Title 64 Series 11
Department of Health and Human Resources
Office of Inspector General
Office of Health Facilities Licensure and Certification
BEHAVIORAL HEALTH CENTERS LICENSURE

Summary of Public Comments:

Section 1 – General

Comment
1.7. Purpose – add "to ensure the provision of services and supports that are individualized and person-centered" to the sentence stating purpose.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
Rule applies to public, private, for profit and non-profit but exempts most all providers- defeats the purpose stated in 1.7 - If providers are delivering BH services then a license is needed. Erosion of the rules for some but not for others creates an unfair playing field.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
The licensure rule should not be used to force agencies to provide services that are not reimbursed. This is happening now and Commissioner Beane agreed with this statement in the Public Meeting, but nothing was added to the rule preventing future unfunded mandates.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
CMS has a Final Rule regarding Integrating Settings (CMS 2249-F and CMS 2296-F) that apply to all settings owned or leased by provider agencies who provide services under any of the 1915© HCBS Waivers, 1915(i) State Plan HCBS and 1915(k) Community First Choice regarding person-centered planning, privacy, access to lockable entrance doors, sharing units with choice of roommates, freedom to furnish/decorate sleeping/living units, visitors, etc. There needs to be a general statement that any providers who provide services to any of those programs must be in compliance with this Rule. This is very important; this guidance is coming from CMS.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Section 2 – Application and Enforcement

Comment
Section 2.5. Exemptions – We agree with the exemptions for services provided through a Medicaid self-directed community-based waiver (2.5.2) and Specialized Family Care (SFC) providers providing only services to individuals in SFC settings (2.5.10). We believe another exemption should be added for families that provide services through the Medicaid home and community-based I/DD Waiver in totality, whether services are being provided through the self-directed option or the traditional option. The other two

exemptions mentioned can be, in the case of self-directed option and are, in the case of SFC, provided by people other than family members. We can think of no justification for setting a stricter standard for natural families providing such services.

Response

The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment

Section 2.5.6. This needs to be amended to include Fellowship Homes and halfway houses for support of individuals with addictions.

Response

The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment

2.5.6 Does emergency shelter include crisis units?

Response

The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment

2.5.10. The exemption for Specialized Family Care Providers - is this even if they are employed by a licensed BH agency and providing a licensed behavioral health service such as IDD Waiver direct support services?

Response

The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment

Section 2.5.10. This section on Exemption of Specialized Family Care Providers needs to be expanded to include Natural Family and Adoptive Family Homes providing IDDW services.

Response

The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Section 3 – Definitions

Comment

3.1. Abuse definition should include insufficient supervision, failure to intervene when indicated, placement in an unsafe environment, lack of appropriate monitoring and reference that neglect is abuse.

Response

The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment

3.1. Abuse — We believe this proposed change weakens the definition of abuse and strongly oppose it. The definition should be very clear, as it is currently. The proposed definition is open to a great deal of interpretation and makes it harder to agree on whether a situation or incident constitutes abuse. For instance, who will determine whether "significant" physical or emotional harm has occurred? What will be the criteria for the term "significant?" We believe the definition should also include the clarification that abuse

also includes those actions committed by a contractor or volunteer working for the provider. Likewise, we disagree with the removal of the clarifying definitions of psychological and verbal abuse. (Sections **3.1.b and 3.1.c).**

Response

The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment

3.1 Abuse. – Can you further define imminent risk?

Response

The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment

3.1. What is the definition of significant, or how do determine what is significant and what isn't

Response

The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment

3.1 – Abuse definition removed are concerning.

Response

The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment

3.1. The definition of abuse includes the term significant. This needs to be defined. What is significant physical or emotional harm to me may be very different than what it is to you. Both CMS and the OIG are very concerned about the health and safety of the HCBS members and thus the definition should be strengthened and made very clear.

Response

The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment

3.1. Abuse DRWV is concerned that the proposed definition of "abuse" may result in instances of abuse going unreported or underreported. DRWV recommends the use of a more expansive definition of abuse by either including a definition of the terms "significant physical or emotional harm" and "serious harm," or by removing the terms "significant" and "serious" from the definition. DRWV recommends inclusion of the federal definition found in 42 U.S.C. §1397j(1) which defines "abuse" as "the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm."

Response

The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment

Definitions-Why the change in definition on abuse, it would appear that the items marked through would still be appropriate to be considered abuse.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.3. Advocate — We do not understand why this definition is being removed and disagree with the removal.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.4. Aversive Procedures — We disagree with the removal of this definition.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
The definition of Aversive Procedures needs to be added back in. This should not be omitted now.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.5. Assessment — We suggest the definition be changed to read, "Formal and informal evaluations of a person by qualified personnel using skills of examination, including appraisal and analysis of data collected to provide care and services."
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.7. Behavioral Intervention — The word "plan" should be added back into the definition. "A written behavior support approved by the service planning team." makes little sense. A plan is written. We also suggest adding "A behavioral intervention plan utilizes positive behavior support methods that focus on skill development and replacement of negative behavior."
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.7. In addition to the service planning team, the consumer and/or the guardian should also approve the plan.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.8. Civil Rights — We question the reasoning for removing this definition.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.9 Chemical Restraint (new) — We suggest the addition of "an emergency procedure when less restrictive approaches fail."
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.11 is this a duplicate of 3.6 Behavioral Health Service
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.11 Corporal Punishment — We do not agree with the use of corporal punishment but question the reasoning for the removal of the definition.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.12 Critical Incident — As with the more detailed definitions of abuse which are being proposed for removal, we disagree with the extremely vague definition being proposed as a replacement in **3.15.**
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
Critical Incident – DRWV is concerned that the narrowed definition of "critical incident" may result in significant events that could affect treatment and exercise of rights going undocumented or reported. The definition of "critical incident" should include all unusual or unexpected events that may impact treatment. This should take into consideration incidents where consumers experienced harm, risk of harm, medical or behavioral instances, or situations that may impact a consumer physically or emotionally. These instances should be noted in treatments plans and reviewed by the consumer's treatment team.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
The prior definition of Critical Incident needs to be added back in. Our providers use that definition in terms of what to report into the WV Incident Management System.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
Critical incidents can include abuse/neglect and also critical incidents can be things that do not involve abuse or neglect
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.1.5. Definition specifies critical incident as one that does not meet the definition of abuse/neglect. Incidents of abuse/neglect are considered to be critical incidents. Should the passage say "may or may not meet the definition of abuse/neglect"?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.12 Through 3.22c – not sure why all were removed?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
Not sure why 3.24 through 3.38 were moved?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.18. Is it really necessary to add yet another "name" to the long list of individuals who are legal representatives of a consumer? Also, WHO is the individual or entity who makes the determination that an individual is DESIGNATED?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.20. Elopement. – Add when an IDD consumer leaves against clinic advice.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.20. Elopement – the section "during times the provider is being compensated for providing care" is not needed.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.21 Human Rights Committee, and 3.22 Informed Consent We question the removal of these definitions. Are Human Rights Committees and Informed Consent no longer being required? The Council would strongly disagree.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
We still need Human Rights Committees, please do not take these out.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.21. – HRC is this defined in another section? This was taken out.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
Human Rights Committee – DRWV recommends the definition of "Human Rights Committee" not be removed from the regulation.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.22. Employee. – remove contracted and volunteers.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.22. – Informed consent should be left in.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.24.k. Mechanical Supports — This definition was incorrectly placed under the definition of Legal Representative. We agree it should be moved to a more appropriate place, but question why it is being removed altogether.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.25 Medication Error, and 3.26, which includes the actual definition —This section also needed to be cleaned up, but we question why the definition has been removed entirely.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.25. – medication error – is this referenced in another section?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.26. the actual definition of inappropriate is "not suitable or proper in the circumstances". There are many behaviors which are inappropriate, yet are not necessarily hazardous; otherwise, this seems ok
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.26 Inappropriate behavior — We suggest removing the word "hazardous" and replacing it with "disruptive or increases risk of harm, and." Not all inappropriate behavior is hazardous.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.27. Should include reference to the legal process or standard for such determination. Otherwise who makes the decision that a person is incapacitated?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.27. Incapacitated Adult. – Add as defined by WV code.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
3.27 Neglect — The Council strongly opposes the removal of the current definition of neglect and the replacement with **3.32**, which substantially weakens it.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.28. The initial plan of service needs a timeframe designated for when the admission process is completed.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made in a different section of the rule to clarify.

Comment
3.29. Intensive Community-based Stabilization and Maintenance Program. – Further define applicable programs.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.32. Neglect. – Add go with the state definition of Neglect. 16-2-29-3.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.32. Neglect – the term "unreasonable" needs removed this term cannot be well defined and is open to interpretation. In addition, failure to implement the IPP should be included.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
Neglect – DRWV recommends removing the word "unreasonable" from the suggested definition, as failure of a caregiver to provide the care necessary to ensure health and safety is unreasonable.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.33. Non-critical incident should have "injuries of unknown origin" contained in the definition.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
3.34. Non-Methadone Medication-Assisted Programs for Addictions and Co-occurring Disorders. – Remove Non-Methadone and take out (other than methadone).
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
3.36. The term Physician Extender is outdated and offensive to APRNs who are independent practitioners. If a term like this is to be used to lump together Pas and NPs, the more acceptable term is mid level providers.
Response
The Department has reviewed these comments. This comment is general in nature and offers no specific amendment.

Comment
3.37 Not sure how this is different from expanded plan of service.
Response
The Department has reviewed these comments. This comment is general in nature and offers no specific amendment.

Comment
3.37. How is this different from 3.23 Expanded Plan of Service
Response
The Department has reviewed these comments. This comment is general in nature and offers no specific amendment.

Comment
3.40. – The definition of physical restraint includes "a drug or medication that is used as a restriction to manage…" Medications are chemical restraints and if not defined in another section, should have its own definition.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.41. What entity is responsible for the care, custody and protective oversight of the individual during respite care? Is this person an employee of the provider?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.41. Respite. After primary care-giver add and/or consumer.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.41 Respite — We suggest the insertion of the words "and/or consumer" at the end of the second sentence. We believe respite from the primary care-giver can be equally necessary for the individual for whom care is provided.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, some changes were made.

