



OFFICE OF THE SECRETARY OF STATE
STATE OF WEST VIRGINIA

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Betty Ireland
Secretary of State

OFFICE OF THE SECRETARY OF STATE
SECRETARY OF STATE

DATE: July 17 2007

TO: Kathie King

AGENCY: Health and Human Resources

FROM: Judy Cooper, Manager, Administrative Law Division

The attached rule filed by your agency has been entered into our computer system. Please review, proof and return it with any corrections. If there are no corrections, please sign this memo and return it to this office. We will send you a final version of the rule for your records.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

SERIES: 3 TITLE: 78 Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia

The attached rule has been reviewed and is correct.

SIGNED: _____ PRINT NAME: _____

TITLE OF PERSON SIGNING: _____

DATE: _____

The attached rule has been reviewed and needs correcting. The corrections have been marked.

SIGNED: Kathie D. King PRINT NAME: Kathie D. King

TITLE OF PERSON SIGNING: Program Manager, Division of Children and Adult Services

DATE: July 25, 2007

NOTE: If you are not the person who handles this rule, please forward to the correct person.

Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, West Virginia 25305

**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 set forth in sections 2.3 of this rule (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. -- May 2, 2007.

1.4. Effective Date. -- July 1, 2007.

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 are 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 requirements Sections 1 through 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 are exempt from this rule and are governed by the Department's rule "Child Placing Agencies Licensure", 78CSR1, 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 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 or 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

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

2.3. Exemptions

This rule does not apply to the following:

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

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

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

2.3.e. Adoption and foster family care facilities recognized as such by the Department of

Health and Human Resources; and,

2.3.f. 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 organization 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 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 child 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 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 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 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 who 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 children 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 organization, approved prior to implementation, that outlines the steps an organization shall take to correct areas of non-compliance 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 or 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. Early Periodic Screening, Diagnosis and Treatment (EPSDT) -- The child health component of the Medicaid program which establishes standards of medical care for children.

3.34. 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.

3.35. 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.

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

3.37. Group Residential Treatment -- Provision of supervision, room, board and psychosocial or rehabilitative treatment for children who are in need of out-of-home care and may be considered emotionally, developmentally and or behaviorally challenging. The definition does not include any organization more narrowly defined elsewhere in this rule, nor does it include children placed in a private residence classified as a foster family or foster home by the Department.

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

3.39. 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.

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

3.41. 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.

3.42. Institutional Investigative Unit -- A unit of the Department authorized by the Secretary to investigate complaints of child abuse or neglect. *too many periods*

3.43. 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.

3.44. 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.

3.45. Intervention -- The actions of the health care/organizational staff designed to help the child complete the objectives contained within his or her care plan.

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

3.47. Maternity and Parenting Facility -- Provision of supervision, room, board and psychosocial or habilitative care for young women who are pregnant or parenting.

3.48. 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.

3.49. Multidisciplinary Treatment Team -- A legally identified team as defined in W. Va. Code §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 organization representative who may assist in providing recommendations for the particular needs of the child and family.

3.50. Objective -- Desired measurable outcomes related to a goal stated in terms understandable to the child and his or her parent or guardian and agreed upon by the interdisciplinary team.

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

3.52. 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.

3.53. 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 child's social, emotional, behavioral and educational functioning.

3.54. Parents 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.

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

3.56. 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.

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

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

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

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

3.61. Program -- A system of services provided to those persons who are clients of an organization.

3.62. 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.

3.63. 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.

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

3.65. 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.

3.66. 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.

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

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

3.69. Quality Committee/Officer -- An individual or group of individuals whose responsibility is 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.

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

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

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

3.73. Residential Crisis Support/Shelter Care -- A form of short-term residential care for children which temporarily provides food, shelter, clothing and other necessary crisis intervention

and stabilization services for children experiencing emotional, familial or behavioral crises.

3.74. 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.

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

3.76. 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 method that involves the physical holding of a child for the purpose of conducting routine physical examinations or tests or to protect the child from falling out of bed or to permit the child to participate in activities without the risk of physical harm to the child. This 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 child's freedom of movement that is not a standard treatment for the child's medical or psychiatric condition.

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

3.78. Residential Living Unit -- Living quarters used by a particular group of children 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.

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

3.80. 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 shall review the organization's facilities and buildings on a quarterly basis for safety, cleanliness and proper maintenance.

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

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

3.83. 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.

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

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

3.86. Supervision -- The observation, oversight, and guidance of the child or group of children by the staff members assigned to their care.

3.87. 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.

3.88. Time-Out -- A behavior management technique that is part of an approved treatment program and may involve the separation of the child 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.

3.89. 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.

3.90. 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 supersede definitions related to funding streams.

3.91. 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.

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

3.93. 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.

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

3.95. 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. The organization shall surrender an invalid license to the Secretary on written demand.

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

4.1.e. The organization shall apply for a new license when the ownership of an organization changes. The new owner may not operate until a license is issued.

4.1.f. An organization shall 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. The Secretary shall perform an on-site inspection 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 for:

4.2.a.1. Establishment of a new facility;

4.2.a.2. A change in location;

4.2.a.3. A change in ownership;

4.2.a.4. A change in the population served, including but not limited to gender, age and capacity; or

4.2.a.5. Upon expiration of existing license.

4.2.b. The organization shall submit the completed application 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. The organization shall provide all required information or the application is invalid.

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

4.2.e. A member of the governing body and the chief executive officer shall sign the application.

4.2.f. The application shall 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 local Health Department.

4.2.g. The governing body or its designated authority shall ensure adequate resources to support the organization's services. If a new organization or an expansion of an existing organization, the governing body shall demonstrate sufficient operating funds for at least six months. The 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 shall demonstrate financial stability. The organization shall submit 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 organization.

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 this rule. A license may be amended at any time during the cycle to reflect changes in the program, structure or population.

4.3.b. The Secretary shall issue an initial license to organizations establishing a new service found to be in compliance with regard to policy, procedure, organization, record keeping and service environment rules. It expires not more than six months from date of issuance and may not be re-issued.

4.3.c. The Secretary shall issue a provisional license to organizations seeking 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 child. It expires not more than six months from date of issuance and may not be re-issued.

4.3.d. The Secretary shall issue a regular license to organizations complying with this rule. It expires not more than two years from the date of issuance.

4.4. Construction and Renovation

4.4.a. Before construction or extensive renovation begins, an organization 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 requested by the Secretary.

4.5.c. An organization shall permit access to employees, members of the governing board and children receiving services from the organization as requested 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. The Secretary shall inspect a licensed organization thirty to ninety days prior to the expiration of its license.

4.5.f. The Secretary shall issue a report within ten working days of completion of an inspection.

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 Secretary shall keep the names of a complainant and of any child involved in the complaint or investigation and any information that could reasonably lead to their identification confidential.

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 child, 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. The report shall specify the areas of non-compliance with the rule it violates, and describe the precise data, observation or interview to support the 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 child or staffs file; and

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

4.7.d. The Secretary shall not make a report public until the organization has the opportunity to review the report and submit a

Corrective Action Plan, if necessary.

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 areas of 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. Any action taken or procedures proposed to correct the areas of non-compliance and prevent their reoccurrence;

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

4.8.a.3. The signature of the chief executive officer or his or her designee.

4.8.b. The Secretary shall approve, modify or reject the proposed Corrective Action Plan in writing. The organization may make modifications 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. The organization shall submit a revised Corrective Action Plan within ten working days whenever the Secretary rejects a Corrective Action Plan.

4.8.e. The organization shall immediately correct an area of non-compliance that risks the health or safety of child 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 a specific requirement has been granted through a prior written agreement. This

agreement shall specify the specific requirement to be waived, the duration of the waiver, and the terms under which the 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 is 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 or reduce child 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, or 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 child;

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. The 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 organization 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

An organization is 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

Any person, corporation, governmental official or child welfare organization, 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 there 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 organization 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. of this rule.

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

5.1. Rights and Responsibilities

5.1.a. The organization shall inform all children 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 shall reflect the consequences of areas 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 with the organization during admission; 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 child's record shall contain documentation that the individual received an explanation of his or her rights and responsibilities, initialed by the child and/or parent or guardian.

5.1.d. Written rights shall 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; and

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; and

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 the 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 shall 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 child.

5.2.c. The organization shall have in place a policy detailing admissions procedures for each service and the 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 the 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 the 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 organization, 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 child'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 regards to the 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 or 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 children rooms or property which shall be respectful of privacy rights. The organization shall document any search carefully.

