

**WEST VIRGINIA
SECRETARY OF STATE**

KEN HECHLER

ADMINISTRATIVE LAW DIVISION

Form #3

Do Not Mark In This Box

APR 11 4 40 PM '99

OFFICE OF THE SECRETARY OF STATE
WEST VIRGINIA

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

Division of Health

AGENCY: Department of Health and Human Resources TITLE NUMBER: 64

CITE AUTHORITY W. Va. Code §§27-9-1 and 27-17-3 and 27-1A-4(g) in conjunction with
27-1A-6(6) and -7.

AMENDMENT TO AN EXISTING RULE: YES NO

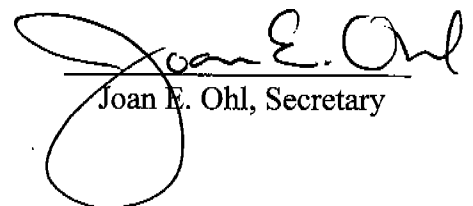
IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 11

TITLE OF RULE BEING PROPOSED: Behavioral Health Centers Licensure

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


Joan E. Ohl, Secretary

\$20.50

BRIEF SUMMARY OF THE RULE
BEHAVIORAL HEALTH CENTERS LICENSURE

64CSR11

Summary: This proposed legislative rule repeals and replaces the existing behavioral health licensure rule. The new rule contains sections on application and enforcement; state administrative procedures; governance; health and safety; consumer services; consumer rights; substance abuse services; and penalties. The purpose of this replacement is to update and clarify the licensure standards to meet the expanded variety of service providers.

For further information contact: John M. Wilkinson, Director, Office of Health Facility Licensure and Certification, Bureau for Public Health, Department of Health and Human Resources, telephone (304) 558-0050, State Capitol Complex, Building 3, Room 550, Charleston, West Virginia 25305.

Copies of the proposed rule may be purchased from the Administrative Law Division of the Office of the Secretary of State, State Capitol Complex, Building 1, Suite 157K, Charleston, West Virginia 25305-0771, phone (304) 558-6000.

**STATEMENT OF CIRCUMSTANCES WHICH REQUIRE THE PROPOSED RULE
BEHAVIORAL HEALTH CENTERS LICENSURE**

64CSR11

The current rule was written and adopted in 1984. Minor changes to allow for child care agencies to be licensed were adopted in 1990. The number of behavioral health centers established and licensed since the initial rule has grown from 16 to 82. The variety of services has drastically expanded from some residential services and outpatient for the chronically mentally ill, developmentally disabled, and substance abuse to a myriad of provider types and services, i.e., partial hospitalization, crisis residential, children's residential services, care management and early intervention. In assessing compliance for many of these services, it has been difficult to adapt the current rule. With the advent of managed care for the behavioral health system, it is vital for the state to have a rule which is drafted in up-to-date language, includes provisions that address all components of the various services offered by providers and protects the health and safety of the residents of West Virginia.

QUESTIONNAIRE

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

DATE: August 6, 1999

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

Division of Health

FROM: (Agency name, Address & Phone No.) Department of Health and Human Resources

State Capitol Complex, Building 3, Room 265, Charleston, WV 25305

Telephone: (304) 558-5598

LEGISLATIVE RULE TITLE: Behavioral Health Centers Licensure, 64CSR11

1. Authorizing statute(s) citation: WV Code §§ 27-9-1 and 27-17-3 and
27-1A-4(g) in conjunction with 27-1A-6(6) and -7.

2. a. Date filed in State Register with Notice of Hearing or Public Comment
Period:
June 30, 1999

b. What other notice, including advertising, did you give of the hearing?
The proposed rule will be distributed to all licensed behavioral health centers and the:
WV Assoc. for Behavioral Healthcare Providers; Coalition of Independent Behavioral
Health Service Providers; WV Alliance for the Mentally Ill; WV Child Care Association;
and WV Mental Health Consumers Assoc.

c. Date of Public Hearing(s) or Public Comment Period ended:
July 30, 1999

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

Attached X No comments received _____

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

August 6, 1999

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

Beth Marquart, Director, Office of Regulatory Development

Department of Health and Human Resources

Building 3, Room 265, Capitol Complex

Charleston, West Virginia 25305

(304) 558-5598 FAX: (304) 558-6051 bethmarquart@wvdhhr.org

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

V. Sue Cater, Director

Behavioral Health Program

Department of Health and Human Resources

Capitol Complex Building 3, Room 550

Charleston, West Virginia 25305 (304) 558-0050

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

- a. Give the date upon which you filed in the State Register a notice of the

time and place a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

b. Date of hearing or comment period:

N/A

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

N/A

d. Attach findings and determinations and reasons:

Attached N/A

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Licensure of Behavioral Health Centers. 64CSR11

Type of Rule: Legislative ___ Interpretive ___ Procedural

Agency: Division of Health
 Department of Health and Human Resources

Address: Building 3, Capitol Complex
 Charleston, W. Va. 25305

1. Effect of the Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	\$	\$	\$	\$ 0	\$ 0
Personal Services					
Current Expense					
Repairs & Alterations					
Equipment					
Other					
Revenue					

2. Explanation of above estimates.

The Department anticipates that the costs of the licensure program will not be affected by the revised rule.

3. Objectives of this rule:

This proposed amended legislative rule rewrites and replaces the existing behavioral health licensure rule. The new rule contains sections on application and enforcement; state administrative procedures; department reports and records; governance; health and safety; consumer services; consumer rights; substance abuse services; and penalties. The purpose of the revision is to update and clarify the licensure standards. The current rule is more than fourteen (14) years old.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific Groups of Citizens.


None.

C. Economic Impact on Citizens/Public at Large.

None.

Date:

Signature of Agency Head or Authorized Representative



Joan E. Ohl, Secretary
Department of Health and Human Resources

64CSR11

**TITLE 64
LEGISLATIVE RULES
DIVISION OF HEALTH**

**SERIES 11
BEHAVIORAL HEALTH CENTERS LICENSURE**

**FOR REVIEW BY THE
LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

64CSR11

**TITLE 64
LEGISLATIVE RULES
DIVISION OF HEALTH**

**SERIES 11
BEHAVIORAL HEALTH CENTERS LICENSURE**

TABLE OF CONTENTS

§64-11-1. General	1
§64-11-2. Application and Enforcement	1
2.1. Application	1
2.2. Enforcement	1
§64-11-3. Definitions	2
§64-11-4. State Administrative Procedures	9
4.1. General Licensure Provisions	9
4.2. Construction and Renovation	11
4.3. Inspections	11
4.4. Complaint Investigation	12
4.5. Plans of Correction	13
4.6. Reports and Records	14
§64-11-5. Governance	14
5.1. Operating Authority	14
5.2. Governing Body	14
5.3. Administration	15
5.4. Financial	15
5.5. Center Responsibility	16
5.6. Personnel	18
5.7. Staff Training	18
5.8. Requirements for Residential Staff	19
5.9. Human Rights Committee	19
5.10. Transportation Services	20
5.11. Quality Assurance	20
§64-11-6. Health and Safety	20
6.1. General	20
6.2. Fire Code	21

64CSR11

6.3. Requirements for Physical Environment	21
6.3.a. Water Supply	21
6.3.b. Sewage Disposal	21
6.4. Structures, Grounds, Equipment	22
6.5. Lighting, Ventilation, Heating	22
6.6. Requirements for Group Homes, Residential Treatment Facilities (24 Hour)	22
6.7. Consumer Grouping	23
6.8. Consumer Records	24
6.9. Records Management	24
§64-11-7. Consumer Services	25
7.1. Program Description	25
7.2. Assessment and Planning	25
7.3. Treatment Plan	26
7.4. Treatment Plan Review	28
7.5. Consumer Discharge	28
7.6. Behavior Intervention	29
7.7. Critical Incidents and Crisis Management	30
7.8. Medical and Psychiatric Emergency Services	31
7.9. Emergency Medical and Psychiatric Services in Residential Treatment Facilities:	31
7.10. Medication Services	31
7.11. Medication Management	32
7.12. Group Homes and Residential Treatment Services (Adult and Minors)	32
7.13. Residential Treatment Services for Minors (24 Hours)	33
7.14. Shelter Services for Minors.	33
7.15. Partial Hospitalization Programs	33
7.16. Staffing for Partial Hospitalization Programs	34
7.17. Educational Programs	34
§64-11-8. Consumer Rights	35
8.1. Basic Rights	35
8.2. Violation of Consumer Rights	37
8.3. Serious Injury or Death Reports	38
§64-11-9. Substance Abuse Services	38
9.1. Public Inebriate Shelter Services	38
9.2. Detoxification Services	38
9.3. Residential Substance Abuse Services	39
§64-11-10. Penalties	39

64CSR11

§64-11-11. Administrative Due Process 40

64CSR11

TITLE 64
LEGISLATIVE RULES
DIVISION OF HEALTH

SERIES 11
BEHAVIORAL HEALTH CENTERS LICENSURE

OFFICIAL
SECRET
AUG 3 4 47 PM '99
SINIA
STATE

§64-11-1. General.

1.1. Scope. -- This rule establishes general standards and procedures for the licensure of behavioral health services and programs. This rule should be read in conjunction with the definitions in W. Va. Code § 27-1-1 et seq. and the provisions of W. Va. Code §§ 27-9-1 and 27-17-1 et seq. The W. Va. Code is available in public libraries and on the Legislature's webpage, <http://www.legis.state.wv.us/>.

1.2. Authority. -- W. Va. Code §§ 27-9-1 and 27-17-3 and 27-1A-4(g) in conjunction with 27-1A-6(6) and -7.

1.3. Filing Date. --

1.4. Effective Date. --

1.5. Repeal and Replacement of Former Rule. -- This legislative rule repeals and replaces "Licensure of Behavioral Health Centers," 64CSR11, effective April 6, 1990.

§64-11-2. Application and Enforcement.

2.1. Application. This rule applies to a center, as defined by this rule, that offers services to individuals with mental illness, mental retardation, behavioral disability, developmental disability or addiction, as defined in §§27-1-2, -3 and -11, and 27-17-1(a) and (b), or offers preventive services for these disabilities.

2.2. Enforcement. This rule is enforced by the secretary of the department of health and human resources.¹

¹The department of health and human resources (DHHR) was created by the Legislature's reorganization of the executive branch of state government in 1989, and the department of health was renamed the division of health and made a part of the DHHR (W. Va. Code §5F-1-1 et seq.). Administratively within the DHHR, the bureau for public health through its commissioner carries out the public health functions of the division of health.

64CSR11

§64-11-3. Definitions.

3.1. Abuse. --

3.1.a. Physical Abuse. -- Any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

3.1.b. Psychological Abuse. -- Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.

3.1.c. Verbal Abuse. -- Any use of oral, written or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to:

3.1.c.1. Yelling or using demeaning, derogatory, vulgar, profane or threatening language;

3.1.c.2. Threatening tones in speaking;

3.1.c.3. Teasing, pestering, molesting, deriding, harassing, mimicking or humiliating a consumer in any way; or

3.1.c.4. Making sexual innuendo.

3.2. Administrator. -- The person responsible for carrying out the governing body's policy and the day-to-day operation of the center.