Comment
3.42 Restraint — We suggest the addition of "time limited" to the description.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.43 Seclusion — We suggest the addition of "prohibited procedure" to the definition. We realize that later in this Rule **(12.20.2)** it is stated that seclusion is not permitted in any licensed community-based program, except for a psychiatric residential treatment facility for children or youth. Seclusion has been outlawed in school settings, and we fail to understand why it is still able to be used in treatment facilities for children and youth. Why would a practice not allowed to be used on adults be acceptable for use on children?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
3.45 REMOVE THIS ENTIRE SECTION or combine it with 3.8 Case Management. These are the same service. Someone can choose to have an independent case management/service coordination agency and if they do not offer any other behavioral health service, then they do not need to be licensed through OHFLAC. If they do want to provide other behavioral health services, then they cannot provide these services to

anyone who receives residential services from their agency and they do have to be licensed. The IDDQ manual is changing the term from Service Coordination to Case Management in the 2020 Renewal.

Response

The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment

3.45. Since we are stating that Service Coordination is a behavioral health service we need to notify BMS. They are not wanting to license Service Coordination agencies.

Response

The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment

3.8, 3.45 – clarify case management and service coordination as some agencies use those terms interchangeably.

Response

The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment

3.7 and 3.45. Case Management is indicated as NOT a behavioral health service but Service Coordination is. These terms are often used interchangeably in the field. Can further clarification be given on typical populations served per service, site and location of services and specific professional requirements for each service to further delineate the difference between the two?

Response

The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment

3.47. I see the term Supportive Service being used by providers to negate their responsibility of providing care. If something goes wrong the provider will state, "the consumer was being provided supportive services."

Response

The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment

3.47 how is this different from 3.35 Personal Attendant, 3.25 Habiliation

Response

The Department has reviewed these comments. This comment is general in nature and offers no specific amendment.

Comment

3.50 Volunteer — What is the purpose behind this change of definition? Why would friends or neighbors not be considered as volunteers? People who are under no obligation whatsoever to provide assistance and support, but who offer to do so, are volunteering.

Response

The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Section 4 -- State Administrative Procedures.

Comment
4.1.5. and 4.1.16. 60 days: OHFLAC has no control over the State Fire Marshal's recommendations, which is needed to make a decision on issue a license.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.1.6. The section is confusing we do not always conduct an on-site inspection for an amended application. The section related to inspections within 60 days after an application is received needs changed to, "inspections shall be conducted for all initial and renewals prior to issuing a license"
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.3. Issuance – Without a license the BH center shall be forbidden to have a license for 1 year.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
4.4.2. Regular license. – Make it a 3 year license not 2 year to save money.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
4.4.2 Recommend regular license be 3 year
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
4.4.2 recommend 3 year - this saves the State of West Virginia and providers money on reviews, travel and staffing.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
4.4. -- this states, "following application and review" is this review of the application or on-site review?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
4.4.3.c. – in section 4.4.3.a. such status shall expire not more than six months from the date of issuance and then 4.4.3.c. specifically says a review before or near the end of the six-month provisional period. If the provisional can be issued for less than six months we need to change one of these.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.6 Inspections and Records — We find it troubling that all portions of the current section 4.3. Inspections have been deleted and replaced with detailed information regarding records and minimal language regarding inspections. Currently, licensed centers are inspected at least once every two years, except for residential treatment facilities that are inspected at least once a year. The proposed language includes no requirement for inspections. How will the Secretary ensure the quality of settings and services for which he/she is responsible, and how will people who access services be able to have confidence in a center that has no regular oversight by the licensing entity?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
4.6.1. the section stating consumers or their DLRs shall be interviewed should be changed to "may" be interviewed.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.6.3. reference to "rapid access" not defined. Is subjective with regard to time frame definition of "access", e.g. format/vehicle of provided information
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.6.3 define rapid access for clear understanding of acceptable timeframe
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.6.4. - need to remove or a central administrative office. The records need to be in the same location as the consumer. This should be required for providing the care, custody and protective oversight of the consumer. In addition, for providers with sites in locations all over the state on one license a central administrative office would not allow a surveyor to review the consumer and inspect the consumer record to determine is the proper care was being provided based on the assessment, the medications and the overall wellbeing of the consumer. Further, if the surveyor identifies something that may seem as though the staff are not properly trained the record review for training cannot be readily available. This would also negate the provider's ability to provide rapid access to consumer records.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.6.6. the term clinical needs removed we should be able to inspect all aspects of the provider's operation and premises. If we specify "clinical" there will be misinterpretation of this term.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.6.6. *A consumer may deny access to his or her place of residence unless it is owned or leased by the provider or unless there is evidence of a clear and immediate danger to the health of consumer.* Determined by who?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
4.6.7. Client records. – Add making copies of client records for removal of the site. Need back up documentation.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.6.10. "as described in the section of this rule entitled "Plans of Correction"" should probably be changed to "as described in subsection 4.9 of this rule.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.7.1 -- What is the reason behind the change suggested here by which the Secretary will no longer be required to consider a reported incident to be a complaint? What criteria will be used to judge whether a reported incident will be considered a complaint? We do not see the need for this change and believe it to be another example of the weakening of this rule.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
4.7.3 – we need to change this to the person in charge of the location. In addition, how will we know who the designee is. When doing complaint investigations, we go directly to the location of the consumer/complaint, which is not the location of the administrator.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.7.3. Replace administrator with Chief Executive Officer to remain consistent with definitions
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.7.4. Complaint Investigation. – Have to sign off before they leave.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
4.7.7. I feel this should be in accordance with the Whistleblower Protection Act. I would include some wording stating a complaint made "in good faith". For example, if someone completely makes up some allegation of abuse or neglect by another employee because they wanted to get that employee fired and take their shift, then disciplinary action may result.
Response
The Department has reviewed these comments, and no changes were made. Licensed providers may create a policy to address the issue.

Comment
4.8.4 — We believe this addition would contribute to a greater lack of transparency and that the public and individuals who use services have a right to know if a center is being investigated. A due process appeal could take years. We assume reports indicate whether complaints are alleged or proven.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.9.4 — Is it intended that the Secretary "may" supply a directed plan of correction, or "will" supply one when a second plan of correction submitted by the provider cannot be approved?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
4.9.4. Needs to specify that any "directed" plan of correction will be labeled as such in all public records
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
4.9.7 — Should a definition of "immediate risk" be included in section 64-11-3?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
4.9.5. and 4.9.7. – do we need both?

Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Section 5 – Consumer Rights.

Comment
5.1 Basic Rights — The Council adamantly opposed the deletion of Section 64-11-8, the Basic Rights and Violation of Consumer Rights section in the original draft of the proposed changes. We are pleased to see they have been re-inserted here. With the reinsertion, the definitions of "advocate" and "human rights committee" should be inserted back into the definitions section. We disagree with the complete removal of the governance section, which include sections such as financial handling of consumer's money, general responsibilities of centers, staff training, and human rights committees, and quality assurances.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
5.1.1. Grounds for Penalties and injunctions. – Remove center after behavioral health and change to provider.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
5.1.1.b. and 5.1.1.d. These two sections seem redundant.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
5.2.2. DRWV recommends the term "reasonable time period" be defined in the regulation. For example: The provider must have evidence that all violations, or suspected violations, of a consumer's rights are thoroughly investigated within a reasonable time period, not to exceed 10 days. DRWV recommends replacing the term "Center" in this section with "Provider."
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
5.2.2 – this references the HRC and in another section I noticed the HRC was removed.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
I see no mention of Human Rights Committee requirements. Will this no longer be required?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
5.2.2. Specifies report to Human Rights Committee, but found no other reference to requirement for an HRC. Requirement for HRC has been removed. Should read "Administrator or designee".
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
5.2.2. DRWV recommends the addition of the requirement that providers designate a Human Rights Committee within their organization. The presence of an oversight committee encourages providers to protect the rights of consumers.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
5.2.4 gives consumer the right to appeal to, among others, "the West Virginia advocate." I think this language was originally intended to refer to the state Protection and Advocacy Agency previously known as West Virginia Advocates, but this organization changed their name recently and is not call Disability Rights WV.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
5.11.a. – we need a quality assurance program. If this is not reference elsewhere we need to put it in.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Section 6 – Risk Management.

Comment
Risk Management. 6.1.a, 6.1.b, 6.1.c, 6.1.d, and 6.1.g should remain for safety of consumers.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
6.6.9 Verification that vehicles not owned or leased by the provider that are utilized for consumer transportation have a valid state inspection sticker and are legally registered.
Please add this subsection. The provider subcontracts with the parent to provide transportation services and must make sure the contractor is properly insured: 6.6.9.1 The provider shall maintain evidence that staff transporting consumers in their own vehicles as part of their duties are properly insured either personally or through the provider's insurance in case of automobile accident.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
6.6.8. Should be changed to "secure anchoring of wheelchairs in paralift designed vehicles".
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
6.6.8. -- We suggest the addition of "adequate vehicle modifications, including lifts."
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
6.6.9. Requirement for annual drivers license validation for all staff who might transport is not feasible.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
6.7. This requirement is not feasible. There is no way to do this. We would immediately cease transporting most clients.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
6.8 Should this be moved to Section 8 - Financial Management?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
6.8. I am not aware that there is such thing as an irrevocable letter of credit. All much be renewed at established time frames.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Section 7 -- Legal Compliance.

Comment
7.3.4. Requirement for inspections by Safety Committee or Officer. Should Include designee or designated function.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
7.3.5. Any and all plans of correction or citations. The providers will question this if a time frame is not included, i.e. six years – three licensure cycles.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
7.5.1.b. States that subcontracting provider shall demonstrate that employees are in compliance with regulatory and risk management needs of the provider. Concerned about interpretation of this. "Risk management needs of provider" is ambiguous. What is the purpose of the risk management?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
7.5.1.b – Clarify risk management needs of the provider
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Section 8 – Financial Management.

Comment
8.3 Financial accountability for consumer funds — When Section 5.4 Financial was deleted and replaced here, two important components were not included. We suggest 5.4.e (All money earned by a consumer shall be used for the sole benefit of that consumer.) and 5.4.f (Centers shall allow a consumer or his or her legal representative to use his or her personal funds.) be added back to this section.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Section 9 – Management of Human Resources.

Comment
9.1.2.*"This individual shall ensure that decisions related to the care of the consumer are based on the assessment and treatment needs of the consumer."* Based on treatment plan. Providers cannot be held responsible for surveyor's interpretation of need.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
This section needs to be added. It is vitally important that direct line staff have access to their supervisor staff upon need. 9.1.3 The provider shall develop a process that ensures appropriate supervision of direct service staff. Each staff person on duty shall have access to a supervisory staff person by telephone or face to face contact within fifteen minutes of an initial attempt at supervisory contact.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
9.2.9 Need to eliminate *"verify"* - Provider can verify license and education but experience is more likely self report
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
9.2.9.b. Relevant experience is indicated under education and training. Many employee hires may be new graduates or direct support professionals without prior experience in the field. Would there be a substitution or method of explanation for these situations?
Response
The Department has reviewed these comments, and no changes were made. Licensed providers may create a policy to address the issue.