5.5.e. The organization shall require employees 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. The organization shall not use surveillance cameras or listening devices for routine observation of children in their rooms unless required by judicial order or contract;

5.5.g. The organization shall provide a secure area or locker for a child's possessions if requested by the child; 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 or 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 staffs. The organization shall document the reason for the 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. *insert a period*

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 shall 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 *add comma remove*

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 or her parent or guardian shall sign a consent form that includes:

5.7.e.1. A statement that he or she voluntarily agrees to participate;

5.7.e.2. A statement that the organization will continue to provide services whether or not he or she 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. *remove space*

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

Written policy and procedures shall provide children and their parent or guardian with a formal mechanism for expressing and resolving complaints and grievances. These procedures shall be explained and distributed to children and their parent or guardian. The recipient shall acknowledge receipt of the procedures in writing. The procedures shall:

5.8.a. 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.b. 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.c. 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; and

5.8.d. Indicate that grievances may be filed either orally or in writing and that all staff of the organization are 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 staffs to know and comply with policies and procedures established by the organization.

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

5.10. Protection of Health and Safety

In its daily operations, the organization shall 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/ remove space

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

6.1.c.3. Quality/ remove space

6.1.d. Organizations may 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 as consequences to inappropriate behavior;

6.2.a.3. Critical incidents;

6.2.a.4. Reports and 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. add period

6.2.b. The organization shall conduct a documented, quarterly safety review of all facilities and 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 shall be sampled.

6.3.b. Staffs who conduct case reviews shall evaluate quality and the presence or absence of required documents, and the clarity and continuity of the 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 and 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. Based on the case record review, the reviewer shall prepare a document summarizing case record areas of non-compliance. The organization is responsible for documenting follow-up on areas of 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 child 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. *add period*

6.5.b. The organization shall annually provide the results of all reviews including annual financial audits, accreditation reviews and licensing reviews to the governing body.

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.

The governing body shall be one of the following:

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

7.1.b. Appointed officials of a governmental unit;

7.1.c. A proprietor in case of a sole proprietorship;

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

7.1.e. A body meeting the criteria established by the Secretary of State.

7.2. The governing body shall include no fewer than six members, including men and women with varying abilities, experiences, and cultural backgrounds representative of the community. The governing body may establish an advisory council including men and women with varying abilities, experiences, and cultural backgrounds representative of the community if it can not meet the requirement.

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. An employee or member of the immediate family of an employee of any public organization which regulates or purchases or arranges the services of a privately run organization may not be a member of the

governing body of the organization.

7.5. All members of the governing body or advisory council shall 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, staffs, 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 officer or his or her 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 it 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

4- 7.7.a. The chief executive officer is 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. Staffs, the governing body, advisory council members and consultants shall follow the policy.

7.9. Administrative File for the Organization

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

7.9.a. The governing structure including the charter and articles of incorporation as appropriate;

7.9.b. A mission statement and long term plan;

7.9.c. The most recent audit and financial statement;

7.9.d. The by-laws or other legal basis for its existence;

7.9.e. The organizational structure and the overall administrative lines of authority and organization staff by site;

7.9.f. The name and position of persons authorized to sign agreements and submit official documentation to the appropriate government organization;

7.9.g. The governing body structure and its composition with names and addresses and terms of membership as appropriate;

7.9.h. Existing purchase of service agreements;

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

7.9.j. A master list of all clinical and social service professionals used by the organization, either as employees or contractors, and ~~and~~ *remove semi-colon*

7.9.k. A description and the 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 staffs who sign checks, handle cash or contributions or manage funds, including children's funds, are bonded at the organization's expense or that 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. Staffs transporting children 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 individual's 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 an accident or suit. All bonding policies shall be adequate to replace the aggregate of funds managed by the organization.

8.5. Legal Compliance

The organization shall comply with all applicable federal, state, and local laws, rules 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 shall have 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.

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

8.6.e. The organization shall retain children's records for a minimum of five years following the child's eighteenth birthday.

8.6.f. The organization shall have a policy regarding disposal of records which respects confidentiality and security of child 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 the 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 organization 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 the 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. Expected outcomes as appropriate.

8.7.d. The organization shall ensure a complete personnel file on each contracted clinical employee and 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 or certification;

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

8.7.d.4. Evidence of ability to conduct business in the State of West Virginia;

8.7.d.5. Evidence of a criminal background check.

8.7.e. If the organization contracts for professional services with a licensed practitioner who serves children in his or 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 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 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 child 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 child and his or her parent or guardian. Funds managed on behalf of clients shall not be commingled with organizational funds;

9.4.c.2. Protection of child assets, including a bond sufficient to cover all child accounts, unless the aggregate value of the child 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 staffs 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 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 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, staffs training and development opportunities as appropriate.

10.2.b. The organization shall have policies which are compliant with federal and state statutes, rules 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 under, the age of the staff serving the population shall 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 shall be at least 3 (three) years older than the age of the eldest child.

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. The organization shall submit a request for a Criminal Identification Bureau (CIB) records check and a Protective Services records check to the Department 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 shall document that it has pursued the completion of the records check vigorously. The organization is 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 use 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 to child 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; and

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 child until the CIB record check results are received.

10.2.i. Organizational policy shall prohibit employment of either staffs 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 or 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 or 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; or

10.2.i.16. / Sexual offenses including 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 W. Va. Code §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 staffs. 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 the usual

qualifications for the position in which he or she is employed shall have a written statement justifying reasons for employing this person. Licensure or certification requirements for a position may only be waived or altered by the Secretary.

10.2.o. The organization shall verify the credentials of all organization staff and individuals, who are contract employees of the organization, 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 the staff; and

10.2.p.2. The staffs 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 children 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 beginning their duties and shall maintain documentation of the 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 or Residents

10.4.a. Students covered by this rule are 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.

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 beginning their duties and shall maintain documentation of the training.

10.5. Employee, Volunteer, and Student Records

10.5.a. The organization shall 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. ~~6-~~ An application for employment, volunteer or student service or resume (excepting contracted clinical employees);

10.5.a.3. ~~7-~~ A job description or contract;

10.5.a.4. Reference verification;

10.5.a.5. Documentation of education and/or licensure or 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. ~~8-~~ 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. An initial tuberculosis screening and annual screening thereafter;

10.5.b.2. A 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. The 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 or person to whom he or she is accountable.

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

10.6.c. The organization shall give 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 staff.

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

11.1. Orientation of New Staff

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

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

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 federal confidentiality 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 staffs 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 or 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 and/or replacing inappropriate behaviors.

11.1.d. Until the 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. Staff Training and Content

11.2.a. The organization shall provide training to clinical and direct care staffs 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). This training must be updated every three years;

11.2.a.3. Adult Pulmonary Resuscitation (CPR), unless the organization serves an infant population, in which case both adult and infant cardiopulmonary resuscitation training is required. This training must be 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. This training must be updated annually;

11.2.a.5. Basic de-escalation techniques and passive restraints. This training must be 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. This training must be 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 child;

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

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

11.2.a.11. Procedures for notifying family members, parents or 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 or abdominal thrust or any other life-saving technique for choking/obstructed airway as recognized by the American Red Cross or equivalent.

11.2.b. The organization shall provide a minimum of twelve hours of annual internal continuing education for all program staffs providing direct services to children. 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 shall inform all staffs in writing of its policy defining and prohibiting corporal and degrading punishment.

11.2.d. The organization shall train appropriate staffs 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 children.

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

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

11.3. Supervision

11.3.a. The organization shall have a system of staff 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 staffs 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 shall ensure that supervisory staffs have sufficient time to hold supervisory conferences and conduct evaluation and training activities.

11.3.d. The organization shall adjust supervisory assignments, frequency and duration in response to the findings and recommendation 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 child.

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

12.1.1.2. 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 shall:

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 are 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.

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 vehicles;

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 the 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 its 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. The equipment shall be used by child 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 is 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 an evacuation site, parties to notify, and emergency items to take when evacuating;

12.6.a.3. Describe relocation plans for the service and/or program if it becomes necessary;

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

12.6.a.5. Require notification of the child'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 children. 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 organization 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 staffs providing care and/ or 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 the orientation has taken place.

12.6.f. The organization shall ensure that all staffs 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 staffs with direct contact with children:

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 prepares food for children shall have policies and procedures to ensure clean and safe food preparation and prevent the exchange of communicable diseases. The procedures shall:

12.7.d.1. Require that food service staffs 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 Department's rule, "Food Establishments", 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 that 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 are 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 children.

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. Except for outdoor therapeutic educational programs, there shall be a minimum of sixty square feet per occupant in bedrooms. 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 shall have a direct source of natural light.

12.9.g. Except for outdoor therapeutic educational programs, each child shall have his or her own bed with sufficient linens and covers. 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, showers and 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 shall 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 child 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.

