped.

19.5m. The organization will have policy and procedure in place to assure that if

at any time the child's mother is unable or refusing to care for her child, staff will use appropriate interventions to secure the basic needs of the baby.

19.5.n. All babies will receive daily stimulation to encourage the emotional, physical and intellectual development of the child. This includes:

19.5.n.1. Holding, rocking, and playing whenever possible, including while bathing, dressing and carrying the child;

19.5.n.2. Encouraging positive communications and language development by making eye-to-eye contact with the child, singing, talking, reacting to the child's sounds, naming objectives, reading stories and playing musical games;

19.5.n.3. Paying attention to crying and meeting the immediate needs of the child;

19.5.n.4. Ensuring that no child is routinely left in a crib or playpen, except for sleep or rest; and

19.5.n.5. Providing a child who is awake with play equipment and opportunities to play freely on a clean floor.

19.5.o. The organization shall ensure that all products containing potentially hazardous chemicals, including identified poisons, medications, certain cleaning supplies, and art supplies not clearly labeled as "nontoxic", are inaccessible to all children in a locked cabinet away from food, and when possible, stored in their original containers and never in containers originally designed for food.

19.5.p. The organization shall ensure that all electrical outlets within the reach of a child when not in use are protected by a cover.

19.5.q. The organization shall ensure that when an electrical appliance is used, an adult is present at all times to supervise the use of the appliance.

19.5.r. The organization shall provide a shield to protect a child from hot pipe or radiators and shall not use unvented fuel fire heaters.

19.5.s. The organization shall ensure that barriers and gates are appropriately used.

19.5.s.1. All temporary walls or items being used as physical barriers are firmly anchored so that they pose no threat to the safety of the child.

19.5.s.2. Stairways to which the child has access must have appropriate railing and safety gates or other barriers at the top and at the bottom.

19.5.t. The organization shall ensure that strings, cords and hanging items are of no threat to the children.

19.5.t.1. The drawstring on clothing such as on hoods or collars shall be removed or secured to prevent potential risk to the child.

19.5.t.2. Pacifiers attached to a string or ribbon that is six (6) inches or more in length shall not be placed around a child's neck or affixed to the child's clothing; and

19.5.t.3. No child is to have access to a string or cord that is six (6) inches or more in length and attached to a fixed object, such as a window shade, nor access to any other potentially dangerous hanging item, such as a tablecloth.

19.5.u. The organization shall ensure that there is an outdoor play area appropriate and safe for young children.

19.5.v. The organization shall ensure the safety of the child during transportation. The driver or qualified staff shall ensure that each child three years of age and under is secured in an approved child safety seat.

19.5.w. The organization shall ensure that the overall environment of the children's area of the facility is clean, pleasant in appearance, well lighted and conducive to the development of children.

19.6. Staff Training

19.6.a. The organization shall ensure that all staff are specifically trained to meet the needs of the very young child.

19.6.b. All staff shall be trained within the first thirty days of employment on basic infant care. Prior to completion of training, the new employees shall be scheduled to work only with fully trained staff.

19.6.c. At a minimum, all staff shall be trained in:

19.6.c.1.Child development;

19.6.c.2. Infant CPR and first aid;

19.6.c.3. Basic child care;

19.6.c.4. Sick baby care; and

19.6.c.5. Parenting skills.

§78-3-20 Outdoor Therapeutic Educational Programs

20.1. Definition

20.1.a. Outdoor therapeutic educational programs provide care, supervision and treatment for older children and transitioning adults aged twelve to twenty-one in an outdoor setting where routine and specially planned activities are provided in an outdoor milieu and designed to improve the youth's social, emotional, behavioral and educational functioning.

20.1.b. All aspects of the core rule shall apply with the exception of standards enumerated below.

20.2. Staff Ratios

20.2.a. Staff ratios to youth shall be appropriate for the activity in which the group is engaged.

20.2.b. High risk activities (rock-climbing, rope-walking, white water, etc.) shall be a minimum of four staff to ten residents (4:10).

20.2.c. Away from main camp on low risk activities shall be a minimum of three staff to ten residents (3:10).

20.2.d. In main camp, the ratio shall be a minimum of two staff to ten residents (2:10).

20.2.e. Ratios for groups away from camp may be adjusted downward for smaller groups; however, safety and adequacy of supervision shall be a paramount concern.