Comment
9.3. WV CARES requires individuals who volunteer on a regular basis to go through their background check system, should add something.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the WV CARES statute.

Comment
9.3 Volunteers — We suggest including a requirement for training on abuse/neglect reporting.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
9.4.2 Students serving in an academic placement of more than 30 hours per site per three month quarter may work with consumers independently.....These individuals need to go through WV CARES.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the WV CARES statute.

Comment
9.5.1.g. Related to the comment above, this policy indicates documentation of relevant education or experience as required by job description. Requesting clarification on relevant experience as education and training requirement only if it is indicated as required in the job description?
Response
The Department has reviewed these comments, and no changes were made. Licensed providers may create a policy to address the issue.

Comment
9.6. Disciplinary reviews and termination — People who are terminated due to substantiated abuse need to be reported. Is this covered under another rule or policy?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
9.7.2.d. and 9.7.4. Universal precautions required for all staff in one section but infection control required for staff with direct care responsibilities. Universal precautions and bloodborne pathogens typically included in infection control training. Infection control should be required for all non-medical (physicians/nurses) staff at new hire but not annually.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
9.7.2.d. and 9.7.4 – all staff needs infection control. Would all staff need this as they already have this training?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
9.7.2.d.7 – CPR, First Aid, Heimlich for all staff needs to be required.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
9.7.2.d.7. and 9.7.4. Some medical staff should not be required to take this. Physicians particularly and nurses are taught this in training and should be exempt.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
9.7.2.d.7. This is just a thing I know from having been a lifeguard instructor for so long, but the American Red Cross does not use the Heimlich maneuver for choking victims. Dr. Henry Heimlich, who invented this maneuver, fought with the American Red Cross about this for a long time. He disagreed with the process of administering back blows in addition to the abdominal thrusts. He did not want his name attached to this, so the American Red Cross removed the phrase altogether around 2005 or 2006. The American Heart Association still teaches the Heimlich maneuver without the back blows, so if our legislative rules specifically say "the Heimlich maneuver", we would no longer be able to use the American Red Cross and would have to begin teaching according to the American Heart Association standards. Therefore, I would remove that wording altogether and rephrase.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
9.7.2.d.7. Current rule does not require CPR, First Aid and Heimlich for clinic-based staff. Only direct care. This reads that all staff would be required.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
9.7.2.d.8. – the term "if applicable" should be changed to, "at all locations where consumers are served"
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Section 10. Service Environment.

Comment
10.1.4.g. – the term who have documented training in the use of such items should be used to replace who have been trained to use them.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
10.2.1 The provider shall provide services in an environment (buildings, grounds and equipment) that meets all applicable federal, state and local health, building, safety and fire codes unless the location for services is in the consumer's natural family, adoptive or specialized family care home or in another community-based location not owned or leased by the provider. We are afraid that just labeling the location of services as the consumer's home will allow agencies to provide services to consumers who reside in sub-standard housing. We have heard many times that it is the consumer's choice to live in these places when in reality it is the agency who found the housing for the consumer. The agency should have the consumer's case manager/service coordinator look for safe housing. We are doing people with disabilities a great disservice and not assuring health and safety by letting the provider agencies continue to allow members to sign leases for these sub-standard apartments and houses.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
10.2.8. fire extinguishers should be checked monthly for proper pounds per square inch (PSI) pressure. Other fire suppression systems should be checked annually for a qualified professional.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
10.2.9. by law firearms are allowed in parking lots as long as they are secured in the person's vehicle, they must not be taken out on the property or be brought in to the facility.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
10.2.9. Due to the Parking Lot Gun Bill, firearms are allowed on the grounds, although they may not be in the facilities. Employees may keep legally obtained, secured firearms in their personal vehicle (not company vehicles). These must be out of sight and cannot be taken out of their vehicle on our property.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
10.2.10 – the word "trained" should be added before staff member.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
10.3. – we need to add another requirement that consumers will be provided a diet in accordance with their developmental level, including all modified and special diets.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
Section 10.3 Food Services. It is not adequate to just say that in 10.3.1 10.3.1. If food services are provided or if food is managed by the provider in a consumer residence, food shall be stored, prepared, and served in a sanitary manner.
This says nothing about the actual meals meeting any kind of nutritional standards. The people in IDDW cannot plan or cook their meals themselves and rely on staff to buy and prepare nutritional meals. The old standards need to be put back in to protect these individuals.

10.3.2.1 Food services when provided, shall:
10.3.2.1.1 Meet or exceed national nutritional standards;
10.3.2.1.2 Be planned with regularly documented assistance or a dietitian; and
10.3.2.1.3 Provide well balanced meals and snacks. 10.2.8. fire extinguishers should be checked monthly for proper pounds per square inch (PSI) pressure. Other fire suppression systems should be checked annually by a qualified professional.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Section 11. Compliance with Legal, Health, and Regulatory Requirements.

Comment
11.1 Need clarification that only applies to residential settings
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
11.2 Need clarification that only applies to residential settings
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
11.2.1 Medications can be prescribed and monitored by a licensed physical.....Need to add physician extenders and Advanced Practice Registered Nurse.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
11.1.1.b. – need to add based on the consumer's assessed needs, functional level, identified behaviors and physical limitations.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
11.2.3.a. – need to include route of administration – we also need to include any special instructions for administering medications, such as if the consumer requires thickened liquids, crush crushable meds, may mix with pudding, etc.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
11.2.8 A licensed registered or practical nurse shall be responsible for: THESE ARE DUTIES AN LPN CAN PERFORM and it should not be limited to an RN. You are being more restrictive. Limiting these functions to only an RN will be limiting the Home and Community Based Programs by making RN's responsible for duties that currently LPNs perform on a regular basis. It will also have financial implications.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
11.2.8.b. The consumer is assessed by either (remove) a registered nurse, physician, physician extender, licensed or supervised psychologist as being cognitively.....
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Section 12. Services.

Comment
12.1.1.b. Not sure outcomes can be included in literature for potential clients - expected outcomes will be specific to the client.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
12.1.1.b. -- note sure how outcomes for potential clients can be included.

Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Comment
12.2.d. – this will lead to patient dumping. If referrals are made (which should be required) and another provider is not found, then what happens?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.3.2 Assessments from other provider may be acceptable at the provider's discretion (remove), if comprehensive and performed within the past 45 days. Medicaid has already paid for an assessment, there is no need for the provider to bill Medicaid for completing the same assessment within 45 days, they should accept the current assessment.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.3.7. Specifies documentation that staff have been advised of existence of medical condition, allergies, etc. How should this be documented? Such conditions are documented in medical records in assessment for all staff to see.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.3.7 – needs to have language that addresses focused clients with tx strategy who do not have a tx plan like coordinated care clients do. Tx strategy is typically in the clinician therapy notes, this is clarified when it is located.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.4.1 The consumer shall have the right to a person-centered plan based on the consumer's needs, preferences and for residential settings, the individual's resources. The plan should ensure the individual's rights of privacy, dignity, respect and freedom from coercion and restraint. The plan should facilitate individual choice regarding services and supports, and who provides them. (THIS IS FROM THE CMS INTEGRATED SETTINGS RULE and applies to the waiver programs and is VERY IMPORTANT to be included. There is an entire section the 21st Century CURES act that is all about person-centered planning. It can no longer continue as provider centered planning.)
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.4.1 The provider shall ensure each consumer has a plan of service in a format...unless other intervals are specified by program (not provider) policy and updated or ...Program policy needs to be followed not provider policy.
Response
The Department has reviewed these comments, and no changes were made. Licensed providers may create a policy to address the issue.

Comment
12.4.2 -- We suggest adding the consumer will be informed of his or her right to participate in the development of their service plan.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.5. DLR should be spelled out once so people don't have to figure it out
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.6. Need to add if applicable because if they are receiving focused services only require a treatment strategy not a formal plan
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.6 – needs to include tx strategy for focused care services or state applies only to coordinated care
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.6.1. – the timeframe for the initial needs to be specified, how long is the admission process? I think the timeframe should not exceed seven (7) working days. The provider should have already completed a preliminary assessment prior to the actual admission.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.7.1. First section requires initial plan of care (currently some services do not require a treatment plan (outpatient low end services) and 12.7.1 requires plan of care or treatment strategy be developed when consumer is receiving variety of services. Is confusing. Consumers getting a variety of services should have a treatment plan, but consumers only being seen for med management are low end and a treatment strategy should be sufficient (current practice). Needs to be clarified. Also need to clarify how "treatment strategy" is documented, e.g. physician notes.

Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.7. we need a timeframe for the treatment plan.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.8.2. Requirement for non-behavioral health (and sometimes non agency) providers participation in comprehensive plan & documented by signature rarely happens and would not be possible.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.8.4. Only waiver clients have a service coordination provider. All clients do not have a service coordinator provider. Center case managers provide much of this function.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.8.5. The comprehensive plan must clarify which provider agency is responsible for each aspect of the plan. Objectives for behavioral treatment (remove habilitation and rehabilitation) services must be specific and measured as described in this section.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.8.6. Indicates the provider team is required to receive the final treatment plan within 7 working days. This time frame is inconsistent with some program policy manuals that indicate 14 days
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.13.2.c. this sounds like a non-critical incident (simple incident). Many simple incidents require no monitoring and no correction. Sometimes they are simply documentation of incidents for qa as noted in the definition. Perhaps this should reflect the same language?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.14.2. this is proper for adults. There is no written report required for cps

Response
The Department has reviewed these comments, and no changes were made. This comment is general in nature and offers no specific amendment.

Comment
12.14.2 — We believe the new requirement for the reporting of abuse and neglect is 24 hours.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.14.2. Indicates the initial report shall be made by telephone followed by a written report by the complainant or the receiving agency with 48 hours. Will this be updated to be consistent with the recent mandated reporting legislation requiring 24 hours?
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.14.2. needs updated to recent changes of 24 hours for children.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.15.1 We recommend a hyperlink to the "Reporting and Investigation Guidelines for Incidents involving a Licensed Behavioral Health Services and Supports Provider."
Response
The Department has reviewed these comments, and no changes were made. This comment is general in nature.