12.9.1. A facility shall have one toilet, one lavatory and one bathtub or shower for every six children.

12.9.1.1. Bathrooms shall be clean and maintained in good repair.

12.9.1.2. Bathroom floors and walls shall be moisture resistant and non-absorbent.

12.9.1.3. There shall be no open flame heaters in any facility operated by the organization and used by children.

12.9.2. Bathroom and bedroom facilities shall allow individual privacy unless there is a clear, clinical justification otherwise, which shall be documented on the plan of care. There shall be doors on sleeping areas and bathrooms that can be readily opened from both sides.

12.9.3. Kitchens used for meal preparation shall be provided with the necessary equipment for the preparation, storage, serving and distribution of food to the children and staff.

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12.9.4. Refrigeration equipment shall assure the maintenance of food at or below 45 degrees Fahrenheit; and

12.9.5. Kitchen sinks shall have at least two bowls. If a dishwasher is used, the temperature shall reach a level sufficient to

sanitize dishes. If no dishwasher is used, proper sanitation treatments in the washing process shall be used.

12.9.6. An organization using live-in staff or house parents shall provide adequate, separate living space for these staff.

12.9.6.1. A bed shall be provided in staff quarters for live-in staff or house parents.

12.9.6.2. Staff shall not share bedrooms with children.

12.9.7. Furniture provided for children shall be appropriately designed to meet the size and capabilities of the children. Furnishings shall be maintained in good repair.

12.9.8. 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.

12.9.9. Drugs, staffs files and case records are to be kept in locked storage spaces with authorized access only.

12.9.10. Any room, corridor or stairway within a facility shall be sufficiently illuminated. Corridors in sleeping areas shall be illuminated at night.

12.9.11. Each separate living unit within an organization shall have telephone service.

12.9.12. Every access and exit to the building shall be continuously maintained free of all obstruction or impediments to immediate use.

12.9.13. The use of candles is prohibited.

12.9.14. Children shall swim only in areas which are supervised by a certified individual. A certified individual shall have a current water safety instructor certificate or senior lifesaving certificate from the Red Cross.

12.9.15. On grounds pools shall be in a

secured area and shall comply with the Department's rule, Recreational Water Facilities, 64CSR16.

12.9. 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

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, the current status and the progress in treatment. The Department of Health and Human Resources designee assigned as the child's representative to the MDT is 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

Each child or transitioning adult that enters residential treatment shall have a thorough assessment and a subsequent plan of care, if considered appropriate by a health care professional.

13.2.a. 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 the 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 and/or reason for referral;

13.2.b.3. A history of treatment;

13.2.b.4. A medical history;

13.2.b.5. A social history;

13.2.b.6. A developmental history;

13.2.b.7. An educational or vocational history;

13.2.b.8. A legal history;

13.2.b.9. A substance abuse history;

13.2.b.10. A mental status examination;

13.2.b.11. An assessment of independent living and adaptive living skills;

13.2.b.12. A summary of the child's strengths;

13.2.b.13. A summary of family strengths and weaknesses, and ~~add~~ *newborn. Sem.*

13.2.b.14. A summary of presenting problems or 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 or unique behavioral issues, and, ~~remove semi~~

13.2.c.5. Academic, cognitive and/or vocational testing or assessments.

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;

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13.2.e.7. Recommendations for family visitation unless contraindicated clinically or legally, and, ~~remove semi~~

13.2.e.8. Any recommendations for rights restrictions, ~~insert period~~

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 child 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 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. The organization shall develop a short term or initial plan of care within seventy-two hours of placement 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. A summary of assessments needed for the development of a full diagnostic and treatment perspective and recommendations;

13.3.a.3. A 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. A description of educational services to be provided prior to the development of an extended plan of care, if any;

13.3.a.5. A description of any behavioral interventions or protocols considered likely to be necessary prior to the completion of the full assessment process; and ~~to be removed~~

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13.3.a.6. A description of acute or chronic medical problems that may require treatment prior to the completion of the assessment process.

13.3.b. 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 parents of the child if practicable and not forbidden by the court. The plan shall include a written description of the services to be provided. 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.c. 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 shall meet prior to the end of that time period to develop an extended plan of care.

13.3.d. 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 child and his or her parent and guardian upon discharge.

13.3.e. If a child requires 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. The plan shall include:

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Space*

13.3.e.1. the behaviors to be monitored and modified;

13.3.e.2. the precise action to be taken by staff if the behavior occurs; and

13.3.e.3. documentation staff is 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 child (including at a minimum a licensed or certified master's level professional), the parents, the guardian (if other than parent), and the child him or herself, if the child 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 child or guardian may request the presence of any other individuals they feel may add to the process. However the organization is not responsible for bearing any costs related to the presence of other resources. Teachers or other external providers of service while the child 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. Use 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 or 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 child and child's family as revealed by the comprehensive assessment, including 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 child 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 organization or 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 persons 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 organization has arranged to treat the child and the goals of the 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 shall 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. A 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 child. At no time shall the schedule allow a period of review to extend more than ninety days except as permitted in sections 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 is 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 child (as developmentally appropriate) and his or 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. A 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. A review of any therapeutic service provided by an outside provider, to include a written report from that provider if he or she is not present for the review meeting;

13.5.e.6. A summary of all interventions provided to date;

13.5.e.7. A review of any incidents in which the recipient of service may have been involved since the prior review;

13.5.e.8. A review of discharge plan and permanency plan; and ~~and~~ *sem. calm* ~~new one~~

13.5.e.9. A review of the effectiveness of each psychotropic medication the child is taking at the time of the review.

13.6. Permanency Plans

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

The organization shall develop a written description of each service and program that is available to the public and potential consumers. The description shall include:

14.1.a. The goals of the program;

14.1.b. The expected outcomes of the program;

14.1.c. The services provided by the program;

14.1.d. The usual staffing of the program including ratios and overall credentialing;

14.1.e. Characteristics of children appropriately served by the program; and

14.1.f. 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 child record, regardless of custody.

14.2.b. When residential or other out-of-home services cannot be provided close to a child'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 is 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 the child's condition.

14.2.d. The 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 shall continue to document on-going efforts to include parents and guardians in the treatment process.

14.3. Behavioral and Therapeutic Interventions

An organization that uses therapeutic interventions shall:

14.3.a. Use positive approaches whenever possible to teach pro-social adaptive behavior and to modify behaviors that may be socially or personally maladaptive;

14.3.b. Identify antecedent conditions that may trigger inappropriate behavior and determine the most appropriate intervention;

14.3.c. Apply interventions in a caring and humane manner; and

14.3.d. 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 children 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 child 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; or

14.4.a.17. Use of any technique of manual or 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. The organization is responsible for physicians and other medical staff contracted for service just as it is responsible for physicians considered to be employees. The physicians and other staff shall have personnel files containing the materials or information specified in Section 10.5 of this rule.

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14.5.b. Organizations that administer medication using approved medication assistive personnel shall comply with the Department's rule "Medication Administration by Unlicensed Personnel", 64CSR60, effective July 1, 1999.

14.5.c. A child entering a facility with properly bottled and labeled medications may continue on those medications with appropriate consents, until such time as the organization can obtain current physician's orders, either from the organization's 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 shall 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 shall:

14.5.d.1. Obtain 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 or her will within the shortest period possible;

14.5.d.1.a. When the medication is a psychotropic, the following information shall be provided to the parent or guardian;

14.5.d.1.a.1. Specification of conditions 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. The 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 explain 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. Obtain approval from the parent or legal guardian 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 shall 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 children who receive medications to include:

14.5.e.1.A. Medications administered;

14.5.e.1.B. The date medications were administered;

14.5.e.1.C. The time of administration (medications are to be administered within one hour of the prescribed time unless otherwise allowed by physician's order); and

14.5.e.1.D. The individual administering the medication;

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 shall be properly labeled and packaged and include:

14.5.e.5.A. The name of the person served;

14.5.e.5.B. The dosage and the name of the medication;

14.5.e.5.C. The name of the prescribing physician; and

14.5.e.5.D. An 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; and

14.5.f.2. Provision for locked, supervised storage of medications with access limited to authorized staffs.

14.5.g. Only licensed nursing staff may accept verbal orders for changes in medication regimens. These shall be signed by the prescribing physician within one week.

14.5.h. Organizations shall 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 a child's health and health habits on an initial and on-going basis.

14.5.i. The nursing staff of the organization shall assess each child 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. The assessment shall be based on the child's developmental ability to participate in a plan of care. Children not capable of participating in a plan shall have medications administered by licensed nursing staff or approved medication assistive staffs as set forth in the Department's rule, Medication Administration by Unlicensed Personnel, 64CSR60, effective July 1, 1999.