3.3. Advocate. -- A person or agency that acts on behalf of a consumer to establish, expand, protect and enforce his or her human, legal and civil rights in a consumer's best interest.

3.4. Aversive Procedures. -- Restrictive procedures that impose consequences a consumer finds undesirable in a treatment program to decrease inappropriate behaviors. What is undesirable varies with each consumer but generally includes such measures as fines or loss of privileges. Aversive procedures include, but are not limited to, physical and chemical restraint, time-out and seclusion.

3.5. Behavioral Health Services. -- Any inpatient, residential or outpatient service for the care and treatment of persons with mental illness, mental retardation, behavioral disability,

64CSR11

developmental disability or addiction, as defined in §§27-1-2, -3 and -11, and 27-17-1(a) and (b), or offers preventive services for these disabilities.

3.6. Behavioral Intervention Plan. -- A written plan whose outcome is to teach adaptive behaviors and reduce or extinguish maladaptive behaviors in order to allow the individual to function successfully in the environment.

3.7. Center. -- An entity that provides behavioral health services, except for:

3.7.a. Hospitals governed by Division of Health rule, "Hospital Licensure," 64CSR12;

3.7.b. Twenty-four (24) hour inpatient services located within a general or psychiatric hospital. These services are licensed under Division of Health rule, "Hospital Licensure," 64CSR12;

3.7.c. Nursing homes governed by Division of Health rule, "Nursing Home Licensure," 64CSR13;

3.7.d. Personal care homes governed by Division of Health rule, "Personal Care Home Licensure," 64CSR14;

3.7.e. Residential board and care homes governed by Division of Health rule, "Residential Board and Care Homes", 64CSR65;

3.7.f. Non-supervised apartment living quarters occupied by consumers of the center;

3.7.g. Specialized family care homes under the supervision of the West Virginia department of health and human resources;

3.7.h. Self help groups;

3.7.i. Information and referral services;

3.7.j. A private practice as defined in this rule; or

3.7.k. Entities operated by the state or federal government.

3.8. Civil Rights. -- The rights of personal liberty guaranteed by the Constitutions of the United States and the State of West Virginia, by federal and state statutes and by case law.

3.9. Consumer. -- An individual receiving treatment or services in or from the center.

64CSR11

3.10. Consumer Record. -- A dated and signed written compilation of information that describes and documents the evaluation and present and prospective treatment of a consumer.

3.11. Corporal Punishment. -- The application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior but not including aversive procedures.

3.12. Critical Incident. -- The alleged, suspected, or actual occurrence of any of the following involving a consumer:

3.12.a. Abuse;

3.12.b. Neglect;

3.12.c. Death due to any cause;

3.12.d. Attempted suicide;

3.12.e. Behavior that will likely lead to serious injury or significant property damage;

3.12.f. Fire resulting in injury, relocation or an interruption of services;

3.12.g. Any major involvement with law enforcement authorities;

3.12.h. Injury that requires hospitalization or results in permanent physical damage;

3.12.i. Life-threatening reaction because of a drug or food;

3.12.j. A serious consequence resulting from an apparent error in medication or dietary administration;

3.12.k. Extended and unauthorized absence of a consumer that exceeds his or her treatment plan provision for community access; or

3.12.l. Removal of a consumer from either residential or program services without the consent of a consumer or his or her legal representative.

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

3.14. Discharge. -- The termination of a consumer's affiliation with the center.

64CSR11

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

3.16. Documentation. -- A written record relating to compliance with this rule.

3.17. Emergency Procedures. -- Procedures necessary to control severely aggressive or destructive behaviors that place a consumer or others in imminent danger of physical harm when the timing of those behaviors reasonably could not have been anticipated.

3.18. Functional Analysis. -- A comprehensive assessment process that includes at least: an analysis of the problem behavior, a history of the problem, the antecedent, and consequence of the behavior and an hypothesis as to the function of the behavior.

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

3.20. Governing Body. -- A person or persons with the legal authority and responsibility to set policy and oversee the operations of the center.

3.21. Human Rights Committee. -- A specially constituted committee or committees whose primary function is to assist the center in the promotion and protection of a consumer's rights, and to review, approve and monitor individual programs designed to manage inappropriate behaviors and other programs that are intrusive or involve risks to a consumer's protection and rights.

3.22. Informed Consent. -- The written verification:

3.22.a. That a consumer has or does not have the legal capacity to give informed consent;

3.22.b. That a consumer or his or her legal representative has been informed of the advantages and disadvantages of all aspects of the treatment provided to a consumer; and

3.22.c. That a consumer or his or her legal representative agrees to the treatment.

3.23. Interdisciplinary Team. -- A group including a consumer or his or her legal representative, and representatives from the disciplines and services that design a consumer's treatment plan.

64CSR11

3.24. Legal Representative². - A person or agency with legal authority to exercise some degree of control over a consumer's affairs; namely, one of the following that is the most appropriate to the decision to be made:

3.24.a. A conservator, temporary conservator or limited conservator appointed pursuant to the West Virginia Legal Guardianship and Conservatorship Act, W. Va. Code §44A-1-1 et seq., within the limits set by the order;

3.24.b. A guardian, temporary guardian or limited guardian appointed pursuant to the West Virginia Guardianship and Conservatorship Act, W. Va. Code §44A-1-1 et seq., within the limits set by the order;

3.24.c. An individual appointed as committee or guardian prior to June 9, 1994, within the limits set by the appointing order and W. Va. Code §44A-1-2(d);

3.24.d. A person having a medical power of attorney pursuant to the West Virginia Medical Power of Attorney Act, W. Va. Code §16-30A-1 et seq., within the limits set by the law and the appointment;

3.24.e. A representative payee under the U.S. Social Security Act, Title 42 US Code §301 et seq., within the limits of the payee's legal authority;

3.24.f. A surrogate decision-maker appointed pursuant to the West Virginia Health Care Surrogate Act, W. Va. Code §16-30B-1 et seq., or the West Virginia Do Not Resuscitate Act, §16-30C-1 et seq., within the limits set by the appointment;

3.24.g. An individual having a durable power of attorney pursuant to W. Va. Code §39-4-1, or a power of attorney under common law, within the limits of the appointment;

3.24.h. An individual identified pursuant to W. Va. Code §16-3C-4 to grant consent for HIV-related testing and for the authorization of the release of test results;

3.24.i. A parent or guardian of a minor; or

3.24.j. An individual lawfully appointed in a similar or like relationship of responsibility for a consumer under the laws of this State, or another legal jurisdiction, within the limits of the applicable law.

² Owners and administrators should note that the various types of legal representatives do not necessarily have the lawful authority to act on behalf of the resident in all matters that shall require action by a legal representative. For example, a conservator shall have responsibility for financial affairs, but not personal affairs, such as medical care.

64CSR11

- 3.25. Mechanical Restraint. -- See physical restraint.
- 3.26. Mechanical Supports. -- Devices used to support or align proper body position.
- 3.27. Medication Error. -- Occurs with:
- 3.27.a. The failure to administer a drug ordered by a physician; or
 - 3.27.b. The administration of a drug:
 - 3.27.b.1. Without a physician's order;
 - 3.27.b.2. In the wrong dosage;
 - 3.27.b.3. In the incorrect form;
 - 3.27.b.4. By the incorrect method; or
 - 3.27.b.5. That is incorrect itself.
- 3.28. Neglect. -- Failure to provide goods and services necessary for the consumer to avoid physical or psychological harm.
- 3.29. Objective. -- An expected result or outcome that is stated in measurable terms, has a specified time for achievement and is related to the attainment of a goal.
- 3.30. Partial Hospitalization. -- A comprehensive structured program that uses a interdisciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders. A partial hospitalization program is designed to treat consumers who exhibit severe or disabling conditions related to an acute psychiatric/psychological condition or an exacerbation of a severe and persistent mental disorder.
- 3.31. Policy. -- A statement of the principles that guide and govern the activities, procedures and operations of a program.
- 3.32. Positive Programming. -- An educational process for behavior change that is based on a functional analysis of the presenting problems and involves systematic instruction in more effective ways of behaving.
- 3.33. Private Practice. -- The individual or group practice of a healing art or behavioral

64CSR11

health profession by professionals licensed under State law.

3.34. Procedures. -- The methods by which policies are implemented.

3.35. Program. -- A system of services designed to address the treatment needs of consumers.

3.36. Psychiatric Emergency. -- An incident when a consumer loses control and behaves in a manner that poses substantial likelihood of physical harm to himself or herself or to others.

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

3.38. Psychotropic Drugs -- Medications prescribed by physicians to reduce depression, anxiety, and other manifestations of mental or emotional disturbance.

3.39. Quality Assurance. -- A program designed to objectively monitor and evaluate the quality and appropriateness of consumer services and identify methods to improve services and resolve problems.

3.40. Residential Treatment Facility. -- A structure in which is provided an inpatient, interdisciplinary, psychotherapeutic treatment program on a twenty-four (24) hour-a-day basis for severe behavioral, anxiety, affective, impulse control, chemical dependency and other mental or emotional disorders. This definition includes, but is not limited to, group residential facilities as defined in W. Va. Code §27-17-1(c).

3.41. Restraint. -- A temporary behavior control intervention for reducing or eliminating inappropriate behavior.

3.41.a. Chemical Restraint. -- The use of medications for behavior control.

3.41.b. Physical Restraint. -- Any manual method or mechanical device for behavior control that restricts free movement. Examples of manual methods include therapeutic or basket holds and prone or supine containment. Examples of mechanical devices include arm splints, posey mittens, helmets and straight jackets. Excluded are physical guidance and prompting techniques of brief duration and mechanical supports.

3.42. Seclusion. -- When a consumer is placed alone in an enclosed space, with doors that a consumer cannot open from inside, for his or her protection or the protection of another.

3.43. Secretary. -- The secretary of the State department of health and human resources or

64CSR11

his or her designee.

3.44. Service. -- A functional division of a program; the delivery of care.

3.45. Staff. -- Personnel paid by the center to provide services.

3.46. Substance Abuse. -- Pattern of psychoactive substance misuse indicated by at least one of the following:

3.46.a. Continued use despite knowledge of having a social, occupational, psychological, or physical problem that is caused or exacerbated by use of the substance; or

3.46.b. Recurrent use in hazardous situations, such as driving.

3.47. Substantial Compliance. -- A level of compliance with the requirements of this rule so as to not to impose a risk to the rights, health and safety of a consumer.

3.48. Time-Out. -- A procedure in which a consumer is isolated from an environment to reduce or eliminate a behavior thought to be reinforced by that environment. Different types of time-out include:

3.47.a. Placing a consumer in a quiet corner of the room; and

3.47.b. Removing the consumer to another room which is not locked.

3.49. Treatment. -- A broad range of planned habilitative and/or rehabilitative services, including diagnostic evaluation, counseling, medical, psychiatric, psychological, training, education, and social service care, that are provided to enable a consumer to meet identified goals and objectives.

3.50. Treatment Plan. -- A written design based on the assessment of a consumer's needs and strengths that identifies problems, sets client-centered goals and objectives and describes all services, programs and activities currently required to support the achievement of the goals and objectives.

3.51. Variance. -- A declaration that a rule may be accomplished in a manner different from the manner set forth in the rule.