20.2.f. At night:

20.2.f.1. Under normal weather conditions, sexes shall sleep separately with one counselor assigned to each sex. In cases of extreme weather, sexes may be in the same building or structure but the staff on duty shall functionally separate them;

20.2.f.2. There shall be a minimum of one staff per sleeping group. That staff may be sleeping when the group is in the main camp or in the field. When the group is in the main camp, at least one staff person shall be awake and monitoring youth in total at all times. The organization must have a policy regarding staffing ratios to ensure safety and security of residents at night when away from the main camp.

20.3. Credentials of Staff

20.3.a. Direct care staff shall have a minimum of a high school diploma or GED and skills, certifications and/or abilities unique to the environment, such as residential child care experience, search and rescue certification, wilderness survival skills, camping skills, etc.. Direct care staff will be responsible for group supervision and monitoring on a day to day basis, including teaching basic living skills, role modeling effective individual and group problem-solving skills and anger management, and completing daily documentation as required.

20.3.b. Counselors shall have a minimum of an undergraduate degree in a human services field and shall work under the direct supervision of an appropriately licensed or certified behavioral health professional. Counselors will be responsible for supportive counseling of youth, teaching and modeling appropriate problem-solving and anger management skills, teaching and modeling appropriate interpersonal skills and positive role modeling.

20.3.c. Teachers certified to teach by the state of West Virginia who shall be responsible for the oversight and supervision of the educational program of the organization. The organization must have at least one teacher.

20.4. Staff Training

20.4.a. All staff responsible for the direct care of residents shall be trained in the following areas in addition to those cited in the primary section of this rule:

20.4.a.1. Water procurement, preparation and conservation;

20.4.a.2. Shelter construction;

20.4.a.3. Food preparation and storage in the field;

20.4.a.4. Fire site preparation and fire building;

20.4.a.5. Low impact wilderness expedition and environmental conservation skills and procedures;

20.4.a.6. Sanitation procedures related to food, water and waste;

20.4.a.7. Management of health issues unique to the outdoor therapeutic educational program environment including acclimation to the environment and environmental elements;

20.4.a.8. Basic training in rescue and water safety for those staff responsible for water activities, a minimum of one adult so trained to be present at all times at all water activities;

20.4.a.9. Navigation skills including map and compass use and contour

navigation;

20.4.a.10. Local environmental precautions including sensitivity to terrain, weather, insects, poisonous plants, wildlife and proper response to adverse situations involving any of these factors; and

20.4.a.11. Management of the health and safety of the group in severe weather conditions including a possible evacuation plan.

20.4.b. All new staff shall be accompanied at all times by experienced staff during the first month of employment in the field and until all required trainings have been completed, whichever is later.

20.5. Service Elements

20.5.a. The organization shall have an on grounds educational program that is of sufficient quality to allow students to transfer educational credits to their county of origin. A teacher certified to teach in the state of West Virginia shall be coordinating and providing oversight to the educational program. Whenever possible, the educational program shall be accredited by an appropriate educational accreditation body.

20.5.b. The organization shall have complete policies and procedures to guarantee child/youth safety in any off grounds activity, including but not limited to:

20.5.b.1. Backpacking;

20.5.b.2. Hiking;

20.5.b.3. Tent building and other construction;

20.5.b.4. Ropes courses;

20.5.b.5. Van trips;

20.5.b.6. Off property outings;

20.5.b.7. Canoe trips or white water rafting;

20.5.b.8. Swimming or wading;

20.5.b.9. Mountain biking;

20.5.b.10. Skiing;

20.5.b.11. Soloing; and

20.5.b.12. Rock climbing.

20.5.c. The policy shall discuss the following:

20.5.c.1. Staff to youth ratios for the activity;

20.5.c.2. Staff training and/or certification prerequisite for participation;

20.5.c.3. Youth training/introduction prerequisite for participation, including safety training;

20.5.c.4. Special equipment or provisions required for the activity including safety equipment such as life jackets, safety ropes, helmets, etc., and food, water, etc. as necessary and appropriate;

20.5.c.5. Evacuation plans if such should become necessary during an activity;

20.5.c.6. Safety plans/requirements unique to the activity (e.g., backpacking weights, rope safety and monitoring, etc.);

20.5.c.7. Documentation necessary for the activity.

20.5.d. All policies and procedures shall be in conformity with nationally accepted standards for the activity, if such are available. If staff certification or training is available in the activity, at least one staff present during the activity shall be so trained or certified. During water activities, at least one staff shall be fully certified in water safety/lifesaving.

20.5.e. If the organization contracts with an independent provider to guide or supervise such activities, the contractor shall be appropriately certified if a certification is available.