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 or she is taught to identify his or her medications, recognize possible side effects, describe the purpose for the medication and indicate the time of day and frequency of which he or she is to take the medications;

14.5.j.2. The child 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 prescribed for children in the facility, and can identify each medication on sight. *remove supervision period*

14.5.j.5. Staff is trained in emergency procedures for overdose or abreactions;

14.5.k. The organization shall assess the effect of medication on the child 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

child, staff, and significant others and *secur colon* ~~document~~ *remove*

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.l. 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

An organization shall not use 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 shall be accompanied by specific educational or 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 child and/or as appropriate, his or her parent, guardian or attorney, unless legally contraindicated;

14.7.b.2. Staffs 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. Reasons for referral and admission date;

14.7.d.4. Assessment information;

14.7.d.5. A plan of care including goals and objectives of service;

14.7.d.6. Behavior support plans and/or therapy plans, if any;

14.7.d.7. Reviews of the plan of care as appropriate;

14.7.d.8. Reports from outside or contracted providers of service to the child;

14.7.d.9. Copies of all signed, written consent forms;

14.7.d.10. Routine documentation of ongoing services;

14.7.d.11. Documentation of incidents and/or investigations or reference to a separate incident file for each incident or investigation;

14.7.d.12. Documentation of any therapeutic physical restraints used by the organization with the child in question;

14.7.d.13. Documentation of medication administration for prior months;

14.7.d.14. Educational records as available considering average program length;

14.7.d.15. Recommendations for ongoing and/or future service needs and

assignment of aftercare or follow-up responsibility if needed and appropriate; and

14.7.d.16. A closing summary entered within 30 days of termination or discharge.

14.7.e. The organization shall document a reasonable effort to obtain required materials.

14.7.f. When necessary and appropriate, the case record shall also include:

14.7.f.1. Legal evidence of custody;

14.7.f.2. Court ordered restrictions on the rights of persons served;

14.7.f.3. Psychological, medical, toxicological, diagnostic or psychosocial evaluations;

14.7.f.4. Copies of all written orders for medications or special treatment procedures such as diet and physical therapy;

14.7.f.5. Regular reports from contracted service providers serving the child or family;

14.7.f.6. Reports relevant to the plan of care from other providers serving the child with appropriate releases of information; and

14.7.f.7. Other information essential for delivering service to the child.

14.7.g. Only authorized staffs may make entries into case records and all entries shall be:

14.7.g.1. Specific, factual and pertinent to the nature of the service and the needs of the persons served; and

14.7.g.2. Completed, signed, or electronically identified and dated by the person who provided the service.

14.7.h. 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

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 child achieves the goals of his or her plan of care and/or is no longer in need of out-of-home care;

14.9.b.2. The child 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 child no longer meets eligibility criteria;

14.9.b.5. The child refuses to meet program standards or requirements;

14.9.b.6. The child has needs that

exceed organizational resources; or

14.9.b.7. The child completes court-ordered treatment.

14.9.c. The organization and interdisciplinary team, guardian, placement organization (such as the court), multidisciplinary team, and the person or family shall jointly plan for termination or discharge.

14.9.d. The organization shall link a child that is involuntarily discharged with appropriate services in another organization or in the community whenever possible.

14.9.e. The organization shall enter a closing summary into the case record upon termination of service or within thirty days of termination or discharge 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 child shall notify those organizations, upon termination of services, with the written consent of the person served or his or her guardian. The person served or his or her parent or guardian shall have the right to refuse the notification, which the organization shall document.

14.10. Educational Services

14.10.a. The organization shall develop an educational program for each school-age child in care.

14.10.b. All children in residential child care shall be enrolled in an educational or vocational program (depending on age and the child's expressed desire) and provided with an educational or vocational plan, as appropriate, that is integrated into his or 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 or 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 staffs shall maintain regular contact with school staffs at a frequency appropriate for the severity and type of each child'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 or private school so that information can be exchanged freely and problem behaviors addressed consistently across all environments. Upon admission, the organization is 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 State 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 are exempt from this requirement and shall comply with the requirements set forth in Section 20 of this rule.

14.11.b. Educational staffs 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 in community social, athletic and recreational facilities as appropriate to individual needs and readiness.

14.11.c. There shall be an adequate educational staff to child ratio for the needs and educational goals of the children.

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 child 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 the placements in accord with the goals and timetables of the child's individual educational plans and with the knowledge and cooperation of the local educational authority.

14.11.g. On-ground educational staffs shall facilitate school transfers 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. Children shall have the right to be housed with children of the same approximate ages, developmental levels and social needs. This separation shall be a matter of organizational policy.

14.12.b.1. The organization shall not admit a child under six years of age without prior written approval from the Secretary.

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 Programs

The organization may involve the child in maintenance of the facility (cleaning bedrooms and bathrooms, working in the kitchens, etc.) so long as those work programs 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 the work programs should be included in the organization's descriptions. All work programs shall be evaluated for their therapeutic or habilitative value. The organization shall pay the child for an activity at a level required by state or federal law and the work activity must be voluntary if there is no therapeutic or habilitative value in the activity. Money earned in a work program belongs to the child, 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 programs other than

household "Achores" shall be evaluated and approved by the interdisciplinary team.

14.14. Daily Schedules

The interdisciplinary team shall provide each child with a written daily schedule of activities designed to help him or her develop positive personal and interpersonal skills and behaviors by providing activities that are individualized, and:

14.14.a.  Appropriate to the age, behavioral level, emotional needs, strengths and interests of the child;

14.14.b. Specialized to meet the child's identified strengths and needs as described in the assessment and plan of care;

14.14.c. Normalizing and integrated into the community to the maximum extent possible given the child's clinical needs and behavioral functioning;

14.14.d. Available at all times to the staff and child; and

14.14.e. Comprehensive of all waking hours while allowing a reasonable amount of recreational, study and 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 complexity of the needs of the children. The organization shall 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. Children shall be supervised at all times unless the child 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 ensures 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 in off grounds activities which shall maximize the supervision and safety of children participating in the activities.

14.15.f. The organization shall ensure that when children 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 and out, the person responsible for the child, as appropriate, and the location at which the child 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 use 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 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 the 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 is 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 is 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 shall provide 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.

14.16.^e An organization that provides services to children with developmental disabilities shall adhere to and implement the Principles of Normalization and adapt the organization's therapeutic facilities to meet the developmental needs of the child.

14.16.^x The organization shall provide children 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 children.

14.16.^g The organization shall ensure that children are provided with therapeutic and didactic interventions which directly address his or her substance abuse and any deficits in adaptive functioning relating to or concurrent with the abuse of substances.

14.16.^k If the organization specializes in substance abuse treatment, staffs training shall comprehensively address the latest information, theories and techniques in:

14.16.^k1. Identification, diagnosis and treatment of alcohol and drug abuse;

14.16.^k2. The concept of chemical dependency as a disease; and

14.16.^k3. Prevention activities that address both primary and relapse prevention.

14.16.ⁱ When the initial assessment indicates the presence of a sexually sensitive history (either as offender or victim) the organization shall:

14.16.ⁱ1. Obtain either directly or by contract or referral a thorough assessment of the sexual history and functioning of the child, attending in particular to episodes of victimization or offense;

14.16.ⁱ2. Obtain either directly or by contract or referral specialized treatment interventions as appropriate; and

14.16.ⁱ3. Ensure that the child is appropriately housed and supervised in order to ensure the safety of all of the children.

14.16.^j If the organization specializes in the treatment of sexual offenders:

14.16.^j1. The milieu shall be organized and maintained in such a way as to maximize the safety and supervision of the children at all times; and

14.16.^j2. Staff shall be specially trained in the supervision and treatment of sexually reactive children; and

14.16.^j3. Professional staff shall be trained and certified as appropriate in the treatment of sexually reactive children, or shall be in the process of obtaining certification and properly supervised by certified staff.

14.16.^k If the organization discovers that a child 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.^k1. Fetal alcohol syndrome screening;

14.16.^k2. Prenatal care;

14.16.^k3. Well-baby care; and

14.16.^k4. 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 children on a 24 hour basis.

14.17.b. Each child shall have upon admission or receive within 5 days of admission a current medical screening by a qualified medical practitioner.

14.17.c. In facilities with stays of longer than thirty 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 with stays of longer than thirty 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 a 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 child shall be encouraged to participate in the selection of clothing.

14.18.b. A child's clothing shall be

identifiably his or her own and not shared in common.

14.18.c. Clothing shall be kept clean and in good repair. The child shall be involved in the care and maintenance of his or her clothing. As appropriate, laundering, ironing and sewing facilities shall be accessible to the child.