3.52. Volunteer. -- A person who provides services for no direct financial remuneration, and who meets the center's employment qualifications for health, safety and training.

64CSR11

3.53. Waiver - A declaration that a certain rule is inapplicable in a particular circumstance.

§64-11-4. State Administrative Procedures.

4.1. General Licensure Provisions.

4.1.a. Before establishing, operating, maintaining or advertising within the State of West Virginia, a center shall first obtain from the secretary a license authorizing the operation.

4.1.b. If the secretary determines not to issue a license as applied for, the applicant is notified.

4.1.c. A license is valid for the center named in the application and is not transferable.

4.1.d. An expired or otherwise invalid license shall be surrendered to the secretary on written demand.

4.1.e. License Application.

4.1.e.1. An application shall identify all service locations and offices operated by the center.

4.1.e.2. Initial applications shall be received by the secretary not less than thirty (30) days and not more than sixty (60) days prior to the initiation of services.

4.1.e.3. Renewal applications shall be received by the secretary not less than sixty (60) days prior to the expiration of the current license.

4.1.e.4. Amended license applications shall be received by the secretary under the following circumstances:

4.1.e.5. A change in the geographic location of a service or facility; or

4.1.e.5.A. A change in bed capacity.

4.1.e.6. An application for an initial or renewal license shall identify the governing body, and administrator of the center.

4.1.e.7. After a complete application with required fee for a renewal license has been received, the existing license shall not expire until the new license has been issued or denied.

64CSR11

4.1.f. Issuance.

4.1.f.1. Neither an initial, renewal or a provisional license shall be issued unless an inspection has been made.

4.1.f.2. Following an application review, and any onsite inspections and plans of correction, the secretary shall, if there is substantial compliance with this rule, issue a license in one (1) of three (3) categories:

4.1.f.3. An initial six (6) month license shall be issued to centers establishing a new program or service for which there is insufficient consumer participation to demonstrate substantial compliance with this rule;

4.1.f.4. A provisional license shall be issued when a center seeks a renewal license, and a center is not in substantial compliance with this rule, but does not pose a significant risk to the rights, health and safety of a consumer. It shall expire not more than six (6) months from date of issuance, and not be consecutively reissued, unless the provisional recommendation is that of the state fire marshal.

4.1.f.5. A renewal license shall be issued when a center is in substantial compliance with this rule, and shall expire not more than two (2) years from date of issuance.

4.1.f.6. The secretary may grant a waiver or variance to the provisions of this rule if its application clearly would be impractical and if any alternate arrangements are not detrimental to the health or safety of the consumers or employees of the center. The secretary may provide consultation in obtaining compliance with this rule.

4.1.f.7. The center shall notify the secretary within thirty (30) days after the name of the center is changed, and a license with the new name will not be issued until the license is renewed.

4.2. Construction and Renovation.

4.2.a. The secretary or designee shall inspect new locations for all residential treatment facilities and locations of additions to existing residential treatment facilities prior to the architect's beginning work on final drawings and specifications.

4.2.b. Before construction and extensive renovation begin, an applicant shall submit to the secretary for approval a complete set of drawings and specifications for the architectural, structural and mechanical work.

64CSR11

4.2.c. All extensive renovated and new structures shall meet current Americans with Disabilities Act (ADA) standards.

4.3. Inspections.

4.3.a. To carry out the intent of this rule, the secretary requires inspections by authorized representatives.

4.3.b. Inspections shall include, but are not limited to:

4.3.b.1. Observation of service delivery;

4.3.b.2. Review of life safety and environment;

4.3.b.3. Review of clinical and administrative records; and

4.3.b.4. Interviews with consumers (with the consumer's consent), staff and administrators.

4.3.c. Each licensed center is inspected at least once every two (2) years, except for residential treatment facilities that are inspected at least once a year.

4.3.d. Inspections include every licensed location operated by the center.

4.3.e. The center shall comply with any reasonable requests from the secretary to have access to the service, staff, consumers (with their permission), and records.

4.3.f. Within ten (10) working days of completion of an inspection, the secretary issues a report.

4.3.g. Based on a center's previous substantial compliance with this rule, an onsite inspection is not required for issuance of an amended license.

4.4. Complaint Investigation.

4.4.a. Any person may file a complaint with the secretary alleging violation of applicable laws or rules by a center. A complaint shall state the nature of the complaint and the center by name.

4.4.b. The secretary may conduct unannounced inspections of centers or services involved in a complaint and any other investigations necessary to determine the validity of a

64CSR11

complaint.

4.4.c. At the time of the investigation the investigator shall notify the administrator or person in charge of the location involved in the complaint the reason for the complaint.

4.4.d. Within ten (10) working days of the investigation, the secretary shall provide to the center a written report of the results of the investigation, along with any violations.

4.4.e. The secretary shall provide to the complainant upon request a description of the corrective action the center is required to take and of any disciplinary action the secretary will take.

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

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

4.4.h. Centers are prohibited from discharging or discriminating in any way against a consumer or employee who has been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process.

4.4.i. The secretary may suspend or revoke a license for violating the prohibitions of this section.

4.5. Plans of Correction.

4.5.a. Within ten (10) working days after receipt of the inspection report, the center shall submit to the secretary for approval a written plan to correct all deficiencies that are in violation of this rule, except if a variance is permitted by the secretary. The plan shall specify:

4.5.a.1. Action taken or procedures proposed to correct the deficiencies and prevent their reoccurrence;

4.5.a.2. Date of completion of each action taken or to be taken; and

4.5.a.3. Signature of the administrator.

64CSR11

4.5.b. The secretary shall approve, modify or reject the proposed plan of correction in writing. Modifications shall be made in conjunction with the center.

4.5.c. When the secretary modifies or rejects a plan of correction, the secretary shall state the reasons.

4.5.d. When the secretary rejects a plan of correction, a revised plan shall be submitted within ten (10) working days.

4.5.e. The secretary shall require an immediate correction if a violation severely risks the health or safety of a consumer or other persons.

4.5.f. The secretary determines if corrections have been made.

4.6. Reports and Records.

4.6.a. The secretary shall keep on file a report of any inspection or investigation.

4.6.b. A report shall specify the deficiency and the provision of the rule it violates.

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

4.6.c.1. As specified in this section regarding Complaint Investigations;

4.6.c.2. Information of a personal nature from a consumer or personnel file; and

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

4.6.d. A report made public shall also state whether a plan of correction has been submitted to or approved by the secretary.

§64-11-5. Governance.

5.1. Operating Authority.

5.1.a. The center has evidence of the source of its operating authority, e.g. certificate of incorporation, partnership agreement.

5.1.b. The center and all of its service locations shall prominently display a current license, except in residential treatment facilities where it shall be shown upon request.

64CSR11

5.2. Governing Body.

5.2.a. The center shall have a governing body that sets policies, develops a mission statement, defines services, guides development and ensures the accountability of the center.

5.2.b. The governing body evaluates implementation of policies.

5.2.c. The governing body shall appoint an administrator who has the authority and responsibility to manage the center and implement policy.

5.3. Administration.

5.3.a. The administrator shall define structure and lines of authority.

5.3.b. The administrator shall develop a plan of operation with a mission statement, program goals and a description of services.

5.3.c. The administrator shall establish operational procedures that comply with legally applicable requirements regarding the protection of consumers' assets under the control of the center.

5.3.d. When a board of directors is the governing body, policies, procedures and by laws shall provide for:

5.3.d.1. The orientation of new members to the operations of the center;

5.3.d.2. The description of the board's committee structure;

5.3.d.3. The prevention of a conflict of interest between a board member and the center; and

5.3.d.4. Quarterly meetings with minutes recorded.

5.4. Financial.

5.4.a. The center operates on an annual budget approved by the governing body.

5.4.b. The center's cost accounting system shall provide data that supports the calculation of costs of service delivery based upon actual or potential revenues.

5.4.c. The center receives, disburses, and accounts for its funds in accord with sound

64CSR11

financial practices and generally accepted accounting principles.

5.4.d. The center shall be audited at least annually by an independent certified public accountant.

5.4.e. The center shall have insurance coverage to include general, professional and vehicular liability and property damage.

5.4.f. If the center handles consumer funds or disburses non-fee-for-service funds, such as allowance funds, the center is a fiduciary for the funds and shall maintain a current record and keep separate accounts of each consumer's funds. The center shall provide to a consumer at least monthly and upon request, a statement of his or her account.

5.4.g. All money earned by a consumer is used for the sole benefit of that consumer.

5.4.h. The center shall allow a consumer or his or her legal representative to use his or her personal funds.

5.4.i. The center does not commingle a consumer's funds with the center's funds or with the funds of any person other than another consumer.

5.4.j. If the center handles consumer funds in excess of twenty-five dollars (\$25) per consumer and in excess of five hundred dollars (\$500) for all consumers per month, the center shall obtain a bond in an amount approved by the secretary sufficient to cover all consumer accounts, and the amount shall not be less than two thousand five hundred dollars (\$2,500). When the amount of any bond is insufficient to adequately protect the funds of consumers, the center shall obtain an additional bond in such amount as necessary to adequately protect the funds of consumers.

5.5. Center Responsibility.

5.5.a. The center clearly defines the population for whom services are designed so as to inform potential consumers and referral sources of the center's capacities, availability, and the means required for payment of those services.

5.5.b. The center shall develop and implement a code of ethics that includes, but is not limited to provisions regarding the following:

5.5.b.1. Informed consent and participation of a consumer in decisions about service, care and treatment;

64CSR11

5.5.b.2. The right of a consumer to refuse participation in clinical studies or other research;

5.5.b.3. Privacy and confidentiality of a consumer;

5.5.b.4. That decisions made about care are based solely on the assessment and treatment needs, including consideration of the consumer's wants and desires and other clinical documentation if the consumer's health and behavioral health status;

5.5.b.5. Means of resolving differences with regard to care and treatment decisions;
and

5.5.b.6. Right to file grievances in accordance with prescribed procedures.

5.5.c. At the time of, or prior to, service delivery, the center shall inform a consumer in writing of charges for services.

5.5.d. The center will release consumer information only according to its written policies and legal requirements.

5.5.e. The center shall not discriminate in any matter of employment on the basis of race, color, national origin, ancestry, religion, physical disability or sex.

5.5.f. If the center uses volunteers, it shall implement written policies and procedures for the utilization of volunteers.

5.5.g. All professional staff and consultants of the center shall be in compliance with applicable State professional licensure requirements.

5.5.h. The center shall comply with its written policies and with W. Va. Code §9.6.9 and W. Va. Code §49-6A-5 when there is reasonable cause to suspect that a consumer is neglected or abused.

5.5.i. Except as required by law, before releasing information about a consumer, the center shall obtain consent from the consumer, or his or her legal representative, that includes the following:

5.5.i.1. Specific information to be released;

5.5.i.2. The time period in which this consent is in effect;

64CSR11

5.5.i.3. The recipients; and

5.5.i.4. The purpose of the release.

5.5.j. The center shall protect the confidentiality of a consumer by prohibiting:

5.5.j.1. A consumer's participation in public performance without the consent of the consumer or his or her legal representative; and

5.5.j.2. The use of photographs or videotapes for public relations purposes without the consent of the consumer or his or her legal representative.