Comment
12.15.2.1 Programs that are required to enter incidents into the West Virginia Incident Management System must do so within program guidelines.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.20.2 — Please refer to our comment on seclusion under definitions. At the very least, seclusion should be prohibited for people with intellectual and other developmental disabilities.
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.20.6.c — We suggest re-wording this to read, "Devices used to treat a medical condition may not be used for restraint purposes." As written, using such a device to restrain an individual would not be called restraint but nonetheless would be. We hear of instances in which individuals (often children) are strapped in devices designed for a specific purpose but used intentionally to restrain them (e.g. Rifton chairs).

Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.20.6.e. this language is a little different than above. Perhaps the 2 sections should be "merged" so they are consistent?
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.20.6.e — We are pleased to see the time frame for restraint has been lowered from three hours to 30 minutes.
Response
The Department has reviewed these comments. This comment is general in nature and offers no specific amendment.

Comment
12.20.6.e. Restraint may only be used when less intrusive interventions…more than a half hour without review of the consumer's condition by an appropriate clinician (remove licensed independent practitioner or physical) to evaluate the consumer's immediate situations;……
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.20.6.f. Currently, hospitals and PRTF facilities allow nurses to do the assessment. State law limits writing of orders to medical staff and physician extenders. These regulations are hospital regs. While the Center does no seclusion, or chemical restraints, and only rarely brief physician restraint, no medical staff is available to do the assessment.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
Non-critical incidents – DRWV recommends providing a definition of "non-critical incidents."
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
Emergency Management of Potentially Dangerous Behavior – Subsection 12.20.6(h) – DRWV recommends that the guidelines for use of restraints on a consumer include a specific length of time not to be exceeded for the use of restraints.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.21.2 Add Advanced Practice Registered Nurse

Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.21.2. This is currently done only for clients in 24 hour care programs. It is not done for clients seen only on outpatient. Should be revised.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.22.6.f. Before writing a (remove new) order for the use of a chemical or mechanical restraint for the management of violent or self-destructive behavior, a physician or physician extender or other licensed independent practitioner.....
Response
The Department has reviewed this comment and finds clarification is needed, therefore, changes were made.

Comment
12.28.5. Need to define "assist consumers in obtaining needed medication as part of discharge planning. While prescriptions are given to patients, lack of financial resources is a problem. The Center does not have the financial resources to pay for medication.
Response
The Department has reviewed this comment. Existing provisions in the rule address this issue adequately, and, therefore, no changes were made.

Comment
12.30.5 Should the communication from WV CARES indicating the employee is Good to Hire be included here?
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the WV CARES statute.

Comment
12.30.8.a and b and c – remove habilitation or rehabilitation
Response
The Department has reviewed this comment and is unable to locate this reference due to an incorrect citation. No changes were made.

Section 13. Administrative Due Process; Administrative Appeals and Judicial Review.

Comment
13.6.3. Requiring a plan of correction for deficiencies in question before the IDR process does not seem sensible, because until the IDR process is completed, the plan of correction will not be implemented and this would have been work for nothing. Given the short time frames established it would make more sense to forego the requirement for the plan of action for only the deficiencies in question until the IDR.
Response
The Department has reviewed this comment, and no changes were made in response. The rule provision is consistent with the requirements of the statute.

Lawson, Kathy M

From: Sullivan, Nancy J
Sent: Friday, July 20, 2018 4:40 PM
To: Lawson, Kathy M
Subject: Fwd: 64CSR11 Behavioral Health Centers Licensure Rule Amendment Discussion- Follow Up

From Elliott-looks like little things

Sent from my iPhone
Nancy J. Sullivan, MAJ
West Virginia Department of Health and Human Resources

Begin forwarded message:

> **From:** "Birckhead, Elliot H" <Elliott.H.Birckhead@wv.gov>
> **Date:** July 20, 2018 at 3:28:26 PM EDT
> **To:** "Sullivan, Nancy J" <Nancy.J.Sullivan@wv.gov>
> **Cc:** "Morrison, Beth J" <Beth.J.Morrison@wv.gov>, "Roth, Rebecca E" <Rebecca.E.Roth@wv.gov>, "Tennis, Nikki A" <Nikki.A.Tennis@wv.gov>
> **Subject: FW: 64CSR11 Behavioral Health Centers Licensure Rule Amendment Discussion- Follow Up**
>
> Nancy – The IG's Office was quite responsive to our previous concerns re: this rule, most of which related to the consumer rights provisions being dropped from both 64 CSR 11 and 64 CSR 74 so these are our only additional comments:
>
> Subsection 5.1.3 on pg. 28 includes an = sign rather than an apostrophe after the phrase "legal representative" in the first sentence.
>
> Subsection 5.2.4 on pg. 29 gives consumer the right to appeal to, among others, "the West Virginia advocate." I think this language was originally intended to refer to the state Protection and Advocacy Agency, previously known as West Virginia Advocates, but this organization changed their name recently and is now called Disability Rights WV.
>
> Elliott

From: Lawson, Kathy M
Sent: Thursday, June 21, 2018 4:57 PM
To: Wiseman, Steve A <Steve.A.Wiseman@wv.gov>; Higgs, Linda S <Linda.S.Higgs@wv.gov>; phillshimer@tcgsolution.com; Mark Drennan <Mark@wvbehavioralhealth.org>; MA LSW Marcie Vaughan (mvaughan@shsinc.org) (mvaughan@shsinc.org) <mvaughan@shsinc.org>; Parsons, Cynthia A <Cynthia.A.Parsons@wv.gov>; Raymona Kinneberg <raymona@rksbhcc.com>; jimmybeirne@yahoo.com; Donna Cooke <dcooke@lmamh.org>; lisajones@shcmhc.com; Robertson, April L <April.L.Robertson@wv.gov>; Beane, Cindy L <Cindy.L.Beane@wv.gov>; Dellinger, Cynthia H <Cynthia.H.Dellinger@wv.gov>; Sullivan, Nancy J <Nancy.J.Sullivan@wv.gov>; Birckhead, Elliot H <Elliott.H.Birckhead@wv.gov>; Roswall, Robert E <Robert.E.Roswall@wv.gov>; dgorum@drofwv.org;

lunderhill@drofwv.org; Nowicki, Stacy L <Stacy.L.Nowicki@wv.gov>; glewis@lawv.net; jeff.johnson@wvsenate.gov; charles.roskovensky@wvhouse.gov; lydia@msilaw.org; shickman@socialworkers.org; mgames@northwoodhealth.com; Sudbeck, David G <David.G.Sudbeck@wv.gov>; VanGilder, Vanessa K <Vanessa.K.VanGilder@wv.gov>; craigc@potomachighlandsguild.com; Karen.Yost@Prestera.org; courtney.walsh@thementornetwork.com; ldye@rescare.com; raymona@bicinc.com; tomsusman@tsgsolution.com; scalise@wvsma.org; Kevin@westbrookhealth.com; mark@wvbehavioralhealth.org; Summitt, Ashley E <Ashley.E.Summitt@wv.gov>; Crouch, Bill J <Bill.J.Crouch@wv.gov>; Samples, Jeremiah <Jeremiah.Samples@wv.gov>; Dellinger, Cynthia H <Cynthia.H.Dellinger@wv.gov>; mikel@phgmail.net; shickman.naswwv@socialworkers.org; Raymona Kinneberg <raymona@rksbhcc.com>; Hissom, Debbie E <Debbie.E.Hissom@wv.gov>; Black, Christy D <Christy.D.Black@wv.gov>; Cremeans, Jim H <Jim.H.Cremeans@wv.gov>; Robertson, April L <April.L.Robertson@wv.gov>; Matney, James A <James.A.Matney@wv.gov>; Morrison, Beth J <Beth.J.Morrison@wv.gov>; Roth, Rebecca E <Rebecca.E.Roth@wv.gov>; Tennis, Nikki A <Nikki.A.Tennis@wv.gov>; Lisa Jones <lisajones@shcmhc.com>; Donna Cooke <dcooke@lmamh.org>; Richard Kiley <rkiley@achcinc.org>; Bill Albert (balbert@lawv.net) <balbert@lawv.net>
Cc: Whitmore, Jessica Y <Jessica.Y.Whitmore@wv.gov>; Garlow, Richelle K <Richelle.K.Garlow@wv.gov>; Fields, Sylvia W <Sylvia.W.Fields@wv.gov>; Marra, Jolynn <Jolynn.Marra@wv.gov>
Subject: RE: 64CSR11 Behavioral Health Centers Licensure Rule Amendment Discussion- Follow Up

64 CSR 11 has been filed with the Secretary of State and will be out for public comment until July 21, 2018. A link to the filing is included with this email for your convenience.

Thank you again for your participation and input, and we look forward to receiving and reviewing any written public comments you may have.

http://apps.sos.wv.gov/adlaw/csr/ruleview.aspx?document=16885&KeyWord=

Kathy Lawson
Inspector General
WV Department of Health and Human Resources
Building 6, Room 817
State Capitol Complex
Charleston, West Virginia 25305

Tel: 304-558-2278
Fax: 304-558-1992
Email: kathy.m.lawson@wv.gov

From: Marra, Jolynn
Sent: Friday, June 15, 2018 9:15 PM
To: Wiseman, Steve A <Steve.A.Wiseman@wv.gov>; Higgs, Linda S <Linda.S.Higgs@wv.gov>; philshimer@tcgsolution.com; Mark Drennan <Mark@wvbehavioralhealth.org>; MA LSW Marcie Vaughan (mvaughan@shsinc.org) (mvaughan@shsinc.org) <mvaughan@shsinc.org>; Parsons, Cynthia A <Cynthia.A.Parsons@wv.gov>; Raymona Kinneberg <raymona@rksbhcc.com>; jimmybeirne@yahoo.com; Donna Cooke <dcooke@lmamh.org>; lisajones@shcmhc.com; Robertson,