14.18.d. When uniforms are required, the child and parents or guardians shall be advised of this requirement prior to admission.

14.18.e. The organization shall ensure that discharge plans make provisions for clothing needs at the time of discharge. All personal clothing shall go with a child when he or she is discharged.

14.19. Personal Belongings

The organization shall allow a child 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 a child's property.

14.20. Personal Hygiene

14.20.a. Procedures to ensure that children receive assistance and training in personal 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 child shall be permitted a reasonable degree of freedom in selecting a style of wearing his or her hair and clothing.

14.21. Religion and Culture

14.21.a. Children 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. Children may not be coerced or required to attend religious activities.

14.21.c. The organization shall involve children 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 these 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 the child physically harming himself or herself 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 prohibited 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 guidelines

exist unless the 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 or officer.

15.2.d. At admission each child shall be assessed for his or 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 himself, herself 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 these interventions;

15.2.d.4. Psychological or social factors such as psychosis, claustrophobia or; a history of sexual or physical abuse that would influence the use of the 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 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 these 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 shall be monitored. Consciousness, respiration, agitation, mental status, skin color and skin integrity should be monitored continuously.

15.2.j. Staff members identified as medical professionals 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 child.

15.3. Training

15.3.a. All staffs shall receive documented training in the organization's restrictive behavior management practices.

15.3.b. All direct care, supervisory and clinical staffs 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. The training shall include:

15.3.c.1. Recognizing situations, including medical conditions that may lead to a crisis;

15.3.c.2. Recognizing 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 may be used only in emergency or crisis situations to protect individuals from harming themselves or others;

15.4.a.2. Staffs shall use the least restrictive, safest and most effective methods generally accepted in the field;

15.4.a.3. Physical restraint may be 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 himself, herself or others outweighs

the potential risk of the use of physical restraint. This analysis shall be documented as soon as possible after the use of the restraint;

15.4.a.5. Physical restraint shall be discontinued as soon as possible;

15.4.a.6. All direct service staff shall 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 shall be kept documenting the names of staff restraining children, the names or identifiers for children restrained, the date and the time of restraint, other individuals involved, the circumstances and reasons for physical restraint, the amount of time the child is restrained, and documentation of supervisory review;

15.4.a.8. Use of physical restraint shall 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 the parent or guardian unless he or she indicates in writing that he or she does not wish the notification or unless the parent or guardian has specified parameters for notification (i.e., in case of injury during restraint).

15.4.b. The clinical justification, use, staffs involved, circumstances, efforts to employ less restrictive measures and length of application shall be clearly documented for each instance of physical restraint.

15.4.c. The organization shall review each incident of physical restraint 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 child into compliance;

15.4.d.2. In response to cursing or screaming;

15.4.d.3. For refusal to participate in an activity; or

15.4.d.4. For failure to join a group activity.

15.4.e. The use of physical restraints shall be discontinued as soon as possible, and shall be limited to the following maximum time per episode:

15.4.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.f. Staff shall make periodic attempts to free the child during the period in which the restraint is employed.

15.4.g. 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.h. Following each instance of physical restraint, a meeting shall be held within 24 hours that includes the appropriate staffs (the staff restraining children and supervisory staff) and the person restrained (if developmentally and clinically appropriate) to:

15.4.h.1. Evaluate the well-being of the person served and identify the need for counseling or other services related to the incident;

15.4.h.2. Identify antecedent behaviors and modify the care plan as appropriate;

and

15.4.h.3. Analyze how the incident was handled.

15.4.i. 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 children in its care that shall be in compliance with W.Va. Code §49-6A.

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 W.Va. Code §49-6A. All allegations of abuse and neglect shall be immediately reported by telephone to the Institutional Investigative Unit of the Department 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 will 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.

16.1.c.1. The organization shall limit

internal assessment of an incident to ensuring the safety of the children 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 child or children shall result in the completion of an incident form. Incidents suspected of being subject to mandatory reporting requirements as defined by W.Va. Code §49-6A-1 shall be reported to the Institutional Investigative Unit according to organization policy and procedures. This shall include medication errors with negative outcome for the child 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 incident 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 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 safety;

16.1.g.3. Transfer to a substantially different area of the organization with different children (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 does 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 child 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 child that exceeds his or her plan of care provision for community access;

16.2.a.13. Removal of a child from service without his or 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.

16.2.b. For the purposes of sorting mandatory reporting incidents from other incidents, the issue of lack of appropriate staff oversight shall always be considered. If the incident can be attributed to lack of staff oversight, it is upgraded to a mandatory reporting incident.

16.2.c. All critical incidents shall be documented, investigated by a committee consisting of at least two members not in the direct chain of command for the organization, and shall result in a report which shall be reviewed by the administrator or his or 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 shall describe the incident, possible antecedents, consequences, witnesses, time of day, length of the incident, the 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 shall always be evaluated as an issue. If that lack led to negative outcome for the child, it shall be upgraded to

mandatory reporting. Injuries of unknown origin shall also always be evaluated and considered for potential of abuse in protected populations.

16.2.e. Non-critical incidents include unusual events occurring to a child that needs to be recorded and briefly investigated or reviewed and tracked for risk management or quality improvement purposes. These 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 child 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; or 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.).

insert period

16.2.f. The organization shall keep a central administrative file of all incident reports and any ensuing investigations.

16.2.g. Incident reports shall be completed prior to the end of the shift of the reporter or individual involved. The program supervisor shall review and sign off on the report within one working day. The organization shall make reports by telephone or fax to the Institutional Investigative Unit immediately, when appropriate. Written reports shall follow within 48 hours as appropriate. Internal investigations shall 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. The organization shall submit all incident reports either monthly or quarterly (depending on the size of the organization and number of reports) to the organization's safety committee or 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 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 the 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

All children's 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. Staff Ratios and Training

17.1.a. Staff, for the purposes of this section, are those individuals who are:

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

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

17.1.b. The group residential program shall have a policy regarding care and supervision

of children that ensures that:

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

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

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

17.1.c.1. A minimum of staff to child ratio of 1:6 shall be maintained during waking hours when children are on the grounds with a minimum of one staff present per residential living unit at all times when children are present in the living unit;

17.1.c.2. Additional or back-up care staffs shall be available 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

17.1.c.3. A staff to child ratio of 1:12 shall be maintained during sleeping hours with a minimum, of at least one staff per residential living unit to be awake at all times when children are present in the living unit.

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

17.1.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.

17.1.f. The organization which uses a house parent model shall have a policy that

ensures the safety and supervision of children at night.

17.2. Environmental Issues

17.2.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 child is expected to assume some responsibility for an aspect of facility maintenance (cleaning, cooking, etc.) on an ongoing basis.

17.2.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.

17.2.c. Children shall have clearly identifiable schedules and activities, individualized for their strengths and needs. Each child shall have a unique schedule which identifies therapy times, chore or work assignments, school hours, and other activities.

17.2.d. Staff shall be available in sufficient quantity and with appropriate credentials to address the needs of the child as identified by the assessment and interdisciplinary team process.

17.2.e. The residential program that permits pets shall follow written procedures that address their availability, care, feeding, and maintenance that includes at a minimum, a veterinary evaluation and vaccinations as recommended by the veterinarian in writing.

17.2.f. Service elements unique to the population:

17.2.f.1. If the residential program permits children to operate vehicles while in placement, it shall do so under the following conditions:

17.2.f.1.A. The child has a valid West Virginia driver's permit or license;

17.2.f.1.B. The child's vehicle, if any, is appropriately licensed and insured; and

17.2.f.1.C. The child receives permission in writing from his or her parent or guardian.

17.2.f.2. The organization shall have a written plan of basic daily routines which shall be available to all staffs and updated regularly.

17.2.f.2.A. Children shall participate in planning daily routines.

17.2.f.2.B. Children shall have set routines for waking and going to bed.

17.2.f.3. The organization shall encourage and arrange for children to participate in community and school functions and recreational activities on an individual basis.

§ 78-3-18. Residential Crisis Support/Emergency Shelter Care.

18.1. Service Description

18.1.a. Children's emergency shelter care services are provided to children in need of room, board and supervision and support during a familial or personal crisis.

18.1.b. Children's emergency shelter care services are provided to all children unless services are limited to a specific target population through a written program description or through contract with the Secretary.

18.1.c. Children's emergency shelter care is responsible for making reasonable efforts to assist individuals to find appropriate placement if

admission is impossible because of census, program description, or client variables.