5.5.k. Except in cases of abuse, neglect or exploitation in which the center has responsibility to report to protective services, a consumer or his or her legal representative shall be the primary source of information about the consumer's service needs.

5.5.l. The center shall have and periodically review and revise policies for effective service delivery and protection of consumer rights and shall provide a copy or make a copy available of these policies to all new personnel.

5.5.m. The center shall implement a policy pertaining to communicable diseases affecting both consumers and staff.

5.5.n. A standard first aid kit shall be readily accessible at all times in each facility.

5.6. Personnel.

5.6.a. The center shall provide an adequate number of qualified personnel during all hours of operation to support the functions of the center and ensure the provisions of quality care.

5.6.b. The center shall not employ individuals with a conviction of abuse, neglect or mistreatment.

5.6.c. Staff providing direct care to consumers shall be persons eighteen (18) years of age or older and capable of performing the duties assigned.

5.6.d. For all staff, the center shall maintain a personnel record that includes:

5.6.d.1. The job description and application;

5.6.d.2. Identifying information and emergency contacts;

64CSR11

5.6.d.3. References;

5.6.d.4. Verification of education for staff;

5.6.d.5. Orientation and training records; and

5.6.d.6. Employee performance evaluations.

5.6.e. The center shall provide to an employee, or to his or her designee, access to his or her personnel record.

5.7. Staff Training.

5.7.a. Beginning on the first day of employment, professional and direct care staff shall be oriented and trained on treatment policies and procedures, consumer rights and the use of emergency procedures, such as crisis intervention and restraints.

5.7.b. As part of staff orientation, all direct care staff shall be trained in emergency care, first aid, infectious disease control, cardiopulmonary resuscitation and Heimlich's maneuver.

5.7.c. Employees providing services to consumers shall be trained in the proper care of the consumers to whom they will be providing services (including special needs, health and behavioral health needs) prior to, or within ten (10) days after being assigned to work with the individual. Fully trained staff shall be present until newly hired staff are fully trained.

5.7.d. The center shall have a training and development program that allows personnel to improve their knowledge, skills and abilities.

5.7.e. Staff shall be able to demonstrate the skills and techniques necessary for their jobs and provide evidence that they are qualified to perform the functions associated with them.-

5.8. Requirements for Residential Staff.

5.8.a. In residential facilities, the center shall provide onsite staff with:

5.8.a.1. Immediate access to relevant information in a consumer's records in case of a medical or other emergency; and

5.8.a.2. Assure that the center shall initiate proper procedures for the transfer to an acute care facility, a consumer who poses an imminent physical danger to themselves or others,

64CSR11

or provide adequate coverage to manage a consumer at the residential facility.

5.9. Human Rights Committee.

5.9.a. The center shall maintain a human rights committee to:

5.9.a.1. Hold meetings and keep written minutes of all meetings, including the names and titles of all members and guests present and members absent;

5.9.a.2. Report activities and recommendations, if any, at least annually to the governing body, or a standing committee of the governing body;

5.9.a.3. Review, approve (prior to implementation) and monitor individual consumer behavior plans that include aversive procedures, such as restraint and seclusion, for the control of inappropriate behaviors.

5.9.a.4. Review internal and external investigations of complaints and consumer grievances, including alleged abuse, mistreatment or neglect;

5.9.a.5. Review and approve (prior to implementation) research activities and monitor them every three (3) months, or when changes are contemplated; and

5.9.a.6. Ensure that aversive procedures are used only with the written consent of a consumer or his or her legal representative.

5.9.b. A center with fewer than thirty (30) consumers shall have a minimum of three (3) members on the human rights committee, and a center with more than thirty (30) consumers shall have a minimum of five (5) members.

5.9.c. At least one third of the committee members shall be consumers and no more than one third shall be staff of the center.

5.10. Transportation Services.

5.10.a. When transportation is provided for consumers, the center shall maintain adequate insurance coverage and follow written procedures for:

5.10.a.1. Proper maintenance of vehicles;

5.10.a.2. Adequate passenger supervision;

64CSR11

5.10.a.3. Appropriate passenger restraining systems; and

5.10.a.4. Licensure of drivers.

5.11. Quality Assurance.

5.11.a. The overall scope of the quality improvement process is described in a written plan or outline which sets forth mechanisms, committees, or other means of assigning responsibility for carrying out and coordinating quality improvement process activities, and includes: objectives and scope of the activity; methods of monitoring; reporting of results; and follow-up mechanisms.

§64-11-6. Health and Safety.

6.1. General.

6.1.a. The center shall implement programs in an environment that is safe, accessible and appropriate for the needs of the consumers.

6.1.b. The center shall provide adequate housekeeping, laundry, maintenance, storage, and other administrative support functions required to carry out its services.

6.1.c. The center shall demonstrate through infection control, emergency preparedness and other means that it identifies, monitors, reduces and eliminates health and safety risks.

6.1.d. The center shall evaluate the likelihood of exposure to blood borne pathogens for all persons likely to come in contact with blood.

6.1.e. The center shall have a written plan in case of fire, medical emergencies, natural disasters and other life-threatening situations.

6.1.f. The center shall post by the telephone in all direct care and residential service locations, emergency telephone numbers for the fire department, local police and on-call staff, and capable consumers shall be instructed on how to use them.

6.1.g. The center's services shall comply with all applicable legal requirements.

6.1.h. The center shall be in compliance with Title III of the Americans with Disabilities Act, and shall develop a plan to address the most significant issues of access, i.e., the removal of structural barriers through ramps, widened doorways and accessible parking, removal of obstructing furniture, widening of toilet stalls, installation of grab bars, and other

64CSR11

modifications that are readily achievable within the resources of the center.

6.2. Fire Code.

6.2.a. The center shall have evidence that facilities rented, owned or used for services are in full compliance with the State Fire Code.

6.2.b. The center shall conduct quarterly fire drills in its residential and daytime group setting locations, some of which shall be held during rest or sleeping periods.

6.3. Requirements for Physical Environment.

6.3.a. Water Supply.

6.3.a.1. All water supply systems shall comply with the applicable rules of the department of health and human resources.

6.3.a.2. All drinking water facilities shall be sanitary and accessible.

6.3.b. Sewage Disposal.

6.3.b.1. All facilities shall be served by an approved public sewage system or by a sewage disposal system that has been approved by the secretary according to the design standards and rules of the department of health and human resources.

6.4. Structures, Grounds, Equipment.

6.4.a. All structures, grounds, and equipment shall comply with applicable building codes and health, and the State Fire Code.

6.4.b. The center shall be kept in good repair and maintained in a clean, safe and sanitary condition.

6.5. Lighting, Ventilation, Heating.

6.5.a. By natural or mechanical means, all rooms shall provide adequate heating, illumination and ventilation.

6.5.b. The following shall be prohibited:

6.5.b.1. Unvented, fume-producing heating devices; and

64CSR11

6.5.b.2. Unprotected open heaters.

6.6. Requirements for Group Homes and Residential Treatment Facilities (24 Hour).

6.6.a. Bedrooms shall be adequately furnished and provide a minimum of eighty (80) square feet of floor space per person for one (1) person occupancy and a minimum of sixty (60) square feet of floor space per person for two (2) or more person occupancy.

6.6.b. Each occupant of a facility shall be provided a permanent, separate bed with a clean, comfortable, covered mattress, clean bedding, clean towels and other furnishings appropriate to the length of stay and needs of the occupant.

6.6.c. Each room shall be arranged in consideration of the occupants' clinical needs.

6.6.d. Each bedroom window shall have covering for privacy.

6.6.e. Furnishings shall be homelike and personalized.

6.6.f. Facilities shall have appropriate storage areas for items such as: foodstuffs, utensils, work materials, cleaning supplies, clothing, linens, medicines and toxic materials.

6.6.g. Poisons and other potentially hazardous items shall be kept in a locked place, but may be used by consumers who have been trained to use them.

6.6.h. A facility shall provide safe, comfortable and clean lavatories, bathtubs and showers, equipped with hot and cold running water and a mixing faucet to ensure a water temperature not to exceed one hundred ten (110) degrees Fahrenheit.

6.6.i. A sufficient number of safe, private bathrooms shall be available and accessible.

6.6.j. Solid waste storage shall be sufficient to contain all solid waste in a safe and sanitary manner.

6.6.k. Solid waste, including garbage and refuse, shall be removed from the premises weekly, or more often, if necessary.

6.6.l. Solid waste disposal shall comply with the applicable provisions of the state law and rules.

6.6.m. All plumbing shall meet the requirements of local plumbing codes, or in the absence thereof, the National Plumbing Code.

64CSR11

6.6.n. Grounds and structures shall be maintained free of insects and rodents of public health significance.

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

6.6.p. Food services, when provided, shall:

6.6.p.1. Meet or exceed national nutritional standards;

6.6.p.2. Be planned with regularly documented assistance of a dietitian; and

6.6.p.3. Provide well-balanced meals and snacks according to posted menus.

6.7. Consumer Grouping.

6.7.a. Within programs, groupings shall occur that:

6.7.a.1. Serve the needs of all consumers, including those experiencing a crisis who need an environment that is orderly, peaceful and respectful of a consumer's privacy; and

6.7.a.2. Provide staff to consumer ratios for adequate protection and supervision.

6.8. Consumer Records.

6.8.a. The center shall establish a process for maintaining current, easily accessible consumer records from intake through discharge.

6.8.b. The consumer records shall contain information essential to the services or treatment and include, but is not limited to:

6.8.b.1. Identification data;

6.8.b.2. Applicable social and medical information;

6.8.b.3. A summary of the assessment process;

6.8.b.4. A record of all evaluations;

6.8.b.5. Treatment plans and special treatment procedures;

64CSR11

6.8.b.6. Documentation of ongoing services provided;

6.8.b.7. Legal representative documents;

6.8.b.8. Court orders; and

6.8.b.9. A record of any signed and dated physician's orders prescribed by the center's physician.

6.9. Records Management.

6.9.a. The center shall ensure rapid access to consumer records at all times.

6.9.b. Consumer records shall be retained for a minimum of five (5) years following discharge. In the case of minors, records shall be retained until five (5) years after the consumer's eighteenth birthday.

6.9.c. Consumer records shall be released without written consent as follows:

6.9.c.1. In a proceeding under W. Va. Code §27-5-4 to disclose the results of an involuntary examination made pursuant to W. Va. Code §§27-5-2, 27-5-3 and 27-5-4;

6.9.c.2. In a proceeding under W. Va. Code §27-6A-1 et seq. to disclose the results of an involuntary examination;

6.9.c.3. Pursuant to a court order based upon a finding that said information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining the confidentiality established by this rule.

6.9.c.4. To protect against a clear and substantial danger of imminent injury by a consumer to self or to another; and

6.9.c.5. To staff of the center for treatment or internal review purposes.

6.9.d. A consumer's records shall be released only with the written consent of the consumer or his or her legal representative and only to the persons and to the extent necessary to satisfy the purpose of the release.

6.9.e. Confidentiality of records relating to a consumer's treatment for alcoholism or drug abuse shall be subject to the more protective of: Title 42, Code of Federal Regulations, Chapter I, Subchapter A, Part 2; or this subsection.