April L <April.L.Robertson@wv.gov>; Beane, Cindy L <Cindy.L.Beane@wv.gov>; Dellinger, Cynthia H <Cynthia.H.Dellinger@wv.gov>; Sullivan, Nancy J <Nancy.J.Sullivan@wv.gov>; Birckhead, Elliot H <Elliott.H.Birckhead@wv.gov>; Roswall, Robert E <Robert.E.Roswall@wv.gov>; deorum@drofwv.org; junderhill@drofwv.org; Nowicki, Stacy L <Stacy.L.Nowicki@wv.gov>; glewis@lawv.net; jeff.johnson@wvsenate.gov; charles.roskovensky@wvhouse.gov; lydia@msilaw.org; shickman@socialworkers.org; mgames@northwoodhealth.com; Sudbeck, David G <David.G.Sudbeck@wv.gov>; VanGilder, Vanessa K <Vanessa.K.VanGilder@wv.gov>; craigc@potomachighlandsguild.com; Karen.Yost@Prestera.org; courtney.walsh@thementornetwork.com; ldye@rescare.com; raymona@bicinc.com; tomsusman@tsgsolution.com; scalise@wvsma.org; Kevin@westbrookhealth.com; mark@wvbehavioralhealth.org; Summitt, Ashley E <Ashley.E.Summitt@wv.gov>; Crouch, Bill J <Bill.J.Crouch@wv.gov>; Samples, Jeremiah <Jeremiah.Samples@wv.gov>; Dellinger, Cynthia H <Cynthia.H.Dellinger@wv.gov>; mikel@phgmail.net; shickman.naswwv@socialworkers.org; Raymona Kinneberg <raymona@rksbhcc.com>; Hissom, Debbie E <Debbie.E.Hissom@wv.gov>; Black, Christy D <Christy.D.Black@wv.gov>; Cremeans, Jim H <Jim.H.Cremeans@wv.gov>; Robertson, April L <April.L.Robertson@wv.gov>; Matney, James A <James.A.Matney@wv.gov>; Morrison, Beth J <Beth.J.Morrison@wv.gov>; Roth, Rebecca E <Rebecca.E.Roth@wv.gov>; Tennis, Nikki A <Nikki.A.Tennis@wv.gov>; Lisa Jones <lisajones@shcmhc.com>; Donna Cooke <dcooke@lmamh.org>; Richard Kiley <rkiley@achcinc.org>; Bill Albert (balbert@lawv.net) <balbert@lawv.net>
Cc: Lawson, Kathy M <Kathy.M.Lawson@wv.gov>; Whitmore, Jessica Y <Jessica.Y.Whitmore@wv.gov>; Garlow, Richelle K <Richelle.K.Garlow@wv.gov>; Fields, Sylvia W <Sylvia.W.Fields@wv.gov>
Subject: 64CSR11 Behavioral Health Centers Licensure Rule Amendment Discussion- Follow Up

Hello,

Thank you for participating in the discussion regarding updates to the behavioral health rule. We appreciate your comments and concerns and have already considered multiple changes. Due to a quick turnaround period, we may not be able to address all comments supplied at this time. Please know, this does not mean your comments aren't meaningful.

If the rule is filed with the Secretary of State, there will be public comment period. You are encouraged to again review the rule and submit comments, even if the comments were previously shared.

Again, thank you for your participation and attention to this very important rule.

Jolynn

Jolynn Marra, Director
Office of Inspector General
Office of Health Facility Licensure and Certification

Phone: 304-558-0050

in error, please notify the sender immediately and destroy all copies of the original message.

Disability Rights WV

July 20, 2018

Kathy Lawson, Inspector General
State Capitol Complex, Building 6, Room 817
Charleston, WV 25305
Kathy.m.lawson@wv.gov

Re: DRWV Comments Title 64 Series 11

Dear Ms. Lawson:

Disability Rights of West Virginia (DRWV) is the federally mandated protection and advocacy (P&A) system for the state of West Virginia. As the P&A, DRWV has a heightened interest in all settings in which individuals with disabilities receive services, including settings where individuals receive behavioral health services.

DRWV has reviewed the proposed amendments to West Virginia Code of State Rules Title 64 Series 11 and submits the following commentary.

- **Definitions** §64-11-3.
  - **Abuse** - DRWV is concerned that the proposed definition of "abuse" may result in instances of abuse going unreported or under reported. DRWV recommends the use of a more expansive definition of abuse by either including a definition of the terms "significant physical or emotional harm" and "serious harm," or by removing the terms "significant" and "serious" from the definition. DRWV recommends inclusion of the federal definition found in 42 U.S.C. §1397j(1) which defines "abuse" as "the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm."
  - **Critical Incident** – DRWV is concerned that the narrowed definition of "critical incident" may result in significant events that could affect treatment and exercise of rights going undocumented or reported. The definition of "critical incident" should include all unusual or unexpected events that may impact treatment. This should take into consideration incidents where consumers experienced harm, risk of harm, medical or behavioral instances, or situations that may impact a consumer physically or emotionally. These instances should be noted in treatment plans and reviewed by the consumer's treatment team.

- **Neglect** – DRWV recommends removing the word "unreasonable" from the suggested definition, as failure of a caregiver to provide the care necessary to ensure health and safety is unreasonable.
- **Human Rights Committee** – DRWV recommends the definition of "Human Rights Committee" not be removed from the regulation.

- **Consumer Rights** §64-11-5.2.2
  - DRWV recommends the term "reasonable time period" be defined in the regulation. For example: The Provider must have evidence that all violations, or suspected violations, of a consumer's rights are thoroughly investigated within a reasonable time period, not to exceed 10 days.
  - DRWV recommends replacing the term "Center" in this section with "Provider".
- **Human Rights Committee** – DRWV recommends the addition of the requirement that providers designate a Human Rights Committee within their organization. The presence of an oversight committee encourages providers to protect the rights of consumers.
- **Services** §64-11-12
  - **Non-critical incidents** – DRWV recommends providing a definition of "non-critical incidents."
  - **Emergency Management of Potentially Dangerous Behavior** – Subsection 12.20.6(h) – DRWV recommends that the guidelines for use of restraints on a consumer include a specific length of time not to be exceeded for the use of restraints.

DRWV commends the continued work to expand and protect consumer rights. We sincerely hope our commentary will aid in creating the best possible program for individuals in need of behavioral health services. If you have any questions or concerns regarding the above commentary, please contact me at 304-346-0847 or via email at dgorum@drofwv.org.

Sincerely,

Delcie R. Gorum

Staff Attorney

Comments for 64CSR11

64-11-3-Definitions-Why the change in definition on abuse, it would appear that the items marked through would still be appropriate to be considered abuse.

3.12 Through 3.22c-not sure why all were removed?

Not sure why 3.24 through 3.38 were moved?

3.37 Not sure how this is different from expanded plan of service

4.4.2 Recommend regular license be 3 year

9.7.2.d.7 CPR, First Aid, Heimlich for all staff needs to be required.

12.1.1.b-note sure how outcomes for potential clients can be included

12.6-needs to include tx strategy for focused care services or state applies only to coordinated care

7.5.1.b-clarify risk management needs of the provider

9.7.2.d, 9.7.4-all staff needs infection control

12,3,7-needs to have language that addresses focused clients with tx strategy who do not have a tx plan like coordinated care clients do. Tx strategy is typically in the clinician therapy notes, this is clarified when it is located.

3.1.5-critical incidents can include abuse/neglect and also critical incidents can be things that do not involve abuse or neglect.

4.6.3-define rapid access for clear understanding of acceptable timeframe.

9.7.2d, 9.7.4 would medical staff need this as they already have this training?

3.8, 3.45-clarify case management and service coordination as some agencies use these terms interchangeably

12,14,2-needs updated to recent changes of 24 hours for children.

3.1-Abuse definitions removed are concerning.

10.2.9 by law firearms are allowed in parking lots as long as they are secured in the person's vehicle, they must not be taken out on the property or be brought in to the facility.

Logan Mingo Area Mental Heath
PO Box 176
300 Prosperity Lane, Suite 204
Logan, WV 25601

July 9, 2018

Kathy Lawson
Inspector General
WV Department of Health and Human Resources
OIG
Building 6 Room 817
State Capital Complex
Charleston, WV 25305

64CSR11 Behavioral Health Centers Licensure Amendment to Existing Rule:

Kathy,
These are our comments to submit.

3.1. Abuse. -- Can you further define imminent risk?

3.20. Elopement. - - Add when a IDD consumer leaves against clinic advise.

3.22. Employee. - - Removed contracted and volunteers.

3.27. Incapacitated Adult. -- Add as defined by WV code.

3.29. Intensive Community-based Stabilization and Maintenance Program. -- Further define applicable programs.

3.32. Neglect. - - Add go with the state definition of Neglect. 16-2-29-3.

3.34. Non-Methadone Medication-Assisted Programs for Addictions and Co-occurring Disorders. - - Remove Non-Methadone and take out (other than methadone).

3.41. Respite. - - After primary care-giver add and/or consumer.

4.3. Issuance. - - Without a license the BH center shall be forbidden to have a license for 1 year.

4.4.2. Regular license. - - Make it a 3 year license not 2 year to save money.

4.6.7. Client records. - - Add making copies of client records for removal of the site. Need back up documentation.

4.7.4. Complaint Investigation. - - Have to sign off before they leave.

5.1.1. Grounds for Penalties and injunctions. -- Remove center after behavioral health and change to provider.

64-11-6. Risk Management. - - 6.1.a, 6.1.b., 6.1.c, 6.1.d, and 6.1.g should remain for safety of consumers.

Thank you,

Shelia Foster
Compliance Clerk
Logan Mingo Area Mental Health
304-752-7130 ext 1018

7/23/18 Comments from the Bureau for Medical Services.

General Comments:

1. Sometimes the document refers to consumers and sometimes it says clients. We recommend consumers.

2. Sometimes the document refers to DLR and sometimes it says guardians. We recommend DLR . It still says guardian in section 12.27.3

3. Recommend removing the word Clinic from Clinic Behavioral Health Service(s) throughout the document and just stating Behavioral Health Services. This proposed rule uses CMHC and CCMHC interchangeably and it should be consistent.

4. Recommend either removing Comprehensive Community Mental Health Center (CCMHC) and replacing with Community Behavioral Health Center (CBHC) or putting in both CCMHC/CBHC.

5. CMS has a Final Rule regarding Integrating Settings (CMS 2249-F and CMS 2296-F) that apply to all settings owned or leased by provider agencies who provide services under any of the 1915© HCBS Waivers, 1915(i) State Plan HCBS and 1915(k) Community First Choice regarding person-centered planning, privacy, access to lockable entrance doors, sharing units with choice of roommates, freedom to furnish/decorate sleeping/living units, visitors, etc. There needs to be a general statement that any providers who provide services to any of those programs must be in compliance with this Rule. This is very important; this guidance is coming from CMS.

6. We recommend physician extenders to added as they can prescribe medications now.

7. Section 2.5.6 This needs to be amended to include Fellowship Homes and halfway houses for support of individuals with addictions.

8. Section 2.5.10 This section on Exemption of Specialized Family Care Providers needs to be expanded to include Natural Family and Adoptive Family Homes providing IDDW services.

9. 3.1 The definition of abuse includes the term significant. This needs to be defined. What is significant physical or emotional harm to me may be very different than what it is to you. Both CMS and the OIG are very concerned about the health and safety of the HCBS members and thus the definition should be strengthened and made very clear.

10. The definition of Aversive Procedures needs to be added back in. This should not be omitted now.

11. The prior definition of Critical Incident needs to be added back in. Our providers use that definition in terms of what to report into the WV Incident Management System.