18.1.d. When children are provided shelter without permission of a parent or guardian, the organization shall:

18.1.d.1. Establish the child's legal status;

18.1.d.2. Conduct a brief interview to ascertain the circumstances of the need for admission;

18.1.d.3. Notify the parent or guardian of the admission unless the Shelter documents that the child;

18.1.d.3.^A Is an emancipated minor;

18.1.d.3.^B Has reached age of majority; or

18.1.d.3.^C Could be endangered as a result of notification.

18.1.d.4. Notify the local representative of the Department; and

18.1.d.5. Obtain authorization to provide care for the child if appropriate and necessary.

18.1.d.6. The child shall be informed of the planned notification, which shall occur immediately after admission.

18.1.e. Stays in the Shelter are voluntary unless the child has been ordered into the facility by a legal entity with authority to do so. If a child voluntarily enrolled as a participant chooses to leave the facility, staff shall document efforts to persuade him or 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 the Department's policy.

18.1.f. Children in Shelter care shall be

supervised at all times unless the child 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 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 the time in/out, the person responsible for the child, as appropriate, and the location at which the child may be contacted if necessary.

18.1.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 or she shall also receive a copy of policies regarding standards of conduct in the Shelter at that time. Policies and procedures shall:

18.1.g.1. Define the reasons or conditions for which an individual may be expelled;

18.1.g.2. Delineate a clearly defined process for expulsion, including timely due process provisions;

18.1.g.3. Describe the conditions or process for re-admission to the Shelter; and

18.1.g.4. Require that all reasonable efforts be made to provide an appropriate alternative placement.

18.1.h. All Shelters provide services that are designed to meet the immediate safety and survival needs of the child. As such, they shall provide, either directly or by referral, the following:

18.1.h.1. Sleeping accommodations;

18.1.h.2. Food;

18.1.h.3. Clothing;

18.1.h.4. Personal hygiene supplies and facilities;

18.1.h.5. Crisis intervention;

18.1.h.6. Case management and assistance;

18.1.h.7. A mailing address;

18.1.h.8. Information and referral for services;

18.1.h.9. Linkage to medical services;

18.1.h.10. Eyes on supervision;

18.1.h.11. Supportive group counseling;

18.1.h.12. Supportive individual counseling;

18.1.h.13. Access to recreational activities; and

18.1.h.14. Educational assistance, if necessary.

18.1.i. The Shelter shall:

18.1.i.1. Provide prompt admission;

18.1.i.2. Emphasize short term stay by working aggressively to arrange more appropriate alternative placement;

18.1.i.3. Provide an organized written program of daily activities for each child that includes social, recreational and educational activities;

18.1.i.4. Promote continued contact and communication between a parent or guardian and his or her child unless legally or clinically contraindicated; and

18.1.i.5. Assist in developing supportive aftercare or other services to ameliorate the problems that led to the need for the shelter.

18.1.j. Shelters are exempt from subsection 14.10 (educational services) of this

rule. Shelters shall:

18.1.j.1. Informally evaluate educational needs upon admission of school-age children;

18.1.j.2. Arrange admission to the public school system; and

18.1.j.3. Provide educational activities for each school age child in the Shelter environment as required by the state Department of Education.

18.2. Staff Ratios and Training

The Shelter shall have the following staff:

18.2.a. Direct care staff who provide continuous supervision for children twenty-four hours per day at ratio of not less than 1:5 with one staff present at all times in each residential living unit;

18.2.b. A shelter 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;

18.2.c. A consulting licensed psychologist, available as needed by staff or the children;

18.2.d. A case manager or service coordinator, to provide case management services and supportive counseling. The minimum educational requirements are a bachelor's degree and one year experience working with children and families. The case manager shall be appropriately supervised on a regularly documented basis by a qualified behavioral health clinician or social worker;

18.2.e. A consulting registered nurse available onsite at least weekly who is responsible for:

18.2.e.1. Performing nursing

assessments on each child within five working days of admission;

18.2.e.2. Completing medication administration records for each child, updated as necessary;

18.2.e.3. Monitoring medication administration including supervising Approved Medication Assistance Staffs if necessary;

18.2.e.4. Assessing children for their ability to self-medicate under supervised conditions and developing appropriate educational materials or facilities for educating children about their medications or other health conditions;

18.2.e.5. Educating staff to meet the demands of children with unusual health conditions such as diabetes, epilepsy, etc.; and

18.2.e.6. Monitoring medication availability, storage, record-keeping, and disposal and medication errors.

18.3. Treatment Teams

Shelter treatment teams shall consist of the child if developmentally appropriate, a direct care staff person, the case manager and the shelter manager at a minimum. The consulting psychologist shall review and approve all activities of the treatment team if he or she was not an active participant. When appropriate for children with medical issues, the consulting nurse shall also be a member of the team or shall approve the team's activities in writing. The organization shall notify parents or guardians and the child's social worker and request they participate in team activities unless time lines for team activities prohibit such involvement or parental or guardian 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.

18.4. Care Plans

18.4.a. Shelters are exempt from the plan of care subsections 13.3 and 13.4 of this rule as

long as the child is present in the facility less than thirty days. If the child is present in the facility for thirty or more days, an extended plan of care shall be developed as required by subsection 13.4 of this rule and all other aspects of the rule apply with regard to service delivery, plans of care, and reviews of plans of care.

18.4.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 parent or guardian. From that information, the Shelter shall develop an intake plan which shall describe the following:

18.4.b.1. Further testing, evaluation or collection of information necessary to complete the comprehensive assessment of the child and tentative time lines for completion of that assessment;

18.4.b.2. Safety plans or 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.);

18.4.b.3. Plans for referrals for the necessary medical screenings; and

18.4.b.4. Permission to administer properly bottled medications brought in by the child.

18.4.c. The intake plan shall be completed within twenty-four hours and approved by the admitting parent or guardian within seventy-two hours.

18.4.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 shall be given to improving the child's relationship with his or her family unless clinically or legally contraindicated.

18.4.e. The Shelter shall provide objectives for each problem that it has determined that it shall address prior to discharge.

18.4.f. Objectives shall be stated in simple language, understandable to the child whenever possible.

18.4.g. The intervention to be used in addressing the objective shall be described and the person or persons responsible named, if appropriate.

18.4.h. If an objective includes an individual or group therapy intervention, the intervening organization or provider, whether the Shelter's employee or a contractual or other provider to whom the organization 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. 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 written feedback to the shelter prior to discharge, in writing, regarding progress made in therapy or lack thereof and rationale for the lack of progress.

18.4.i. Physicians or qualified medical practitioners providing services to children in the 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 the rationale for the changes.

18.5. Behavior Plans

18.5.a. If a child requires 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:

18.5.a.1. The behaviors to be monitored and modified;

18.5.a.2. The precise action to be taken by staff if the behavior occurs; and

18.5.a.3. The documentation staff is responsible for supplying, if any.

18.6. Reviews of Plans of Care

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's social worker for approval if the social worker is not available for the weekly team meeting. Parents or guardians shall also receive amendments unless clinically or legally contraindicated.

18.7. Planning for Discharge

The treatment team of the Shelter shall begin planning for discharge at admission. When possible, seven days prior to discharge the child, his or her parent or 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 are:

18.7.a. Remaining problems to be addressed from the initial problem list and any problems added later during the child's stay;

18.7.b. Appropriate placement for the child considering issues of safety, permanency and clinical need;

18.7.c. Recommendations for aftercare including recommended behavioral health and medical services; and

18.7.d. Any other relevant and compelling information or considerations.

§78-3-19. Program Specific Rules for Maternity and Parenting Facilities.

19.1. Maternity Care

Care to a pregnant or parenting adolescent or transitioning adult includes, but is not limited to:

19.1.a. Appropriate health care and health education;

19.1.b. Education needs specific to the pregnant or parenting young woman;

19.1.c. Nutritional guidance and support;

19.1.d. Counseling services specific to making decisions and planning for her child;

19.1.e. Parenting educational services; and

19.1.f. Maintenance of an environment conducive to the safety of children (infant through toddler) and pregnant women.

19.2. Appropriate Health Care and Health Education

19.2.a. The organization shall provide or arrange for health services to the expectant and parenting teens that includes:

19.2.a.1. A written health summary, including family medical history, immunizations, operations and childhood illnesses;

19.2.a.2. A general medical examination which will occur at the time of admission, and an obstetrical/gynecological examination for the pregnant young woman within the first two weeks of admission or sooner if the young woman is considered to be high risk;

19.2.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

19.2.a.4. Direct provision or referral for services to meet the needs of high risk pregnancy or high risk infant care-related issues.

19.2.b. Registered nursing staff with obstetrical/gynecological experience are to be available on the grounds at least twelve hours per day, with twenty-four hour availability onsite.

19.2.c. The pregnant or parenting young woman 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.