64CSR11

6.9.f. The secretary shall have full access to a consumer's records as needed in administering state and federal requirements.

§64-11-7. Consumer Services.

7.1. Program Description.

7.1.a. Each program shall have a written description that accurately describes its services.

7.1.b. When multiple service providers are involved in a consumer's treatment plan, clear, written procedures outlining each provider's responsibility will be established and made available to staff.

7.1.c. Program staff shall be supervised by a person with a master's degree in a human service or health related field. Directors/supervisors of services for children/families shall also have two years post-masters degree experience in the delivery of family services. Program administrators shall have a bachelor's degree and be supervised by a person with a master's degree in a human service or health related field.

7.2. Assessment and Planning.

7.2.a. The center shall have a formal intake process that assesses a consumer using the criteria for admission and only admits a consumer who meets the criteria.

7.2.b. Intake documentation shall include all relevant preliminary diagnostic, social, medical and legal information, and shall be signed and dated by the responsible staff person.

7.2.c. Sufficient information shall be collected during the intake process to develop a written treatment plan within seven (7) days of intake.

7.2.d. The initial assessment shall be entered in a consumer's record within five (5) days of intake interview.

7.2.e. A consumer, or his or her legal representative, shall sign a written consent prior to treatment.

7.2.f. The initial assessment shall include recommendations for further evaluation to identify a consumer's physical, emotional and behavioral needs, social strengths and preferences prior to finalization of the treatment plan; and

64CSR11

7.2.g. Psychiatric or psychological assessments, if needed, shall be conducted by an appropriate professional such as a physician, licensed psychologist or clinician under the supervision of a licensed professional.

7.2.h. Diagnoses shall be:

7.2.h.1. Written in standard language as provided in: the American Psychiatric Association's latest edition of the Diagnostic and Statistical Manual of Mental Disorders; the latest edition of the International Classification of Diseases; or the latest edition of the Classification for Mental Retardation of the American Association for Mental Deficiency; and

7.2.h.2. Based upon accepted professional standards of examinations and factual description of a consumer's symptoms and problems.

7.2.h. When additional evaluations and assessments are completed, recommendations for treatment and training shall be entered in a consumer's record.

7.3. Treatment Plan.

7.3.a. A consumer shall have a written treatment plan that considers a consumer's needs and preferences.

7.3.b. The treatment plan shall be developed within seven (7) days and finalized within thirty (30) days of intake. When a service is less than thirty (30) days, the initial assessment and treatment plan shall be developed within a shorter time frame in accordance with a consumer's needs.

7.3.c. The methods implemented shall be appropriate to a consumer's identified needs.

7.3.d. When warranted the treatment plan shall address behavior management specific to a consumer's needs.

7.3.e. The treatment plan shall include:

7.3.e.1. Identification of the treatment plan participants, which include a consumer, his or her legal representative, provider and service plan participants, and documentation of the extent of their involvement. If a consumer is unable or unwilling to participate, with the reason documented in writing, planning can be done without his or her participation;

7.3.e.2. A consumer's written consent, evidenced by his or her signature, or that of his or her legal representative, for the treatment specified;

64CSR11

7.3.e.3. Goals and Objectives;

7.3.e.3.A. Specific goals shall be based on assessments and improve or maintain the mental health and optimal adaptive functioning of the individual; and

7.3.e.3.B. Measurable objectives shall be related to the goals, have an expected achievement date and include expected outcomes for discharge, and, when appropriate, outcomes for discharge;

7.3.e.4. A description of the services, including outside services, provided to a consumer and directed primarily toward achievement of the expected outcomes, and with what frequency the services shall be provided.

7.3.f. Treatment plans for a consumer with complex needs, or for one who has experienced a significant change in functional abilities, shall be developed and reviewed by an interdisciplinary team.

7.3.g. The center shall ensure that:

7.3.g.1. A consumer is involved in treatment planning and service delivery to the extent possible;

7.3.g.2. Educational services for minors in residential programs are made promptly available;

7.3.g.3. If a consumer attends a school or day program, staff participate with the appropriate personnel in the development of the education component of the treatment plan; and

7.3.g.4. A treatment plan provides for the review of drug dosages and types and explains the rationale for changes or continuation of psychotropic drug regimens; and

7.3.g.5. Signed and dated progress notes or other documentation regarding services provided and outcomes.

7.4. Treatment Plan Review.

7.4.a. Treatment plans shall be reviewed at least every ninety (90) days by the interdisciplinary team unless otherwise specified in the plan but shall not exceed one hundred eighty (180) days. The review summarizes the amount of treatment or training provided, documents progress towards the objectives, indicates problems that impeded progress, and provides a decision to continue the same plan or to modify it.

64CSR11

7.4.b. A review or revision shall also occur at other significant times, including, but not limited to:

7.4.b.1. Admission, transfer, and discharge;

7.4.b.2. Major changes in a consumer's condition;

7.4.b.3. Crisis points; and

7.4.b.4. Transfer between services.

7.4.c. Written consent by a consumer, or his or her legal representative shall be obtained and recorded in the treatment plan. If written consent is not obtained, the record shall indicate why the written consent was not obtained.

7.5. Consumer Discharge.

7.5.a. Discharge planning shall follow the treatment plan.

7.5.b. A written discharge summary shall be entered in a consumer's record within thirty (30) days of discharge and include:

7.5.b.1. The reasons for discharge;

7.5.b.2. A consumer's status and condition at discharge;

7.5.b.3. A final evaluation summary of a consumer's progress toward the goals set in the treatment plan;

7.5.b.4. A plan developed in conjunction with the consumer, when available, for care after discharge and for follow-up; and

7.5.b.5. The signature of the staff completing the summary.

7.6. Behavior Intervention.

7.6.a. Program and direct care staff shall be trained in behavior management, including methods of de-escalating volatile situations and of using nonphysical techniques in such situations, to deal appropriately with aggressive or out of control behavior.

7.6.b. The center shall develop and implement policies and procedures, such as time-

64CSR11

out, seclusion and restraints, for interventions in working with behaviors that are interfering with the consumer's ability to function socially or personally. All behavior intervention plans shall:

7.6.b.1. Be based on a functional analysis of the behavior;

7.6.b.2. Include positive programming to teach a consumer adaptive, more effective behavior;

7.6.b.3. Ensure that a consumer does not discipline another consumer; and

7.6.b.4. Ensure that seclusion and physical restraints are used only as a last resort and used only as long as necessary to manage behavior.

7.6.c. For a consumer for whom a behavior intervention plan is appropriate, the treatment plan shall specify the rationale, the behavioral objective and the methods to be used in treatment, and the data to be collected to assess progress towards objectives.

7.6.d. The center shall ensure that the environment in which the program operates is free from:

7.6.d.1. Conditions that promote maladaptive behavior;

7.6.d.2. Aversive stimuli such as corporal punishment or use of electric shock devices; and

7.6.d.3. Behavior interventions that involve withholding nutrition or hydration, or that inflict physical or psychological pain.

7.6.e. Protective devices may be ordered by a physician to treat a medical symptom or condition for a specified and limited period of time;

7.6.f. When a psychiatric emergency exists and less restrictive measures are not effective, the center may utilize intrusive measures such as the administration of medication, seclusion or mechanical restraints until the crisis is resolved or the consumer can be transported to an inpatient facility.

7.6.g. A consumer shall not be placed in seclusion or a mechanical device used as a physical restraint until he or she is either: examined by an attending physician or other licensed professional, and a discussion is held between a member of the professional staff and available interdisciplinary team members; or a physician or other licensed professional has ordered by telephone these interventions after a member of the professional staff has discussed the situation

64CSR11

with the available interdisciplinary team members.

7.6.h. No seclusion or restraint order shall be valid for more than three (3) hours; but if ordered for longer, the interdisciplinary team shall review a consumer's status and develop a written plan for responding to a consumer's needs.

7.6.i. PRN (as needed) orders for seclusion shall not be permissible.

7.6.j. A consumer in seclusion shall be observed at least once every five (5) minutes and assessed for continued need.

7.6.k. A consumer shall have access to fluids and to the toilet hourly.

7.6.l. Seclusion shall not be used for the treatment of mentally retarded or developmentally disabled consumers.

7.6.m. The center shall ensure that the application of physical restraints does not cause physical pain or damage to a consumer.

7.6.n. When emergency control measures are used, a detailed report shall be written, describing the incident and the rationale for the emergency measures.

7.6.o. Behavior intervention shall be monitored and altered if side effects such as illness, severe physical or emotional stress, or damage occurs or is likely to occur.

7.7. Critical Incidents and Crisis Management.

7.7.a. The center shall maintain a system for critical incident reporting and demonstrate that it uses the system to improve treatment planning and services.

7.7.b. Personnel shall immediately notify a supervisor of any critical incident and clear other consumers from the area.

7.7.c. Unless a consumer is in immediate danger to self or others, staff shall implement the least restrictive methods of crisis management. If less restrictive methods do not work, staff shall intervene until the crisis is resolved or other alternatives are established.

7.8. Medical and Psychiatric Emergency Services.

7.8.a. The center shall have policies and procedures for handling medical and psychiatric emergencies that ensures:

64CSR11

7.8.a.1. Communication with the nearest medical emergency service, hospital and police;

7.8.a.2. A twenty-four (24) hour telephone response system, toll-free to a consumer; and

7.8.a.3. Adequate recording of the emergency and follow-up.

7.9. Emergency Medical and Psychiatric Services in Residential Treatment Facilities:

7.9.a. The center shall respond to a consumer's needs twenty-four (24) hours a day, seven (7) days a week, including providing appropriate triage for a consumer who poses a danger to self or others.

7.9.b. The center shall provide the onsite staff with immediate access to relevant information in a consumer's records in the case of an emergency.

7.9.c. Written policy shall be developed and implemented for the treatment, referral and follow-up of a consumer who attempts or threatens suicide or homicide, or commits or threatens assault.

7.10. Medication Services.

7.10.a. The center shall develop a process for the administration, storage and accountability of all medication, that includes provisions for a medication administration record procedure and is in compliance with state and federal requirements.

7.10.b. The process for prescribing and administering medications shall ensure:

7.10.b.1. That all orders for medications are reviewed at least every ninety (90) days by the physician;

7.10.b.2. That psychotropic drugs are ordered only as part of the treatment plan and with documentation of the diagnosis and the specific behaviors that indicate a need for the medication and the rationale for its choice;

7.10.b.3. That all medications are administered in compliance with the physician's order and State law; and

7.10.b.4. That medication errors, as defined by this rule, and adverse drug reactions are reported immediately in accordance with written procedures, including properly recording it

64CSR11

in a consumer's record and notifying the physician who prescribed the drug.

7.11. Medication Management.

7.11.a. The center shall note changes in a consumer's condition, including adverse reactions, as a result of receiving a medication.

7.11.b. A consumer to the extent capable shall administer his or her own medication.

7.11.c. The center shall provide locked storage for the medication that is not administered by consumers.

7.11.d. The center shall inform a consumer, or his or her legal representative, about the medication prescribed: the dosage, purpose, possible side effects, effects of not taking the medication; and about alternate treatments and their effects;

7.12. Group Homes and Residential Treatment Services (Adult and Minors).

7.12.a. The service shall have rules of conduct for consumers to follow while in residence.