12. We still need Human Rights Committees, please do not take these out.

13. 3.45 REMOVE THIS ENTIRE SECTION or combine it with 3.8 Case Management. These are the same service. Someone can choose to have an independent case management/service coordination agency and if they do not offer any other behavioral health service, then they do not need to be licensed through OHFLAC. If they do want to provide other behavioral health services, then they cannot provide these services to anyone who receives residential services from their agency and they do have to be licensed. The IDDW manual is changing the term from Service Coordination to Case Management in the 2020 Renewal.

14. 6.6.9 Verification that vehicles not owned or leased by the provider that are utilized for consumer transportation have a valid state inspection sticker and are legally registered.

Please add this subsection. The provider subcontracts with the parent to provide transportation services and must make sure the contractor is properly insured:

6.69.1The provider shall maintain evidence that staff transporting consumers in their own vehicles as part of their duties are properly insured either personally or through the provider's insurance in case of automobile accident.

15. This section needs to be added. It is vitally important that direct line staff have access to their supervisor staff upon need.

9.1.3 The provider shall develop a process that ensures appropriate supervision of direct service staff. Each staff person on duty shall have access to a supervisory staff person by telephone or face to face contact within fifteen minutes of an initial attempt at supervisory contact.

16. 9.3 WV CARES requires individuals who volunteer on a regular basis to go through their background check system, should add something.

17. 9.4.2 Students serving in an academic placement of more than 30 hours per site per three month quarter may work with consumers independently.....These individuals need to go through WV CARES.

18. 10.2.1 The provider shall provide services in an environment (buildings, grounds and equipment) that meets all applicable federal, state and local health, building, safety and fire codes unless the location for services in in the consumer's natural family , adoptive or specialized family care home or in another community based location not owned or leased by the provider.

We are afraid that just labeling the location of services as the consumer's home will allow agencies to provide services to consumers who reside in sub-standard housing. We have heard many times that it is the consumer's choice to live in these places when in reality it is the agency who found the housing for the consumer. The agency should have the consumer's case manager/service coordinator look for safe housing. We are doing people with disabilities a great disservice and not assuring health and safety by letting the provider agency's continue to allow members to sign leases for these sub-standard apartments and houses.

19. Section 10.3 Food Services. It is not adequate to just say that in 10.3.1 10.3.1. If food services are provided or if food is managed by the provider in a consumer residence, food shall be stored, prepared, and served in a sanitary manner.

This says nothing about the actual meals meeting any kind of nutritional standards. The people in IDDW cannot plan or cook their meals themselves and rely on staff to buy and prepare nutritional meals. The old standards need to be put back in to protect these individuals.

10.3.2.1 Food services when provided, shall:

10.3.2.1.1 Meet or exceed national nutritional standards;

10.3.2.1.2 Be planned with regularly documented assistance or a dietitian; and

10.3.2.1.3 Provide well balanced meals and snacks.

20. 11.2.1 Medications can be prescribed and monitored by a licensed physical.....Need to add physician extenders and Advanced Practice Registered Nurse.

21. 11.2.8 A licensed registered or practical nurse shall be responsible for: THESE ARE DUTIES AN LPN CAN PERFORM and it should not be limited to an RN. You are being more restrictive. Limiting these functions to only an RN will be limiting the Home and Community Based Programs by making RN's responsible for duties that currently LPNs perform on a regular basis. It will also have financial implications.

22. 11.2.8.b. The consumer is assessed by either (remove) a registered nurse, physician, physician extender, licensed or supervised psychologist as being congnitively.....

23. 12.3.2 Assessments from other provider may be acceptable at the provider's discretion (remove), if comprehensive and performed within the past 45 days.

Medicaid has already paid for an assessment, there is no need for the provider to bill Medicaid for completing the same assessment within 45 days, they should accept the current assessment.

24. 12.5.1 The provider shall ensure each consumer has a plan of service in a format.....unless other intervals are specified by program (not provider) policy and updated or .....

Program policy needs to be followed not provider policy.

25. 12.4.1 The consumer shall have the right to a person-centered plan based on the consumer's needs, preferences and for residential settings, the individual's resources. The plan should ensure the individual's rights of privacy, dignity, respect and freedom from coercion and restraint. The plan should facilitate individual choice regarding services and supports, and who provides them. (THIS IS FROM THE CMS INTEGRATED SETTINGS RULE and applies to the waive programs and is VERY IMPORTANT to be included. There is an entire section the 21st Century CURES act that is all about person-centered planning. It can no longer continue as provider centered planning)

26. 12.10.5 The comprehensive plan must clarify which provider agency is responsible for each aspect of the plan. Objectives for behavioral treatment (remove habilitation and rehabilitation) services must be specific and measured as described in this section.

27. 12.15.1 We recommend a hyperlink to the "Reporting and Investigation Guidelines for Incidents involving a Licensed Behavioral Health Services and Supports Provider."

28. 12.15.2.1 Programs that are required to enter incidents into the West Virginia Incident Management System must do so within program guidelines.

29. 12.11.6.e Restraint may only be used when less intrusive interventions.....more than a half hour without review of the consumer's condition by an appropriate clinician (remove licensed independent practitioner or physical) to evaluate the consumer's immediate situations;.....

30. 12.22.6.f. Before writing a (remove new) order for the use of a chemical or mechanical restraint for the management of violent or self-destructive behavior, a physician or physician extender or other licensed independent practitioner.....

31. 12.30.5 Should the communication from WV CARES indicating the employee is Good to Hire be included here?

32. 12.30.8.a and b and c – remove habilitation or rehabilitation

33. 12.21.2 Add Advanced Practice Registered Nurse

Comments on Behavioral Health Rules

2.5.6 Does emergency shelter include crisis units?
3.1. Abuse definition should include insufficient supervision, failure to intervene when indicated, placement in an unsafe environment, lack of appropriate monitoring and reference that neglect is abuse.
3.7. In addition to the service planning team, the consumer and/or the guardian should also approve the plan.
3.21. on page 6 – HRC is this defined in another section? This was taken out.
3.22. on page 6 – Informed consent should be left in.
3.20. Elopement – the section "during times the provider is being compensated for providing care" is not needed.
3.28. The initial plan of service needs a timeframe designated for when the admission process is completed.
3.25. on page 9 – medication error – is this referenced in another section?
3.32. Neglect – the term "unreasonable" needs removed this term cannot be well defined and is open to interpretation. In addition, failure to implement the IPP should be included.
3.33. Non-critical incident should have "injuries of unknow origin" contained in the definition.
3.41. What entity is responsible for the care, custody and protective oversight of the individual during respite care? Is this person an employee of the provider?
3.40. on page 12 – The definition of physical restraint includes "a drug or medication that is used as a restriction to manage…" Medications are chemical restraints and if not defined in another section, should have its own definition.
3.45. Since we are stating that Service Coordination is a behavioral health service we need to notify BMS. They are not wanting to license Service Coordination agencies.
3.47. I see the term Supportive Service being used by providers to negate their responsibility of providing care. If something goes wrong the provider will state, "the consumer was being provided supportive services."
4.1.6. The section is confusing we do not always conduct an on-site inspection for an amended application. The section related to inspections within 60 days after an application is received needs changed to, "inspections shall be conducted for all initial and renewals prior to issuing a license"
4.4. on page 16 – this states, "following application and review" is this review of the application or on-site review?
4.4.3.c. on page 17 – in section 4.4.3.a. such status shall expire not more than six months from the date of issuance and then 4.4.3.c. specifically says a review before or near the end of the six-month provisional period. If the provisional can be issued for less than six months we need to change one of these.
4.6.1. the section stating consumers or their DLRs shall be interviewed should be changed to "may" be interviewed.
4.6.4. on page 18 - need to remove or a central administrative office. The records need to be in the same location as the consumer. This should be required for providing the care, custody and protective oversight of the consumer. In addition, for providers with sites in locations all over the state on one license a central administrative office would not allow a surveyor to review the consumer and inspect the consumer record to determine is the proper care was being provided based on the assessment, the medications and the overall wellbeing of the consumer. Further, if the surveyor identifies something that may seem as though the staff are not properly trained the record review for training cannot be readily available. This would also negate the provider's ability to provide rapid access to consumer records.
4.6.6. the term clinical needs removed we should be able to inspect all aspects of the provider's operation and premises. If we specify "clinical" there will be misinterpretation of this term.
4.7.3 on page 19 – we need to change this to the person in charge of the location. In addition, how will we know who the designee is. When doing complaint investigations, we go directly to the location of the consumer/complaint, which is not the location of the administrator.
4.9.5. & 4.9.7. on page 21 – do we need both?
5.11.a. on page 26 – we need a quality assurance program. If this is not reference elsewhere we need to put it in.
5.2.2 on page 28 – this references the HRC and in another section I noticed the HRC was removed.

9.7.2.d.8. on page 49 – the term "if applicable" should be changed to, "at all locations where consumers are served"
10.1.4.g. on page 51 – the term who have documented training in the use of such items should be used to replace who have been trained to use them,
10.2.8. fire extinguishers should be checked monthly for proper pounds per square inch (PSI) pressure. Other fire suppression systems should be checked annually by a qualified professional.
10.2.10 on page 51 – the word "trained" should be added before staff member.
10.3. on page 52 – we need to add another requirement that consumers will be provided a diet in accordance with their developmental level, including all modified and special diets.
11.1.1.b. on page 52 – need to add based on the consumer's assessed needs, functional level, identified behaviors and physical limitations.
11.2.3.a. on page 52 – need to include route of administration – we also need to include any special instructions for administering medications, such as if the consumer requires thickened liquids, crush crushable meds, may mix with pudding, etc.
12.2.d. on page 55 – this will lead to patient dumping. If referrals are made (which should be required) and another provider is not found, then what happens?
12.6.1. on page 56 – the timeframe for the initial needs to be specified, how long is the admission process? I think the timeframe should not exceed seven (7) working days. The provider should have already completed a preliminary assessment prior to the actual admission.
12.7. on page 57 – we need a timeframe for the treatment plan.