19.2.d. The organization shall be located within fifteen minutes of a hospital with maternity care.

19.2.e. Standing medical orders for pregnant young women shall be carefully evaluated and shall take into consideration cautions necessary for pregnant young women.

19.2.f. All pregnant or parenting young women shall have access to educational services as appropriate:

19.2.f.1. All pregnant or parenting young women, once assessed, shall participate in some type of educational service such as GED classes, public school, and/or alternative education;

19.2.f.2. Child care services shall be in close proximity to the education facilities; and

19.2.f.3. Supportive services for child care shall be available to assure that the young woman can have necessary study time.

19.3. Nutritional Guidance and Support

19.3.a. All parenting and pregnant young women will be assessed at a minimum within the first thirty days of admission by a registered

dietitian, unless dietary problems are indicated at admission.

19.3.b. Ongoing dietary support shall be encouraged through a nutritional education program and if indicated by individual instruction provided by the registered dietitian or registered nurse.

19.3.c. All pregnant and parenting young women shall receive counseling services specific to parenting and alternative choices, on an ongoing basis.

19.3.d. The organization shall have policy and procedures related to the involvement of the putative father of the baby.

19.3.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.

19.3.f. The organization shall offer an ongoing parent education program with a curriculum that comprehensively addresses at a minimum, the following topics:

19.3.f.1. Personal growth and maturity;

19.3.f.2. Interpersonal relationships;

19.3.f.3. Early childhood development;

19.3.f.4. Infant stimulation and cognitive development;

19.3.f.5. Safety and accident prevention, including First Aid and CPR;

19.3.f.6. Physical care, nutrition, and health of infants and young children;

19.3.f.7. Signs and symptoms of child abuse and neglect;

19.3.f.8. Time, budget, and

household management;

19.3.f.9. Community resources that provide assistance; and

19.3.f.10. Child care use and how to choose providers.

19.3.g. Parenting education may be offered in both a formal and informal setting using classroom instruction, small groups, and individual and experiential teaching methods, based on the needs of the mother.

19.3.h. The organization shall maintain an environment conducive to the safety of a child (infant through toddler) and a pregnant woman.

19.3.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.

19.3.j. All areas shall be child proofed and all infant and child furniture shall be maintained in good repair and meet the Child Product Safety Commission (CPSC) guidelines.

19.3.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 it accordingly.

19.4. Baby Care

19.4.a. An organization shall provide a plan of care for babies that includes, but is not limited to the following:

19.4.a.1. Appropriate health care;

19.4.a.2. Appropriate daily care; and

19.4.a.3. Appropriate daily stimulation.

19.4.b. An organization shall also provide:

19.4.b.1. A warm and child friendly environment; and

19.4.b.2. Staff specifically trained to meet the needs of infants through toddlers.

19.4.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.

19.4.d. The organization shall assure that all children receive health care according to the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) standards of care.

19.4.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.

19.4.f. The organization shall have policy and procedures to assess and treat babies and children who show signs of illness, which include but are not limited to diarrhea, vomiting, fever, etc.

19.4.g. If at any time the baby's mother is unable or refuses to care for her baby, the organization shall have policy and procedures to assure that appropriate interventions are used to secure the health of the child.

19.4.h. Appropriate daily care:

19.4.h.1. The organization shall 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.

19.4.h.2. The organization shall ensure the basic needs of the baby 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.

period

19.4.h.3. All babies under twelve months of age shall have a feeding and diet plan prescribed by the physician.

19.4.i. The organization shall handle breast milk and formula in the following manner:

19.4.i.1. Prepared bottles are to be capped and clearly labeled with the child's name, contents and the date prepared;

19.4.i.2. Prepared bottles are to be refrigerated in a separate section of the refrigerator and accessible only to staff;

19.4.i.3. Breast milk shall be stored in hard plastic or glass bottles with tight lids;

19.4.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;

19.4.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 of receipt;

19.4.i.6. Formula bottles shall be used within twenty-four hours of preparation or discarded; and

19.4.i.7. A microwave oven is not permitted for the heating of breast milk or formula bottles.

19.4.j. Solid food, including cereals are not to be placed in a bottle.

19.4.k. Jar baby food is to be served from a bowl and not from the jar.

19.4.l. Until a baby is able to hold a bottle securely, a baby and the bottle shall be held while the baby is being fed. At no time is the bottle to be propped.

19.4.m. All babies shall receive daily stimulation to encourage the emotional, physical

and intellectual development of the child. This includes:

19.4.m.1. Holding, rocking, and playing whenever possible, including while bathing, dressing and carrying the child;

19.4.m.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;

19.4.m.3. Paying attention to crying and meeting the immediate needs of the child;

19.4.m.4. Ensuring that no child is routinely left in a crib or playpen, except for sleep or rest; and

19.4.m.5. Providing a child who is awake with play equipment and opportunities to play freely on a clean floor.

19.4.n. 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.

19.4.o. The organization shall ensure that all electrical outlets within the reach of a child when not in use are protected by a cover.

19.4.p. 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.

19.4.q. The organization shall provide a shield to protect a child from hot pipes or radiators and shall not use unvented fuel fire heaters.

19.4.r. The organization shall ensure that barriers and gates are appropriately used.

19.4.r.1. All temporary walls or items being used as physical barriers shall be firmly anchored so that they pose no threat to the safety of the child.

19.4.r.2. Stairways to which the child has access shall have appropriate railing and safety gates or other barriers at the top and at the bottom.

19.4.s. The organization shall ensure that strings, cords and hanging items are of no threat to the children.

19.4.s.1. The drawstring on clothing such as on hoods or collars shall be removed or secured to prevent potential risk to the child.

19.4.s.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

19.4.s.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.

19.4.t. The organization shall ensure that there is an outdoor play area appropriate and safe for young children.

19.4.u. 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.

19.4.v. 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.

19.5. Staff Training

19.5.a. The organization shall ensure that all staff is specifically trained to meet the needs of the very young child.

19.5.b. All staff shall be trained within the first thirty days of employment on basic infant care. Prior to completion of the training, the new employees shall be scheduled to work only with fully trained staff.

19.5.c. At a minimum, all staff shall be trained in:

19.5.c.1. Child development;

19.5.c.2. Infant CPR and first aid;

19.5.c.3. Basic child care;

19.5.c.4. Sick baby care; and

19.5.c.5. Parenting skills.

§78-3-20. Outdoor Therapeutic Educational Programs.

20.1. Staff Ratios

20.1.a. Staff ratios to children shall be appropriate for the activity in which the group is engaged.

20.1.b. Staff ratios for high risk activities (rock-climbing, rope-walking, white water, etc.) shall be a minimum of four staff to ten children. (4:10).

20.1.c. The staff ratio for away from main camp on low risk activities shall be a minimum of three staff to ten children (3:10).

20.1.d. In main camp, the staff ratio shall be a minimum of two staff to ten children (2:10).

20.1.e. Staff ratios for groups away from camp may be adjusted downward for smaller groups; however, safety and the adequacy of supervision shall be a paramount concern.

20.1.f. At night:

20.1.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;

20.1.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 children at all times. The organization shall have a policy regarding staffing ratios to ensure the safety and security of children at night when away from the main camp.

20.2. Credentials of Staff

20.2.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 shall 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.

20.2.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 shall be responsible for supportive counseling of children, teaching and modeling appropriate problem-solving and anger management skills, teaching and modeling appropriate interpersonal skills and positive role modeling.

20.2.c. Teachers certified to teach by the state of West Virginia shall be responsible for the oversight and supervision of the educational program of the organization. The organization shall have at least one teacher.

20.3. Staff Training

20.3.a. All staff responsible for the direct care of children shall be trained in the following

areas in addition to those cited in subsection 11 of this rule:

20.3.a.1. Water procurement, preparation and conservation;

20.3.a.2. Shelter construction;

20.3.a.3. Food preparation and storage in the field;

20.3.a.4. Fire site preparation and fire building;

20.3.a.5. Low impact wilderness expedition and environmental conservation skills and procedures;

20.3.a.6. Sanitation procedures related to food, water and waste;

20.3.a.7. Management of health issues unique to the outdoor therapeutic educational program environment including acclimation to the environment and environmental elements;

20.3.a.8. Basic training in rescue and water safety for those staff responsible for water activities. A minimum of one adult so trained shall be present at all times at all water activities;

20.3.a.9. Navigation skills including map and compass use and contour navigation;

20.3.a.10. Local environmental precautions including sensitivity to terrain, weather, insects, poisonous plants, wildlife and the proper response to adverse situations involving any of these factors; and

20.3.a.11. Management of the health and safety of the group in severe weather conditions including a possible evacuation plan.