7.12.b. The residents shall be provided foods that promote healthful living.

7.12.c. Onsite staff shall ensure that each resident receive training and practice good habits in personal care, hygiene and grooming.

7.12.d. Residents who require twenty-four (24) hour staffing shall not be left unattended during normal sleeping hours.

7.12.e. Residents shall be referred for ongoing mental health service and assisted in keeping appointments and participating in treatment programs. Documentation of referrals shall be kept in a consumer's record.

7.13. Residential Treatment Services for Minors (24 Hours).

Programs and services for minors are child-centered and family-focused with integrated therapeutic and educational interventions that respect the child's developmental process. Programs and services for minors recognize the central importance of the child's family relationships in the treatment process and shall involve, to the extent possible, parents or caretakers in the intake and treatment planning process, implementation and evaluation.

64CSR11

7.13.a. Services shall have policies and procedures that describe:

7.13.a.1. Type of service or program;

7.13.a.2. Treatment modalities available; and

7.13.a.3. The level of family/guardian or legal representative involvement expected.

7.13.b. The discharge process includes: child and family/guardian or legal representative involvement, personnel responsible for discharge decision and provisions for aftercare.

7.14. Shelter Services for Minors.

7.14.a. The shelter shall meet basic emergency residential needs of a child in a community-based, open facility that ensures a safe living environment and provides an organized program of activities and counseling based on the intake assessment of the child's needs, interests and skills.

7.15. Partial Hospitalization Programs.

7.15.a. Within the confidentiality provisions of this rule, and unless it is documented in a consumer's record that it is clinically inappropriate, a partial hospitalization program shall provide general information related to mental illness, treatment, diagnosis and prognosis, and shall involve family members or significant others.

7.15.b. The clinical supervisor of a partial hospitalization program shall be onsite at least twice weekly and shall monitor the program sufficiently to ensure familiarity with the services, the consumers and their needs and capabilities and with the roles and abilities of the staff.

7.15.c. The center shall ensure on-call availability of a supervisor when one is not onsite.

7.15.d. The goal of treatment programs for minors shall be the return of students to school and shall be supported by transitional activities such as visits to the local school and classroom experiences that encourage students gradual integration.

7.15.e. Treatment plans shall be current and have evidence of daily attention by clear, legible, behavior-related notes on a consumer who attends the partial hospitalization program for

64CSR11

that day. The notes shall be related to a consumer's objectives and provide the basis for the treatment plan review.

7.16. Staffing for Partial Hospitalization Programs.

7.16.a. The partial hospitalization program shall comply with the following staffing requirements:

7.16.a.1. Minors: One (1) staff member for every five (5) children and at least one (1) mental health staff member who is qualified to provide psychotherapy services and who does not have a caseload larger than twelve (12) consumers, shall be provided.

7.16.a.2. School-Based Minors: The staff shall include teachers, teacher's aides and treatment staff in school-based programs in which the treatment and educational needs of the children are met together in a school room.

7.16.a.3. Adults: One (1) staff member for every six (6) adults shall be provided.

7.17. Educational Programs.

7.17.a. If the center provides an educational component to its programs onsite, it shall provide:

7.17.a.1. An education director, staff, and staff ratios that meet the state requirements of the department of education; and

7.17.a.2. Educational services designed to maintain the educational and intellectual development of a consumer.

7.17.b. Clinicians shall confer periodically with teachers or principals on the progress of a consumer.

7.17.c. There shall be documentation in a consumer's record of periodic evaluations of educational achievement in relation to medications and psychotherapeutic needs.

7.17.d. An appropriate teacher to consumer ratio shall be provided so that teachers can give special attention to consumers at different stages of treatment and education.

7.17.e. The educational facility shall have space, an adequate number of classrooms and materials commensurate with the scope of its activities.

64CSR11

§64-11-8. Consumer Rights.

The protection of civil rights for consumers with disabilities is of extreme importance. Special attention and efforts are essential to ensure that a consumer's human and civil rights are promoted, exercised and protected.

8.1. Basic Rights.

8.1.a. A consumer shall have rights including, but not limited to:

8.1.a.1. The right to treatment and services that support a consumer's liberty and result in positive outcomes to the maximum extent possible;

8.1.a.2. The right to treatment and services in the least restrictive, most appropriate and potentially most effective setting;

8.1.a.3. The right to an individualized treatment plan as defined under this rule;

8.1.a.4. The right to ongoing informed participation in the treatment plan process;

8.1.a.5. The right to refuse treatment at any time;

8.1.a.6. The right to a legal representative when unable to act on his or her own behalf;

8.1.a.7. The right to be free from involuntary experimentation;

8.1.a.8. The right to freedom from restraint or seclusion. Restraint and seclusion shall only be used in situations where there is imminent danger to the consumer or others and all less restrictive methods of control have been used;

8.1.a.9. The right to a humane treatment environment in which personal dignity and self-esteem are promoted;

8.1.a.10. The right to confidentiality of records, as provided in this rule;

8.1.a.11. The right to access his or her own consumer records in accordance with state law;

8.1.a.12. The right to assert grievances, orally or in writing, with respect to the infringement of all rights, including the right to have all grievances considered in a fair, timely

64CSR11

and impartial procedure;

8.1.a.13. The right of access to an available advocate in order to understand, exercise and protect his or her rights;

8.1.a.14. The right to be informed in advance of any charges for services,;

8.1.a.15. The right to all available services without discrimination because of race, religion, color, sex, sexual orientation, disability, age, national origin, or marital status;

8.1.a.16. The right to exercise his or her civil rights;

8.1.a.17. The right to referral, as appropriate, to other providers of behavioral health services;

8.1.a.18. The right to be free from physical, verbal, sexual or psychological abuse or punishment;

8.1.a.19. The right to be free from unnecessary or excessive medication;

8.1.a.20. The right to medication that is not used as punishment, for the convenience of staff, as a substitute for programming, or in quantities that interfere with the treatment program;

8.1.a.21. The right to be free from uncompensated labor, except for consumers in residential facilities who perform housekeeping tasks; and

8.1.a.22. The right to be informed orally, in writing and in appropriate language and terms, of the rights described in this section;

8.1.a.23. A residential consumer shall have:

8.1.a.23.A. The right to be housed with consumers of the same approximate ages, developmental levels and social needs;

8.1.a.23.B. The right to unimpeded access to his or her attorney or religious advisor;

8.1.a.23.C. The right to constant access to his or her personal possessions unless contraindicated by treatment needs; and

64CSR11

8.1.a.23.D. The right to private communication with others by mail, in person and by telephone.

8.1.b. Rights and personal liberties may be limited by established policies and procedures when the limitation of the right is clinically appropriate and clearly justified in writing.

8.1.c. A consumer's rights and responsibilities shall devolve only to a legal representative as defined in this rule and to the extent that the legal representative's acts are not hostile or adverse to the best interests of a consumer. This provision does not relieve the center of the responsibility of informing a consumer as required by this rule, to the extent that a consumer is capable of understanding the matter, nor does it in any way deprive a consumer of his or her legal rights granted under State or federal law;

8.2. Violation of Consumer Rights.

8.2.a. A consumer, an employee, or any other individual may make a complaint to the center. A supervisor shall report to the administrator within twenty-four (24) hours regarding all violations, or suspected violations, of a consumer's rights, except in the case of physical abuse for which immediate notification shall be made.

8.2.b. The administrator shall initiate a thorough investigation within twenty-four (24) hours after receiving a report of a life-threatening complaint, and within three (3) business days for other complaints. Within a reasonable time period the administrator shall provide a written report to the human rights committee of his findings and of the actions taken to prevent further occurrences. A consumer or consumers shall be identified by case number only.

8.2.c. The center shall make a notation of the incident and the effect of the incident on a consumer's illness or treatment in a consumer's record.

8.2.d. If the administrator's findings and actions on behalf of a consumer regarding a violation of the consumer's rights is unfavorable, insufficient or not forthcoming within a reasonable time, the consumer, or his or her legal representative, may appeal to the governing body of the center, the State licensure body, the West Virginia advocate or other appropriate resource.

8.3. Serious Injury or Death Reports.

8.3.a. The center shall investigate any incident that results in serious injury or death, report it to appropriate authorities and to the secretary, and keep a written report on it.

64CSR11

§64-11-9. Substance Abuse Services.

9.1. Public Inebriate Shelter Services.

9.1.a. Trained personnel shall screen a consumer to determine his or her need for medically monitored detoxification or for referral to acute medical care.

9.1.b. The shelter shall monitor a consumer at not less than fifteen (15) minute intervals for the first four (4) hours following admission, and each hour thereafter, and provide:

9.1.b.1. A documented evaluation of a consumer;

9.1.b.2. Documentation of vital signs taken every four (4) hours; and

9.1.b.3. Documentation of any changes in withdrawal symptoms.

9.1.c. A shelter shall not discharge a consumer to a responsible adult until after an evaluation is complete, unless there are unusual circumstances, e.g., transfer for medical or security reasons.

9.1.d. A shelter shall not discharge a consumer unless the committing authority has approved the release or until a consumer's blood alcohol count is below .05, and there is no observable indication of intoxication.

9.1.e. If a consumer leaves the shelter prior to being discharged, the referring court and the sheriff's office shall be notified.

9.1.f. The shelter shall inform a consumer of alternative services and, upon a consumer's request, assist in arranging follow-up appointments.

9.1.g. The shelter shall submit recommendations to the court as required for the disposition of publicly inebriated individuals.

9.2. Detoxification Services.

9.2.a. The center shall perform a physical examination and screening at a consumer's intake to determine the need for medical services.

9.2.b. A physician shall be available for medical consultation twenty-four (24) hours per day, seven (7) days per week.

64CSR11

9.2.c. During the withdrawal process, qualified personnel shall maintain contact with a consumer regarding the consumer's detoxification protocol.

9.2.d. The center shall provide counseling designed to motivate a consumer in the treatment process and give emotional support during withdrawal from substances.

9.2.e. The center shall refer a consumer to a more intensive level of medical care if screening and medical examination indicate that more intensive medical monitoring or management is required.

9.3. Residential Substance Abuse Services.

9.3.a. The center shall ensure the availability of a physician for medical consultation twenty-four (24) hours per day, seven (7) days per week.

9.3.b. The center shall ensure the availability of onsite nursing staff sufficient to address the assessed medical needs of a consumer.

9.3.c. The center shall maintain policies and procedures to handle contraband substances brought into the residential facility.

§64-11-10. Penalties.

10.1. The secretary may deny the center's application for licensure or licensure renewal; revoke or suspend a license; order an admissions ban, a reduction in consumer census or in licensed bed capacity of a residential program for one (1) or more of the following reasons:

10.1.a. The secretary makes a determination that fraud or other illegal action has been committed;

10.1.b. The center has violated federal, state or local law relating to building, health, fire protection, safety, sanitation or zoning;

10.1.c. The center conducts practices that jeopardize the health, safety, welfare or clinical treatment of a consumer;

10.1.d. The center has failed or refused to submit reports or make records available as requested by the secretary; or

10.1.e. A facility has refused to provide access to its location or records as requested by the secretary.