20.5.f. General safety considerations:

20.5.f.1. Personal gear supplied to youth shall be appropriate in size, amount and protectiveness for the youth and the expected weather;

20.5.f.2. No child shall be expected to pack more than 30% of his/her body weight at any time and special health considerations shall be taken into account should such be necessary;

20.5.f.3. Adequate food and water shall be available to staff and youth at all times in all activities;

20.5.f.4. Equipment shall be regularly inspected as a matter of policy by the safety committee or its designee for signs of wear or damage and said inspections shall be documented and monitored;

20.5.f.5. Prior to any water activity, the swimming ability of all youth and staff shall be evaluated and documented by an appropriately trained staff person. The organization must document that adequate arrangements for protection of non-swimmers have been made on each activity;

20.5.f.6. Soloing activities shall only be conducted with the written consent of a licensed mental health clinician who has personally evaluated the youth within twenty-four hours prior to the onset of the solo activity. At all times, staff shall be in earshot of a distress call should such be necessary and shall conduct random face to face checks of the status and condition of the child on intervals not to exceed six hours; and

20.5.f.7. The organization shall have a policy to ensure safety and security of residents who are acutely disturbed and/or suicidal.

20.6. Abrogation of Client Rights

20.6.a. Removal of access to clothing as a safety measure:

20.6.a.1. While items of clothing may not be withheld as a punishment, youth may be prevented from access to certain items of clothing (such as belts) as a safety measure. The criterion shall be whether the potential safety created by the restriction outweighs the harm of the restriction. The organization shall have a written policy regarding restriction of access to articles of clothing, approved by the governing body.

20.7. Environmental Issues

20.7.a. The environment of an outdoor therapeutic educational program is by definition limited in its handicapped accessibility. The organization shall have an admissions policy which clearly describes its degree of accessibility to clients with physical handicaps. The organization shall make reasonable effort to enable family members with physical handicaps to access residents, family therapy interventions and program sites.

20.7.b. Outdoor therapeutic education facilities are generally considered to be inappropriate for serving residents with serious physical handicaps; however, the organization shall be responsible for finding a method of incorporating family members with physical handicaps to a maximum degree into the therapeutic process.

20.7.c. The organization shall have policies pertaining to the following with reference to any activities conducted away from the main campus or building:

20.7.c.1. Unique adaptations to dietary requirements as appropriate;

20.7.c.2. Sanitation and infection control;

20.7.c.3. Waste management;

20.7.c.4. Food storage and handling;

20.7.c.5. Maintenance of safe body temperature;

20.7.c.6. Clothing and footwear;

20.7.c.7. Field equipment;

20.7.c.8. Communication with the main campus or management on an on-going and emergency basis;

20.7.c.9. Medication storage and security away from camp;

20.7.c.10. Disaster/severe weather plan including procedures for evacuation; and

20.7.c.11. Procedures to follow for runaways/elopements.

§78-3-21. Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled

21.1. Definition

21.1.a. Intermediate care facilities for residents with mental retardation and developmental disabilities shall comply with the federal Conditions of Participation (42 CFR §440.150 et. seq. and §483.410 through §483.480) except where state licensing standards are more stringent and shall apply.

21.2. An intermediate care facility for the mentally retarded/developmentally disabled may accept a seventeen year old into an adult group home under the following conditions:

21.2.a. The average age, developmental levels and social needs of the residents in the home is approximately that of the youth unless the prospective resident and the other residents of the home have developmental disabilities which are severe/profound and/or the residents are non-ambulatory/nonverbal or multiply physically handicapped;

21.2.b. The home has arranged educational programming for the resident which is as normative as possible;

21.2.c. The resident has a reasonable ability to participate in age-appropriate community activities;

21.2.d. The placement is developmentally consistent with other residents of the home; and

21.2.e. None of the residents of the home have a history of sexual predation.

21.3. Restrictive behavior management techniques shall conform to federal guidelines for intermediate care facilities for the mentally retarded/developmentally disabled.

§78-3-22. Psychiatric Residential Treatment Facility

22.1. Definition

22.1.a. A psychiatric residential treatment facility for persons under twenty-one is a freestanding or physically distinct part of a psychiatric inpatient organization that provides services and treatment to residents who do not need acute care, but require intensive and coordinated services in a residential setting in a manner consistent with federal requirements (42 CFR §483.350 and §441.151). The psychiatric residential treatment facility provides a continually, medically-supervised interdisciplinary program of behavioral health treatment.

22.2. Accreditation Requirements

22.2.a. A psychiatric residential treatment facility shall be appropriately accredited as required by federal standards. Where differing accreditation, certification or licensing standards exist, the most exacting standard shall apply.