20.3.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.

20.4. Service Elements

20.4.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.

20.4.b. The organization shall have complete policies and procedures to guarantee child safety in any off grounds activity, including but not limited to:

20.4.b.1. Backpacking;

20.4.b.2. Hiking;

20.4.b.3. Tent building and other construction;

20.4.b.4. Ropes courses;

20.4.b.5. Van trips;

20.4.b.6. Off property outings;

20.4.b.7. Canoe trips or white water rafting;

20.4.b.8. Swimming or wading;

20.4.b.9. Mountain biking;

20.4.b.10. Skiing;

20.4.b.11. Soloing; and

20.4.b.12. Rock climbing.

20.4.c. The policy shall discuss the following:

20.4.c.1. Staff to child ratios for the activity;

20.4.c.2. Staff training and/or

certification prerequisites for participation.

20.4.c.3. Child training prerequisites for participation, including safety training;

20.4.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;

20.4.c.5. Evacuation plans if they should become necessary during an activity;

20.4.c.6. Safety plans unique to the activity (e.g., backpacking weights, rope safety and monitoring, etc.); and

20.4.c.7. The documentation necessary for the activity.

20.4.d. All policies and procedures shall be in conformity with nationally accepted standards for the activity, if they are available. If staff certification or training is available in the activity, at least one staff present during the activity shall be trained or certified. During water activities, at least one staff shall be fully certified in water safety and lifesaving.

20.4.e. If the organization contracts with an independent provider to guide or supervise the activities, the contractor shall be appropriately certified if a certification is available.

20.4.f. General safety considerations:

20.4.f.1. Personal gear supplied to children shall be appropriate in size, amount and protectiveness for the child and the expected weather;

20.4.f.2. No child shall be expected to pack more than 30% of his or her body weight at any time and special health considerations shall be taken into account if they are necessary;

20.4.f.3. Adequate food and water shall be available to staff and children at all times in all activities;

20.4.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 the inspections shall be documented and monitored;

20.4.f.5. Prior to any water activity, the swimming ability of all children and staff shall be evaluated and documented by an appropriately trained staff person. The organization shall document that adequate arrangements for protection of non-swimmers have been made on each activity;

20.4.f.6. Soloing activities shall only be conducted with the written consent of a licensed mental health clinician who has personally evaluated the child within twenty-four hours prior to the onset of the solo activity. At all times, staff shall be in earshot of a distress call if it is 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

20.4.f.7. The organization shall have a policy to ensure safety and security of children who are acutely disturbed and/or suicidal.

20.5. Abrogation of Client Rights

While items of clothing may not be withheld as a punishment, children 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.

20.6. Environmental Issues

20.6.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 a reasonable effort to enable family members with physical handicaps to

access children, family therapy interventions and program sites.

20.6.b. Outdoor therapeutic education facilities are generally considered to be inappropriate for serving children with serious physical handicaps; however, the organization is responsible for finding a method of incorporating family members with physical handicaps to a maximum degree into the therapeutic process.

20.6.c. The organization shall have policies pertaining to the following with reference to any activities conducted away from the main campus or building:

20.6.c.1. Unique adaptations to dietary requirements as appropriate;

20.6.c.2. Sanitation and infection control;

20.6.c.3. Waste management;

20.6.c.4. Food storage and handling;

20.6.c.5. Maintenance of safe body temperature;

20.6.c.6. Clothing and footwear;

20.6.c.7. Field equipment;

20.6.c.8. Communication with the main campus or management on an on-going and emergency basis;

20.6.c.9. Medication storage and security away from camp;

20.6.c.10. Disaster and severe weather plan including procedures for evacuation; and

20.6.c.11. Procedures to follow for runaways and elopements.

§78-3-21. Intermediate Care Facilities for the Mentally Retarded or Developmentally Disabled.

21.1. Compliance

Intermediate care facilities for children 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 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 adult residents in the home is approximately that of the child unless the prospective child and the other adult residents of the home have developmental disabilities which are severe or profound and/or the adult residents are non-ambulatory, nonverbal or have multiple physical handicaps;

21.2.b. The home has arranged educational programming for the child which is as normative as possible;

21.2.c. The child has a reasonable ability to participate in age-appropriate community activities;

21.2.d. The placement is developmentally consistent with other adult residents of the home; and

21.2.e. None of the adult 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 or developmentally disabled.

§78-3-22. Psychiatric Residential Treatment Facility.

22.1. Compliance

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 children 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). A psychiatric residential treatment facility provides a continually, medically-supervised interdisciplinary program of behavioral health treatment.

22.2. Accreditation Requirements

A psychiatric residential treatment facility shall be appropriately accredited as required by federal standards. Where differing accreditation, certification or licensing standards exist, the more stringent standard applies.

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 children) with the 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 shifts 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 staffs 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 section 11 of this rule, 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

The residential treatment facility shall provide the following clinical services:

22.5.a. A physician shall be available twenty-four hours a day, seven days a week to respond to medical and psychiatric emergencies;

22.5.b. A psychiatrist shall perform observation and assessment at least weekly;

22.5.c. 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.d. 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 health;

22.6.a.2. Physical health;

22.6.a.3. Nursing;

22.6.a.4. Psychosocial history;

22.6.a.5. Recreational activities;

22.6.a.6. Spiritual and 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. An 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. A psychiatric evaluation shall be completed within twenty-four hours of admission and shall include:

22.6.d.1. The reason for admission;

22.6.d.2. The current clinical presentation;

22.6.d.3. Psychosocial stressors related to the recent illness;

22.6.d.4. A current or potential risk to self or others;

22.6.d.5. A history of the present illness;

22.6.d.6. A past psychiatric history;

22.6.d.7. A developmental assessment;

22.6.d.8. The presence or absence of physical disorders or conditions affecting the

presenting problem;

22.6.d.9. An alcohol and/or drug history; and

22.6.d.10. A 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.4. Pertinent medical problems requiring nursing attention;

22.6.g.5. Current risk and safety factors;

22.6.g.6. Nutritional status;

22.6.g.7. Immunization status; and

22.6.g.8. 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 a plan of care.

22.7.c. The plan of care shall be reviewed by the interdisciplinary team for effectiveness and shall be revised when major changes in treatment occur, or at least every thirty days.

22.8. Transfer Agreement

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 transitioning 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

Restrictive Behavior Management techniques shall conform to all federal guidelines for psychiatric residential treatment facilities.

§78-3-23. Therapeutic Residential School.

23.1. Staff Ratios and Training

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

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

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

23.1.b. The therapeutic residential school shall have a policy regarding care and supervision of children that ensures that:

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

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

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

23.1.c.1. A minimum staff to child ratio of 1:10 during the waking hours when children are on the grounds with a minimum of one staff person present per residential living unit at all times;

23.1.c.2. The availability of additional or back-up care staffs for emergency situations or to meet special needs presented by the child (e.g. physician appointments, behavioral outbursts, acute suicidality, etc.) ; and

23.1.c.3. A staff to child ratio 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.

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

23.1.e. As appropriate to the ages and needs of persons in care, the organization shall ensure that one or more trained professional staff members are 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.

23.1.f. The organization which uses a house parent model shall have a policy that

ensures the safety and supervision of children at night.

23.2. Environmental Issues

23.2.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 child is expected to assume some responsibility for an aspect of facility maintenance (cleaning, cooking, etc.) on an ongoing basis.

23.2.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 children.

23.2.c. Children shall have clearly identifiable schedules and activities, individualized for their strengths and needs. Each child shall have a unique schedule which identifies therapy times, chore or work assignments, school hours, and other activities.

23.2.d. Staff shall be available in sufficient quantity and with appropriate credentials to address the needs of the child as identified by the assessment and interdisciplinary team process.

23.2.e. The residential therapeutic school that permits pets shall follow written procedures that address their availability, care, feeding, and maintenance that includes at a minimum, a veterinary evaluation and vaccinations as recommended by the veterinarian in writing.

23.2.f. Service elements unique to the population:

23.2.f.1. If the organization permits children to operate vehicles while in placement, it

shall do so under the following conditions:

23.2.f.1.A. The child has a valid West Virginia driver's license or permit;

23.2.f.1.B. The child's vehicle, if any, is appropriately licensed and insured; and

23.2.f.1.C. The child receives permission in writing from his or her parent or guardian, as appropriate.

23.2.f.2. The organization shall have a written plan of basic daily routines which shall be available to all staffs and updated regularly.

23.2.f.2.a. Children shall participate in planning daily routines.

23.2.f.2.b. Children shall have set routines for waking and going to bed.

23.2.f.3. The organization shall encourage and arrange for children to participate in community, school functions and recreational activities on an individual basis.