64CSR11

10.2. If a license has been revoked, the secretary may stay the effective date of revocation by no more than ninety (90) days if the center can show that the stay is necessary to ensure appropriate placement of consumers.

§64-11-11. Administrative Due Process.

11.1. Any person aggrieved by an order or other action by the secretary based on this rule, or W. Va. Code §§27-9-1 or 27-17-1 et. seq., may request in writing a hearing by the secretary in accordance with the Division of Health rule, "Rules of Procedure for Contested Case Hearings and Declaratory Rulings," 64CSR1, a copy of which may be obtained from the Secretary of State.

PUBLIC COMMENTS AND DEPARTMENT RESPONSES

Behavioral Health Centers Licensure, 64CSR11

General Comment: This rule is vague and non-specific and will permit subjectivity on the part of the Secretary, which opens the door for potential contested findings. There was no provider input into this Rule. Suggestion is to withdraw the Rule and establish a committee to include providers so that meaningful input may be given.

General Comment: The Rule as proposed needs to be further modified to add clarification to a number of sections. The potential for contested findings is significant with the Rule as it now stands. Further, the Rule should be more integrated with other rules, specifically the Behavioral Health Consumer Rights Legislative Rule 64CSR74. The use of common definitions for abuse and neglect would allow for uniform implementation. There is a need for common consumer rights requirements that are either reported in both rules or are cited in one rule referencing the other. One should cite the other. Further recommended that a complete list of consumers' rights in the form of a Bill of Rights be developed that would meet both standards. It is suggested that the Department withdraw the Rule and establish a committee consisting of consumers, providers and the Department to review and suggest modifications of the Rule. The committee process was successfully used in rewriting 64CSR74 to include providers, consumers and the Department.

Response: The proposed rule is very similar to a rule that was sent out for comments on July 29, 1996. At that time, comments from the providers were addressed, many of them by incorporating the suggestions into the rule. At that time, there were no suggestions to withdraw the rule. With a few changes and additions in content, and a thorough editing by the regulatory editors, we believe the body of the Rule is not that dramatically different from what the requirements are currently with certain areas addressed to provide for the variety of different services licensed under the Rule. The rule, as written, is an attempt to bring the language and essential requirements of the current rule (CSR 64) into contemporary language, and to forego "process" into more "outcome" measurable content. This is in keeping with national trends in mental health regulatory bodies. In fact, the rule was reviewed in 1996 by a national mental health consultant who made many of the suggestions not to be so prescriptive. We do not agree that the Rule should be withdrawn. With the addition of approximately 56 more centers offering services than in 1990, it is essential that a Rule be drafted that addresses this number and variety of new services. By incorporating the following comments that are applicable, we believe the rule will fulfill its purpose.

General Comment: Fiscal Note 4B: The Department claims no economic impact. With the CIB requirements alone, there is a minimum charge of \$10.00 per person - with over 200 new employees last year, suggest department request input on the potential financial impact.

Response: There has been no change to the initial and reprocessing fee of \$10.00 for a behavior health license. See changes to rule at 5.6.e deleting the specific requirement for CIBs..

General Comment: The concept of "a variance" needs to be included and its definition. "A declaration that a rule may be accomplished in a manner different from the manner set forth in the rule." This is especially important as this rule contains much more general and vague language. Note that at 4.1.e.3.B.4, Variance and Waiver (see below) are referenced.

Response: See additional definitions at 3.50 and 3.52.

General Comment: The issue of dual licensing though a reality is not defined in this document. The issue of operating with different standards from two state bodies is of great concern.

Response: This issue is not relevant to these standards and should be addressed through Department policy.

General Comment: WV Code, Section 49-2B requires that all settings wherein children reside must be licensed as child care facilities. The present draft regulations then would be superimposed only on licensed child care facilities which desire to participate in Medicaid funding. I believe the proposed regulations should in some manner address this statutory requirement as a "threshold to eligibility for a Behavioral Health center License."

Response: The Application of this rule, as noted at 2.1, applies to a "center" that offers services for the care and treatment, etc. A center is defined at 3.7 as "an entity that provides behavioral health services." There is no stipulation that these requirements only apply if a center is funded by Medicaid. Comment is not clearly understood. The child care centers were incorporated under CSR Title 64 of the Legislative Rules for Behavioral Health Centers in 1990 by removing such entities from the exceptions at 3.3 (current rule).

General Comment: These regulations do not pertain to such settings as Inpatient Psychiatric Unites. I would recommend that the proposed rule governing behavioral health centers should address this (reporting) mandate.

Response: Since this rule does not apply to inpatient psychiatric centers (note exceptions at 3.7.b) there would be no reason to address this request.

General Comment: the rule as proposed mixes services, locations and facilities together and assumes that services will be reviewed wherever they may be provided. Review of individual consumers or groups of consumers are contingent upon the consumer's willingness to participate. The rules and regulations will need to assure that the consumer's rights are protected even during a licensing review process.

Response: Agree. Note addition to 4.3.b.4: "Consumer's right to not participate in interviews unless willing will be protected."

General Comments: The definitions used for Abuse, Neglect and other terms in common with consumer rights should have the same definitions in order to avoid confusion and misinterpretation.

Response: It is not necessary to have consistency between the two rules. The purposes of the Consumer's Rights is different from the centers' rule.

General Comment: After reading the comments, it was decided that reference to time-out needed to be retained from the current rule. The following will be included at 7.6.c: When a time-out procedure is used, staff shall document in the consumer's record the reason for the removal, and at 7.6.d, "When time-out procedures are used, the consumer shall be monitored by staff at all times and the consumer shall be returned to the situation from which they were removed as soon as they have regained control of their behavior. 7.6.e: "If interventions, such as time-out, restraint or seclusion occurs three (3) days in a week or three (3) weeks in a row, a treatment plan to manage the inappropriate behavior shall be designed. The plan shall designate the maximum times for the use of time-out. When time-out exceeds fifteen (15) minutes, the plan shall be approved by the human rights committee prior to implementation.

General Comment: Overall, we found the proposed regulations to be somewhat vague, leaving a lot to personal interpretation.

Response: Hopefully, the changes made following comments will remedy this.

General Comment: I had a difficult time identifying what was new or different in the regulations. Usually when proposed changes occur the reader can identify those changes by the way they are highlighted or otherwise identified. It was difficult to leaf through copies of OFLAC and Child Caring regulations at the same time and identify if there was a change or not.

Response: Note on the summary of the rule that the rule repeals and replaces the existing rule. Consequently, the whole rule would be highlighted to indicate changes. These rules did not change, or revise the Child Care regulations.

§3.1.a

Comment: The definition of physical and verbal abuse should be the same as in the WV Code. If the “higher level of care” is to be defined here, then that standard needs to be clearly identified.

Comment: Definitions are not consistent with Chapter 49. Should not licensure definition be the same for consistency?

Response: This definition is taken from the Health Care Finance Administration’s term used across all health care entities: hospitals, nursing homes, etc. According to Regulatory Development, if the intent is in the code, the wording does not have to be the same.

Comment: “Unnecessary or improper use of physical restraint” is vague.

Response: “Unnecessary means unessential, “improper” means not suitable or right. The times and proper usage of restraints is addressed elsewhere.

Comment: “Use of unnecessary force” is vague. “Inappropriate removal from a treatment program” needs deleted. Treatment programs may determine that a client is not appropriate for the program, and need immediate discharge. This should not be defined as physical abuse.

“Restriction of communication or withdrawal of privileges” should not be defined as physical abuse.

Response: Agree definition is too cumbersome. Definition will omit 3.1.a.1 - 3.1.a.9. Because of the removal of parts of the definition of abuse at 3.1.a.6, the following regulation will be added to the rule at 7.6.n: “Consumers shall not be removed from a therapeutic program as a form of punishment. When consumers lose control of their behavior to the extent that participation constitutes a danger to themselves or others, they may be removed from the treatment program, in which case staff shall attempt to assist the consumer to a level of functioning that allows participation, or design a new treatment plan to fit the consumer’s needs. Also, privacy of communication is addressed at 8.1.a.23.D.

§3.1.b

Comment: Psychological Abuse - Because this is a new licensure definition, is this a term-of-art? Could the types of abuse included here be put under “verbal abuse” as effectively?

Response: This type of abuse could be verbal, however, many forms of psychological abuse are non-verbal.

§3.4

Comment: The consequences that are indicated in this standard are narrow in scope and do not

reflect the full range of therapeutic alternatives that may be appropriate. The standard should state that any adverse procedure utilized to decrease inappropriate behaviors must be included as a part of the consumer's treatment plan except in the case of an emergency.

Response: A definition is just that, it determines the meaning of a word. What this suggests is that the "process" for aversive procedures be in the definition. Please see 7.3.c and 7.3.d which require that the methods used to implement a treatment plan be appropriate to his needs, and, the plan shall address behavior management. Emergency use of aversives is addressed at 3.36. The use of aversives is not prohibited. Also addressed at 5.9.a.3 which requires the Human Rights Committee to review.

§3.12

Comment: Critical Incidents definition of: 1) "behavior that will likely lead to..." need parameters and 2) "major involvement with law enforcement authorities" needs defined.

Response: 1) Behavior is self-defined as any overt manifestation of body movement that could potentially cause harm. 2) Not parking tickets, but arrest for assault, etc.

Comment: "Serious consequence resulting from an apparent error in medication or dietary administration" need clarified."

Response: Change to: "A consequence requiring medical treatment resulting from an apparent error in medication or dietary administration;"

§3.18

Comment: This term may need to be further explored and more specific in explanation. Functional Analysis means different things to different people especially to the Office of Medical Services. That office makes reference to an antiquated method of behavioral analysis, but refers to it as functional analysis. I think this could cause confusion.

Response: Will include in the wording: "A comprehensive assessment process that includes at least: an analysis of problem behavior, a history of the problem, the antecedent, and consequence of the behavior and an hypothesis as to the function of the behavior."

§3.22

Comment: Informed Consent. This appears to call for an assessment and a judgment to be rendered at the time of informed consent about the capacity of an individual to give consent. Suggest - "That a consumer has or does not have the legal capacity to give informed consent.

Response: Agree. Will make a change to suggested definition.

§3.22.a

Comment: Informed Consent. This appears to call for an assessment and a judgment to be rendered at the time of informed consent about the capacity of an individual to give consent. Suggest - "That a consumer has or does not have the legal capacity to give informed consent."

Response: Agree. Wording will be changed.

§3.27.

Comment: "Inappropriate application of behavior intervention" needs deleted. If there is

concern about hand on approaches, then that is really a physical abuse issue. If the issue is other than that then it needs to be reflected accordingly.

Response: Agree. In keeping with HCFA's definition, sentence deleted.

§3.29

Comment: Partial Hospitalization - This is a definition that presumes one knows with a PH program is like in an inpatient setting. Suggest using the Medicare definition, "A comprehensive structured program that uses a multi-disciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders. A Partial Hospitalization program is designed to treat consumers who exhibit severe or disabling conditions related to an acute psychiatric/psychological condition or an exacerbation of a severe and persistent mental disorder."

Response: Will be changed to wording in comment.

§3.31

Comment: A wonderful idea with no method of reimbursement. Medicaid regulation is very specific about what is reimbursable if providing behavior management.