22.3. Staffing

22.3.a. The average staffing ratio for a psychiatric residential treatment facility shall be one staff to three patients (1:3) at all times (one staff whose primary responsibility is providing direct care for every 3 residents) with capability to increase staff ratio in response to acuity, extending to the provision of one-on-one (1:1) care when necessary.

22.3.b. Nursing coverage shall include a registered nurse during day and evening with at minimum, a licensed practical nurse overnight.

22.3.c. There shall be a supervisor present on all shifts and staff shall have access to other administrative personnel at all times.

22.4. Staff Training and Credentials

22.4.a. All direct care staff shall have a minimum of a high school diploma or GED and professional staff shall have appropriate education and certification consistent with professional licensing standards.

22.4.b. In addition to the requirements for staff training prescribed in the Core Rules, direct care staff shall receive refresher training in emergency safety interventions twice a year, which shall include both didactic and experiential activities. This training may include, but is not limited to:

22.4.b.1. Conflict resolution;

22.4.b.2. Managing behavior;

22.4.b.3. Psychiatric emergencies; and

22.4.b.4. Avoiding power struggles.

22.5. Treatment Services

22.5.a. The residential treatment facility shall provide the following clinical services:

22.5.a.1. A physician shall be available twenty-four hours a day, seven days a week to respond to medical and psychiatric emergencies;

22.5.a.2. A psychiatrist shall perform observation and assessment at least weekly;

22.5.a.3. Routine assessments shall be performed by the physician to effectively coordinate all treatment, manage medication trials and/or adjustments, minimize serious side effects, and provide medical management of all psychiatric and medical problems; and

22.5.a.4. A weekly note shall be made by the attending or covering psychiatrist that evaluates the patient's current condition and progress in treatment and outlines any recommendations for revisions in the plan of care.

22.6. Assessments

22.6.a. A comprehensive assessment process shall include evaluation of:

22.6.a.1. Psychiatric;

22.6.a.2. Physical health;

22.6.a.3. Nursing;

22.6.a.4. Psychosocial;

22.6.a.5. Recreational activities;

22.6.a.6. Spiritual/cultural preferences and interests;

22.6.a.7. Behavioral and adaptive living skills, both strengths and deficits; and

22.6.a.8. Educational functioning.

22.6.b. Additional diagnostic assessment shall be provided as needed, either onsite or by using community providers.

22.6.c. All required clinical assessments shall be completed prior to the development of the master plan of care. Assessments conducted within thirty days prior to admission by qualified professionals may be used if reviewed and approved for treatment planning by the responsible psychiatrist and Interdisciplinary Treatment Team.

22.6.d. Psychiatric evaluation shall be provided within twenty-four hours of admission and shall include:

22.6.d.1. The reason for admission;

22.6.d.2. Current clinical presentation;

22.6.d.3. Psychosocial stressors related to the recent illness;

22.6.d.4. Current or potential risk to self or others;

22.6.d.5. History of present illness;

22.6.d.6. Past psychiatric history;

22.6.d.7. Developmental assessment;

22.6.d.8. Presence or absence of physical disorders or conditions affecting the presenting problem;

22.6.d.9. Alcohol and/or drug history; and

22.6.d.10. Mental status examination.

22.6.e. A diagnosis on all five axes shall be given, based on the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

22.6.f. A physical health examination shall be provided within 24 hours of admission.

22.6.g. A Registered Nurse shall provide a nursing assessment within 24 hours of admission. The assessment shall document:

22.6.g.1. A general history of the patient's and family's health;

22.6.g.2. The patient's current medications;

22.6.g.3. Allergies;

22.6.g.3. Pertinent medical problems requiring nursing attention;

22.6.g.4. Current risk and safety factors;

22.6.g.5. Nutritional status;

22.6.g.6. Immunization status; and

22.6.g.7. Sleep patterns.

22.7. Plan of Care

22.7.a. A preliminary plan of care shall be developed within seventy-two hours of admission.

22.7.b. The interdisciplinary team shall have thirty days to complete all assessments while providing any immediately necessary psychiatric and therapeutic treatment. Prior to the end of the thirty-day period or when all initial assessments are completed, whichever comes first, the team shall complete an plan of care.

22.7.c. The plan of care is reviewed by the interdisciplinary team for effectiveness and is revised when major changes in treatment occur, or at least every thirty days.

22.8. Transfer Agreement

22.8.a. The organization shall have a written transfer agreement with one or more hospitals that ensures that an individual can be transferred to an appropriate setting in a timely manner when transfer is necessary for more intensive psychiatric care or for emergency or specialized medical care.