Section / Page	Title	Comments
2.1 Page 1	Application	rule applies to public, private, for profit and non-profit but exempts most all providers- defeats the purpose stated in 1.7 - If providers are delivering BH services then a license is needed.
3.11 Page 7	Clinic behavioral health service	is this a duplicate of 3.6 Behavioral Health Service
3.37 Page 11	Plan of Service	how is this different from 3.23 Expanded Plan of Service
3.47 Page 13	Supportive Service	how is this different from 3.35 Personal Attendant, 3.25 Habiliation
4.4.2 Page 16	Regular License	recommend 3 year - this saves the State of West Virginia and providers money on reviews, travel and staffing.
4.4.6 Page 18	Inspection and records	*A consumer may deny access to his or her place of residence unless it is owned or leased by the provider or unless there is evidence of a clear and immediate danger to the health of consumer.* **Determined by who?**
4.7.3 Page 19	Complaint Investigation	Replace administrator with Chief Executive Officer to remain consistent with definitions
4.9.4 Page 21	Plans of Correction	Needs to specify that any "directed" plan of correction will be labeled as such in all public records
6.8 Page 32	Risk Management	Should this be moved to Section 8 - Financial Management?
9.1.2 Page 45	**Deployment and Supervision of Staff**	***"This individual shall ensure that decisions related to the care of the consumer are based on the assessment and treatment needs of the consumer."*** **Based on treatment plan. Providers cannot be held responsible for surveyor's interpreation of need.**
9.2.9 Page 45	Personnel Practices	Need to eliminate *"verify"* - Provider can verify license and education but experience is more likely self report
9.7.2.d.7	**Orientation of new staff**	**Current rule does not require CPR, First Aid and Heimlich for clinic based staff. Only direct care. This reads that all staff would be required.**
11.1 Page 52	Empergency Planning and Response	Need clarification that only applies to residential settings
11.2 Page 53	Medication Control and Administration	Need clarification that only applies to residential settings
12.1.1.b Page 55	Service Descriptions	Not sure outcomes can be included in literature for potential clients - expected outcomes will be specific to the client.
12.6 Page 57	**Initial Plan of Service**	**Need to add if applicable because if they are receiving focused services only require a treatment strategy not a formal plan**
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As Recommended by Commissioner Beane, there needs to be language indicating that there will not be an expectation that services will be provided which are not reimbursable. The minimum safety standard is set by the waiver budget, and there should not be an expectation to exceed that without reimbursement for the service.		

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5.1.1b and 5.1.1 d		These tow sections seem redundant.
3.18	DLR	Is it really necessary to add yet another "name" to the long list of individuals who are legal representatives of a consumer? Also, WHO is the individual or entitity who makes the determination that an individual is DESIGNATED?
3.26	inappropriate behavior	the actual definition of inappropriate is "not suitable or proper in the circumstances". There are many behaviors which are inappropriate, yet are not necessarily hazardous; otherwise, this seems ok
12.13.2.c	incidents	this sounds like a non-critical incident (simple incident). Many simple incidents require no monitoring and no correction. Sometimes they are simply documentation of incidents for qa as noted in the definition. Perhaps this should reflect the same language?
12.14.2	incident reporting	this is proper for adults. There is no written report required for cps
12.20.6.e	restraint	this language is a little different than above. Perhaps the 2 sections should be "merged" so they are consistent?

West Virginia
Developmental Disabilities Council

110 Stockton Street
Charleston, WV 25387

WV Developmental Disabilities Council
Comments on proposed changes to
Title 64 Legislative Rule Series 11 Behavioral Health Centers Licensure

July 20, 2018

The WV Developmental Disabilities Council is appreciative of the opportunity to comment on changes being proposed to the Behavioral Health Centers Licensure Rule.

The Council is a 31-member organization, the majority of those Members being individuals with developmental disabilities and family members who are appointed by the Governor.

The Council's mission is to assure that West Virginia citizens with developmental disabilities receive the services, supports, and other forms of assistance they need to exercise self-determination and achieve independence, productivity, integration and inclusion in the community.

One of the Council's roles is to work for systems' change on behalf of West Virginians who have developmental disabilities, and in that role, we offer the following comments.

64-11-1. General

1.7. Purpose – add "to ensure the provision of services and supports that are individualized and person-centered" to the sentence stating the purpose.

64-11-2. Application and Enforcement

2.5 Exemptions – We agree with the exemptions for services provided through a Medicaid self-directed community-based waiver (2.5.2) and Specialized Family Care (SFC)providers providing only services to individuals in SFC settings (2.5.10).

We believe another exemption should be added for families that provide services through the Medicaid home and community-based I/DD Waiver in

totality, whether services are being provided through the self-directed option or the traditional option. The other two exemptions mentioned can be, in the case of the self-directed option and are, in the case of SFC, provided by people other than family members. We can think of no justification for setting a stricter standard for natural families providing such services.

Comments in the definitions section will be addressed in the order they appear in the document, which may not be numerical order since many definitions have been struck and new definitions are being proposed.

64-11-3. Definitions

3.1. Abuse – We believe this proposed change weakens the definition of abuse and strongly oppose it. The definition should be very clear, as it is currently. The proposed definition is open to a great deal of interpretation and makes it harder to agree on whether a situation or incident constitutes abuse. For instance, who will determine whether "significant" physical or emotional harm has occurred? What will be the criteria for the term "significant?"

We believe the definition should also include the clarification that abuse also includes those actions committed by a contractor or volunteer working for the provider.

Likewise, we disagree with the removal of the clarifying definitions of psychological and verbal abuse. (Sections **3.1.b and 3.1.c**).

3.3. Advocate – We do not understand why this definition is being removed and disagree with the removal.

3.4. Aversive Procedures – We disagree with the removal of this definition.

3.5. Assessment – We suggest the definition be changed to read, "Formal and informal evaluations of a person by qualified personnel using skills of examination, including appraisal and analysis of data collected to provide care and services."

3.7. Behavioral Intervention – The word "plan" should be added back into the definition. "A written behavior support approved by the service planning team." makes little sense. A plan is written.

We also suggest adding "A behavioral intervention plan utilizes positive behavior support methods that focus on skill development and replacement of negative behavior."

3.8. Civil Rights – We question the reasoning for removing this definition.

3.11 Corporal Punishment – We do not agree with the use of corporal punishment but question the reasoning for the removal of the definition.

3.12 Critical Incident – As with the more detailed definitions of abuse which are being proposed for removal, we disagree with the extremely vague definition being proposed as a replacement in **3.15**.

3.21 Human Rights Committee, and **3.22 Informed Consent** – We question the removal of these definitions. Are Human Rights Committees and Informed Consent no longer being required? The Council would strongly disagree.

3.9 Chemical Restraint (new) – We suggest the addition of "an emergency procedure when less restrictive approaches fail."

3.26 Inappropriate behavior – We suggest removing the word "hazardous" and replacing it with "disruptive or increases risk of harm, and." Not all inappropriate behavior is hazardous.

3.24.k. Mechanical Supports – This definition was incorrectly placed under the definition of Legal Representative. We agree it should be moved to a more appropriate place, but question why it is being removed altogether.

3.25 Medication Error, and **3.26.** which includes the actual definition – This section also needed to be cleaned up, but we question why the definition has been removed entirely.

3.27 Neglect – The Council strongly opposes the removal of the current definition of neglect and the replacement with **3.32**, which substantially weakens it.

3.41 Respite – We suggest the insertion of the words "and/or consumer" at the end of the second sentence. We believe respite from the primary care-giver can be equally necessary for the individual for whom care is provided.

3.42 Restraint – We suggest the addition of "time limited" to the description.

3.43 Seclusion – We suggest the addition of "prohibited procedure" to the definition. We realize that later in this Rule (**12.20.2**) it is stated that seclusion is not permitted in any licensed community-based program, except for a psychiatric residential treatment facility for children or youth. Seclusion has been outlawed in school settings, and we fail to understand why it is still able to be used in treatment facilities for children and youth. Why would a practice not allowed to be used on adults be acceptable for use on children?

3.50 Volunteer – What is the purpose behind this change of definition? Why would friends or neighbors not be considered as volunteers? People who are under no obligation whatsoever to provide assistance and support, but who offer to do so, are volunteering.

64-11-4. State Administrative Procedures.

4.6 Inspections and Records – We find it troubling that all portions of the current section **4.3. Inspections** have been deleted and replaced with detailed information regarding records and minimal language regarding inspections. Currently, licensed centers are inspected at least once every two years, except for residential treatment facilities that are inspected at least once a year. The proposed language includes no requirement for inspections. How will the Secretary ensure the quality of settings and services for which he/she is responsible, and how will people who access services be able to have confidence in a center that has no regular oversight by the licensing entity?

4.7 Complaint Investigation.

4.7.1 – What is the reason behind the change suggested here by which the Secretary will no longer be required to consider a reported incident to be a complaint? What criteria will be used to judge whether a reported incident will be considered a complaint? We do not see the need for this change and believe it to be another example of the weakening of this rule.

4.8.4 – We believe this addition would contribute to a greater lack of transparency and that the public and individuals who use services have a right to know if a center is being investigated. A due process appeal could take years. We assume reports indicate whether complaints are alleged or proven.

4.9.4 – Is it intended that the Secretary "may" supply a directed plan of correction, or "will" supply one when a second plan of correction submitted by the provider cannot be approved?

4.9.7 – Should a definition of "immediate risk" be included in section 64-11-3?

64-11-5 ~~Governance~~. Consumer Rights.

5.1 Basic Rights – The Council adamantly opposed the deletion of Section 64-11-8, the Basic Rights and Violation of Consumer Rights section in the original draft of the proposed changes. We are pleased to see they have been re-inserted here. With the reinsertion, the definitions of "advocate" and "human rights committee" should be inserted back into the definitions section.

We disagree with the complete removal of the governance section, which include sections such as financial handling of consumer's money, general responsibilities of centers, staff training, and human rights committees, and quality assurances.

64-11-6. ~~Health and Safety~~. Risk Management

6.6 Transportation – We suggest the addition of "adequate vehicle modifications, including lifts."

64-11-8 ~~Consumer Rights~~ Financial Management

8.3 Financial accountability for consumer funds – When Section 5.4 Financial was deleted and replaced here, two important components were not included. We suggest 5.4.e (All money earned by a consumer shall be used for the sole benefit of that consumer.) and 5.4.f (Centers shall allow a consumer or his or her legal representative to use his or her personal funds.) be added back to this section.

64-11-9. ~~Substance Abuse Services~~. Management of Human Resources.

9.3 Volunteers – We suggest including a requirement for training on abuse/neglect reporting.

9.6. Disciplinary reviews and termination – People who are terminated due to substantiated abuse need to be reported. Is this covered under another rule or policy?

64-11-12. Services

12.4. Planning for services

12.4.2 – We suggest adding the consumer will be informed of his or her right to participate in the development of their service plan.

12.14. Abuse and Neglect.

12.14.2 – We believe the new requirement for the reporting of abuse and neglect is 24 hours.

12.20.2 – Please refer to our comment on seclusion under definitions. At the very least, seclusion should be prohibited for people with intellectual and other developmental disabilities.

12.20.6.c – We suggest re-wording this to read, "Devices used to treat a medical condition may not be used for restraint purposes." As written, using such a device to restrain an individual would not be called restraint but nonetheless would be. We hear of instances in which individuals (often children) are strapped in devices designed for a specific purpose but used intentionally to restrain them (e.g. Rifton chairs).

12.20.6.e – We are pleased to see the time frame for restraint has been lowered from three hours to 30 minutes.

Please note that we do not believe this set of comments is exhaustive. They represent those the staff of the DD Council were able to produce in the time allotted.

Section / Page	Title	Comments
2.1 Page 1	Application	rule applies to public, private, for profit and non-profit but exempts most all providers- defeats the purpose stated in 1.7 - If providers are delivering BH services then a license is needed. Erosion of the rules for some but not for others creates an unfair playing field.
3.11 Page 7	Clinic behavioral health service	is this a duplicate of 3.6 Behavioral Health Service
3.37 Page 11	Plan of Service	how is this different from 3.23 Expanded Plan of Service
3.47 Page 13	Supportive Service	how is this different from 3.35 Personal Attendant, 3.25 Habiliation
4.4.2 Page 16	Regular License	recommend 3 year - this saves the State of West Virginia and providers money on reviews, travel and staffing.
4.4.6 Page 18	Inspection and records	*A consumer may deny access to his or her place of residence unless it is owned or leased by the provider or unless there is evidence of a clear and immediate danger to the health of consumer.* **Determined by who?**
4.7.3 Page 19	Complaint Investigation	Replace administrator with Chief Executive Officer to remain consistent with definitions
4.9.4 Page 21	Plans of Correction	Needs to specify that any "directed" plan of correction will be labeled as such in all public records
6.8 Page 32	Risk Management	Should this be moved to Section 8 - Financial Management?
9.1.2 Page 45	**Deployment and Supervision of Staff**	***"This individual shall ensure that decisions related to the care of the consumer are based on the assessment and treatment needs of the consumer."*** **Based on treatment plan. Providers cannot be held responsible for surveyor's interpreation of need.**
9.2.9 Page 45	Personnel Practices	Need to eliminate *"verify"* - Provider can verify license and education but experience is more likely self report
9.7.2.d.7	**Orientation of new staff**	**Current rule does not require CPR, First Aid and Heimlich for clinic based staff. Only direct care. This reads that all staff would be required.**
11.1 Page 52	Empergency Planning and Response	Need clarification that only applies to residential settings
11.2 Page 53	Medication Control and Administration	Need clarification that only applies to residential settings
12.1.1.b Page 55	Service Descriptions	Not sure outcomes can be included in literature for potential clients - expected outcomes will be specific to the client.
12.6 Page 57	**Initial Plan of Service**	**Need to add if applicable because if they are receiving focused services only require a treatment strategy not a formal plan**
Pg.28, 5.2.2	Violation of Consumer Rights	Specifies report to Human Rights Committee, but found no other reference to requirement for an HRC. Requirement for HRC has been removed. Should read "Administrator or designee".
Pg. 32, 6.8	Risk Management	I am not aware that there is such thing as an irrevocable letter of credit. All much be renewed at established time frames.
Pg. 34, 7.3.4	Legal Compliance	Requirement for inspections by Safety Committee or Officer. Should Include designee or designated function.
Pg. 37, 7.5.1.b	Contractual Relationships	States that subcontracting provider shall demonstrate that employees are in compliance with reglatory and risk management needs of the provider. Concerned about interpretation of this. "Risk management needs of provider" is ambiguous. What is the purpose of the risk management?
Pg. 49, 9.7.2.d.7; 9.7.4	Employee Records	Universal precautions required for all staff in one section but infection control required for staff with direct care responsibilities. Universal precautions and bloodborne pathogens typically included in infection control training. Infection control should be required for all non-medical (physicians/nurses) staff at new hire but not annually.
Pg. 56, 12.5	Participation of DLR in Planning	DLR should be spelled out once so people don't have to figure it out
Pg. 56, 12.3.7	Services	
Pg. 57, 12.6.1, 12.7.1	Initial Plan of Service	First section requires initial plan of care (currently some services do not require a treatment plan (outpatient low end services) and 12.7.1 requires plan of care or treatment strategy be developed when consumer is receiving variety of services. Is confusing. Consumers getting a variety of services should have a treatment plan, but consumers only being seen for med management are low end and a treatment strategy should be sufficient (current practice). Needs to be clarified. Also need to clarify how "treatment strategy" is documented, e.g. physician notes.
pg. 7, 3.1.5	Definition of critical incident	Definition specifies critical incident an one that does not meet the definition of abuse/neglect. Incidents of abuse/neglect are considered to be critical incidents. Should the passage say "may or may not meet the definition of abuse/neglect"?
pg. 8, 3.27	Definition of incapacitated adult	Should include reference to the legal process or standard for such determination. Otherwise who makes the decision that a person is incapacitated?

Section / Page	Title	Comments
pg. 18, 4.6.3	Inspections and Records	reference to "rapid access" not defined. Is subjective with regard to time frame definitition of "access", e.g. format/vehicle of provided information
Pg. 32, 6.6.8	Transportation	Should be chaneged to "secure anchoring of wheelchairs in paralift designed vehicles".
pg. 32.6.6.9	Transportation	Requirement for annual drivers license validation for all staff who might transport is not feasible.
pg. 32, 6.7	Transportation	This requirement is not feasible. There is no way to do this. We would immediately cease transporting most clients.
Pg. 49, 9.7.2.d.7, 9.7.4	CPR/Heimlich/first aid	Some medical staff should not be required to take this. Physicians particularly and nurses are taught this in training and should be exempt.
Pg. 56, 12.3.7	Assessment Intake Procedures	Specifies documentation that staff have been advised of existence of medical condition, allergies, etc. How should this be documented? Such conditiions are documented in medical records in assessment for all staff to see.
pg. 58, 12.8.2	Coordination of Service	Requirement for non-behavioral health (and sometimes non agency-providers participation in comprehensive plan & documented by signature rarely happens and would not be possible.
pg. 58, 12.8.4	Coordination of Service	Only waiver clients have a service coordination provider. All clients do not have a service coodinator provider. Center case managers provide much of this function.
Pg. 65,20.6.f	Behavioral interventions	Currently, hospitals and PRTF facilities allow nurses to do the assessment. State law limits writing of orders to medical staff and physician extenders. These regulations are hospital regs. While the Center does no seclusion, or chemical restraints, and only rarely brief physican restraint, no medical staff is available to do the assessment.
Pg. 66, 12.21.2	Medical/Dental Procedures	This is currently done only for clients in 24 hour care programs. It is not done for clients seen only on outpatient. Should be revised.
Pg. 70, 12.28.5	24-hour program/medical monitor	Need to define "assist consumers in obtaining needed medicaion as part of discharge planning. While prescriptions are given to patients, lack of financial resources is a problem. The Center does not have the financial resources to pay for medication.
Pg. 72, 13.6.3	Information Dispute Resolution	Requiring a plan of correction for deficiences in question before the IDR process does not seem sensible, because until the IDR process is completed, the plan of correction will not be implemented and this would have been work for nothing. Given the short time frames established it would make more sense to forego the reqiurement for the plan of action for only the deficiencies in question until the IDR.
2.5.10 Page 2	Application and Enforcement	The exemption for Specialized Family Care Providers- is this even if they are employed by a licensed BH agency and providing a licensed behavioral health service such as IDD Waiver direct support services?
3.8, 3.45, Page 7 and 45	Definitions	Case Management is indicated as NOT a behavioral health service but Service Coordination is. These terms are often used interchangeably in the field. Can further clarification be given on typical populations served per service, site and location of services and specific professional requirements for each service to futher delineate the difference between the two?
9.2.9.b, page 47	Personnel Practices Education and Training	Relevant experience is indicated under education and training. Many employee hires may be new graduates or direct support professionals without prior experience in the field. Would there be a substitution or method of explanation for these situations?
9.5.1.g., page 48	Employee, Volunteer, and Student Records	Related to the comment above, this policy indicates documentation of relevant education or experience as required by job description. Requesting clarfication on relevant experience as a education and training requirement only if it is indicated as required in the job description?
12.8.6, page 59	Coordination of Service	Indicates the provider team is required to receive the final treatment plan within 7 working days. This time frame is inconsistent with some program policy manuals that indicate 14 days
12.14.2, page 62	Abuse and Neglect	Indicates the initial report shall be made by telephone followed by a written report by the complainant or the receiving agency with 48 hours. Will this be updated to be consistent with the recent mandated reporting legislation requiring 24 hours?
Complete document		I see no mention of Human Rights Committee requirements. Will this no longer be required?
	3.1 Abuse	What is the definition of significant, or how do determine what is significant and what isn't
4.7.7		I feel this should be in accordance with the Whisteblower Protection Act. I would include some wording stating a complaint made "in good faith". For example, if someone completely makes up some allegation of abuse or neglect by another employee because they wanted to get that employee fired and take their shift, then disciplinary action may result.

Section / Page	Title	Comments
9.7.2.d.7 (pg.51)		This is just a thing I know from having been a lifeguard instructor for so long, but the American Red Cross does not use the Heimlich maneuver for choking victims. Dr. Henry Heimlich, who invented this maneuver, fought with the American Red Cross about this for a long time. He disagreed with the process of administering back blows in addition to the abdominal thrusts. He did not want his name attached to this, so the American Red Cross removed the phrase altogether around 2005 or 2006. The American Heart Association still teaches the Heimlich maneuver without the back blows, so if our legislative rules specifically say "the Heimlich maneuver", we would no longer be able to use the American Red Cross and would have to begin teaching according to the American Heart Association standards. Therefore, I would remove that wording altogether and rephrase.
10.2.9 (pg. 53)		Due to the Parking Lot Gun Bill, firearms are allowed on the grounds, although they may not be in the facilities. Employees may keep legally obtained, secured firearms in their personal vehicle (not company vehicles). These must be out of sight and cannot be taken out of their vehicle on our property.
3.36	Physician Extender	The term Physician Extender is outdated and offensive to APRNs who are independent practitioners. If a term like this is to be used to lump together Pas and NPs, the more acceptable term is mid level providers.
5.1.1b and 5.1.1 d		These tow sections seem redundant.
		The licensure rule should not be used to force agencies to provide services that are not reimbursed. This is happening now and Commissioner Beane agreed with this statement in the Public Meeting, but nothing was added to the rule preventing future unfunded mandates.