22.9. Transitioning adults

22.9.a. The psychiatric residential treatment facility may serve individuals aged eighteen to twenty-one so long as the young adult is court ordered, voluntary or committed under the requirements of Chapter 27 of the West Virginia Code.

22.9.b. The building, staff and activities shall be in compliance with Section 25 of this rule.

22.10 Restrictive Behavior Management

22.10.a. Restrictive Behavior Management techniques shall conform to all federal guidelines for psychiatric residential treatment facilities.

§78-3-23 Therapeutic Residential School

23.1. Definition

23.1.a. A therapeutic residential school is a long term, residential, educational facility providing post-secondary education preparation, room, board, and supervision while providing a structured environment and therapeutic support to older children and transitioning adults aged 12-21 who may need emotional, behavioral, familial, social, intellectual, and/or academic development.

23.1.b. All aspects of the core rule shall apply with the exception of standards enumerated below.

23.2. Staff Ratios and Training

23.2.a. Staff, for the purposes of this section, is defined as those individuals who are:

23.2.a.1. Fully oriented and trained according to organizational policy; and

23.2.a.2. Have job responsibilities which pertain only to the provision of child care, treatment and supervision.

23.2.b. The therapeutic residential school shall have a policy regarding care and supervision of residents that ensures that:

23.2.b.1. Residents receive adequate supervision for their age, developmental functioning and emotional and behavioral needs; and

23.2.b.2. The care plan as developed by the interdisciplinary team is implemented as written for each resident.

23.2.c. Residents shall be cared for and supervised at the following levels, with clinically justified modifications when house parents are employed:

23.2.c.1. Minimum staff to resident ratio of 1:10 during the waking hours when residents are on grounds with a minimum of one staff person present per residential living unit at all times;

23.2.c.2. Availability of additional or back-up care personnel for emergency situations or to meet special needs presented by the residents (e.g. physician appointments, behavioral outbursts, acute suicidality, etc.) ; and

23.2.c.3. Staff to resident ration of 1:12 during the sleeping hours with a minimum of at least one staff per residential living unit to be awake at all times.

23.2.d. The organization shall have a policy regarding supervision of residents in off-grounds activities which shall ensure that residents are adequately supervised at all times.

23.2.e. As appropriate to the ages and needs of persons in care, the organization shall that one of more trained professional staff member is on duty or available via an on-call system on a 24 hour basis to provide continuous supervision to each residential living unit within a residential program.

23.2.f. The organization which utilizes a house parent model shall have a policy that ensures the safety and supervision of residents at night.

23.3. Enviornmental Issues

23.3.a. To the maximum extent possible, the organization providing therapeutic residential school services shall be non-institutional in appearance and practices. Each child or transitioning adult shall be permitted to have personal space, personal possessions and a place to store those possessions unless clinically contraindicated. Each resident is expected to assume some responsibility for an aspect of home/facility maintenance (cleaning, cooking, etc.) on an ongoing basis.

23.3.b. Group therapeutic and residential living activities should be conducted in

an appropriately sized group format, taking into consideration best practice standards for the sex, developmental status and diagnosis of the members.

23.3.c. Residents shall have clearly identifiable schedules and activities, individualized for their strengths and needs. Each child must have a unique schedule which identifies therapy times, chore or work assignments, school hours, and other activities.

23.3.d. Staff must be available in sufficient quantity and with appropriate credentials to address the needs of the child or youth as identified by the assessment and interdisciplinary team process.

23.3.e. The residential therapeutic school that permits pets must follow written procedures that address their availability, care, feeding, and maintenance that includes at a minimum, veterinary evaluation and vaccinations as recommended by the veterinarian in writing.

23.3.f. Service elements unique to the population/environment:

23.3.f.1. If the organization permits residents to operate vehicles while in placement, it shall do so under the following conditions:

23.3.f.1.A. The resident has a valid West Virginia driver's license or permit;

23.3.f.1.B. The resident's vehicle, if any, is appropriately licensed and insured; and

23.3.f.1.C. The resident receives permission in writing from his guardian/custodian and parent, as appropriate.

23.3.f.2. The organization shall have a written plan of basic daily routines which shall be available to all personnel and updated regularly.

23.3.f.2.a. Residents shall participate in planning daily routines.

23.3.f.2.b. Residents shall have set routines for waking and going to bed.

23.3.f.3. The organization shall encourage and arrange for residents to participate in community, school functions and recreational activities on an individual basis.