Response: Positive programming should be built into any behavior management plan, regardless of reimbursement. If an individual is showing anger by aggression, he should be taught to verbalize his anger. Otherwise, there is no use for the plan.

§3.35

Comment: Protective devices are more than the current definition indicates. Suggest a language change to "Protective Device-any appliance or device that helps protect a consumer from injury or that is used to aid in the healing of an injury. Appliance used may include a brace, pad, helmet, covering, bandage, etc."

Response: A protective device is a medical restraint used in the healing process.. Devices used to protect from injury are included in the definition of physical restraint in 3.39.b. A helmet could be either, depending on the purpose for which it is used.

§3.42

Comment: Semi-independent Living Facility - Does not make any distinction between a Center owned facility and a non-center owned facility. Suggest adding the phrase, "An apartment or home owned by the Center that..."

Comment: A private home is not a facility yet services may be provided in apartments or private homes.

Response: Term has been deleted.

§3.44

Comment: Staff - Vague. Centers use a variety of means to secure and provide services and in some form or the other pays all of these. Suggestion" "Individuals hired directly by the center and placed on the Center's payroll system to provide Behavioral Health Services."

Comments: All persons paid by the center are not staff. Employees paid by the center are staff. Recommend changing the language to reflect "Staff-Employees paid by the center to provide services."

Response: In determining whether consumers needs are being met through the center's services, whomever is directly involved with providing the care or treatment that is paid by the center is considered "staff" and should be held accountable. Additionally, some personnel do not work with consumers to provide services. We believe the definition is adequate.

§3.48

Comment: Consumers receive either or both habilitative and rehabilitative services. Suggest rewording to reflect the option. Suggest, "Treatment - "A broad range of planned habilitative and/or rehabilitative services."

Response: Agree. Change will be made.

§ 3.49

Comment: The work "all" connotes an exhaustive, definitive, all-inclusive list of services. Please delete it as a treatment plan is not for this purpose. It is to identify only those specific, limited services that will meet the goals and objectives.

Response: The regulation requires that all services required to support the goals and objectives be listed on the treatment plan. If the goals and objectives are specific, then it follows the services would be also.

Comment: The treatment plan should reflect all the services, programs and activities currently being implemented. Should also add "agreed to by the clients."

Response: Agree to add "currently." The provision of agreement by the client is addressed at 7.3.e.2.

§3.50

Comment: Volunteers may not meet "employment qualifications", but the agency may have "volunteer qualifications". If there is a concern that volunteers need to be screened in the manner of employees, then can't we identify that?

Comment: Volunteered should be afforded the opportunity to receive training . Suggest rewording to "Volunteers should meet all the qualification for the services they are providing and should be afforded the opportunity to receive health, safety and training appropriate to their functions."

Response: The requirement require training, and that volunteers be healthy and at non-risk. This isn't too much to ask. The center may have other qualifications, which would be addressed at 5.5.f. Wording stays the same.

§3.7.g

Comment: What is a specialized family care home?

Response: Those homes that are not under the direction of a licensed entity.

§3.7.k

Comment: Does this include WV Children's Home?

Response: Yes.

§3.24

Comment: Where is DHHR defined? If it is under (j) a parent or guardian of a minor, it is not

clear who would make the decision.

Response: This section is taken from the codes listed and is required to be in the rule. During the time the child is in the custody of DHHR, the Department is the legal representative.

§3.39

Comment: What is the difference between a Mechanical device and a mechanical support. One is allowed and one is not.

Response: A mechanical device is defined at 3.39 - a type of restraint. A mechanical support can be a medical necessity, such as a wheel chair, body brace, etc. and would only be used by a physician's order. See 3.25.

§4.1.a

Comment: Type of license should be defined.

Response: Since the name of the rule is "Behavioral Health Centers Licensure" it would seem apparent.

§4.1.d

Comment: States that an expired or invalid license be surrendered. What is an otherwise invalid license and why should an expired license be surrendered?

Response: If an aversive action has been taken and a license revoked, or a provisional license issued in lieu of a full license, the original license would be invalid. It would only be surrendered if the Secretary wanted it to prevent services from being provided from an unlicensed entity.

§4.1.e.2.A.

Comment: The process for initial application will need to be outlined further. The time line for site review and initial provisional license should be made clear.

Response: This is office procedure and should not be regulatory. There is no initial provisional license. There is an license that is issued for 6 months. 4.1.e.3.A. requires that no license be issued unless an inspection has been made.

§4.1.e.2.E

Comment: What fee:

Response: The licensure packet, for initial and re-newal, sets a \$10.00 fee for processing.

§4.1.e.2.C & 1

Comment: Amended applications would allow for changes in location, intensity and capacity with only notification to the secretary and does not address the certificate of need process, which would allow flexibility to current providers to expand. The license should expire when indicated, and be re-issued after application and review. The ability to grant a waiver should be defined more clearly than "application would be impractical" and "not detrimental".

Response: Note that the regulation only applies to "amended license applications," not an amended license. The rule does not address the Health Care Authority's role mainly because most new or revised services for licensed centers do not currently require a CON. The reason the office needs to know when these changes are made are two-fold: Our data system needs to be

current (this is used by HCA) and many sites are “clinical,” meaning, the physical site is required to be licensed for Medicaid billing purposes and in these cases, it would not be feasible to wait until the next licensure process. Residential sites are usually added to the license at this time. However, most other services are changed at the renewal time.

§4.1.e.2.C.2

Comment: Too vague. There is no guidance as to what change in intensity reaches the threshold of a “change.”

Comment: There would need to be clear guidelines as to what constitutes the changes indicated in this standard. The change of location is clear while the change of location of service may be subject to interpretation, as well as intensity.

Response: Agree the change in intensity is vague. This would not be a change that would indicate a change in licensure. Deleted.

§4.1.e.2.D

Comment: The identification of a senior management staff should not be part of initial or renewal license.

Response: Agree. Deleted.

§4.1.e.3.B

Comment: Indicates that a provisional license can not be reissued but does not indicate what should happen if a center is not in substantial compliance.

Response: The regulation states that a provisional license “will” be issued if not in substantial compliance. A report will be sent to the center if this be the case, and a plan of correction, if approved by the Secretary, is expected to be implemented. If the center is not in substantial compliance on the follow-up review, then, chances are, the provisional will not be reissued. So there can only be one instance of “non-substantial compliance.” consecutively. This rule has been in force since 1984.

§4.1.e.3.B.1

Comment: There is not a definition of consumer participation. Does it mean consumers participating in the planning of the program or receiving the program. The Rule will need to be clear as to what consumer participation means and what constitutes sufficient.

Response: Since there is no regulation that requires consumers to participate in the planning of a program, the obvious answer would be participating in the program. If there are no consumers, and a center cannot open a site without a license, there would be no consumer participation in the program. Additionally, it is not required to define words that ordinarily are used the same as in the dictionary.

§4.1.e.3.B.2

Comment: What is the difference when a provisional is given for amended and renewal?

Response: Mistake in wording. Sentence shall now read: “A provisional license shall be issued when a center seeks a renewal license...”

Comment: Unless the provisional is given by the state fire marshal. This is confusing.

Response: This means that the fire marshal can give two provisional recommendations followed by a provisional license and this can be done consecutively.

§4.1.e.3.B.3

Comment: how much compliance is substantial?

Response: The agency has not elected to frame points, or levels of compliance as other units in have, such as personal care home. This wording is in the current regulations and has served well to base a center's non-compliance on. Scope and severity are used as the compliance basis.

Comment: Renewal and amended are vastly different. Should these be defined somewhere:

Response: To avoid confusion, 4.1.e.2.C will be moved to 4.1.e.3.B.4 and read as so: An amended license shall be issued upon application when the center: Changes the geographic location of a service or facility or adds a new service site.

Comment: It appears that their belief is that a provisional is issued when a center seeks an amended license. That is not always the case, at least, not for us.

Response: Please note, the mention of the word "amended" is under section "Application Submission," and the provisions address an initial, renewal and renewal application. It does not address the issuance of a license. Under "Issuance," three types of license are mention, initial, renewal or provisional. Centers do not apply for a "provisional" license. This may is issued after a survey, complaint or based on the fire marshal's report.

4.2

Comment: This section allows the Secretary to substitute her judgement on the siting of a residential treatment facility for that of the Board. This rule expands the Secretary's authority beyond this scope and should be modified to remove judgment. The Secretary's authority does not give her the right to intervene or assert an interest in a Center before it is established, only after a Center files for a license. Tense is present, not future. Should be deleted or modified to conform to the Secretary's more limited authority.

Response: In different wording, this same requirement is in the CSR 64 current regulations. The obvious understanding is this is for already licensed centers who wish to build a facility that is to be licensed, in which case the plans should be inspected prior to construction (this has been the case since the current regulations were written). And also, for extensive renovations to already existing sites (also the case since regs were written).

Comment: The governing body must determine the appropriate services and must be responsible for center owned facilities. The purchase of land, the design and construction are the responsibility of the governing body. Establishing standards for construction, etc, is the state's responsibility. Pre-site approval goes beyond the licensure standards.

Response: See response above.

§4.2.a

Comment: It this necessary for licencing:: The secretary actually going to all proposed sites all sites being renovated seems burdensome and time consuming.

Response: Yes, it is necessary.

§4.1.e..B.4

Comment: A waiver or variance. At whose determination is one or the other used?

Response: See addition of waiver and variance at 3.50 and 3.52.

§4.2.a

Comment: Taken literally, the Secretary shall inspect the addition of a storage building to a residential treatment facility.

Response: Only if the center wants that building licensed.

Comment: Identifies the Secretary (not her/his designee) as having to inspect new locations for all residential treatment facilities. Will it always be the Secretary?

Response: To be as literal as possible, addition will be made: "...or her designee...)

§4.2.b

Comment: Drawings and specifications for architectural work are usually quite massive. Plus they take architectural expertise to read, interpret, and understand. This is not within the skills of OHFLAC staff. I think this is an unnecessary regulation because of this.

Response: OHFLAC has always had a registered architect who meets state board requirements to review hospitals, nursing homes, behavior health centers, hospices, renal dialysis centers, personal care and residential board and care homes. These facilities must meet the Guidelines for the Design and Construction of Hospitals and Health Care Facilities, published by the Institute of the Architectural Academy, 1996-97. OHFLAC also has on staff a registered pharmacist, several RNs and a consultant MD.

4.2.c

Comment: What if it is just a partial renovation or physically handicapped customers are not appropriate placements?

Response: "Extensive" added to renovations. This is a federal requirement, we really don't have any option. The center would ask for a waiver or variance.

§4.2.d

Comment: Language is too subjective and taken literally causes the Secretary to substitute her judgement for that of the Board before purchase of property and before a License is applied for. Delete this requirement.

Comment: What does conveniently as possible mean?

Response: Wording deleted.

§4.3

Comment: Inspection by authorized representatives is appropriate as long as consumer's rights are respected and observed. Consumers have the right not to be observed at their request. Consumers have the right not to be interviewed.

Response: See general comments concerning consumers' rights and addition of consumers' rights concerning interviews. It would be impossible to keep from observing consumers if all sites are visited. Certainly, steps should be taken to observe their rights in the residential homes and this is addressed in survey protocol.

§4.3.b -

Comment: The term “shall” requires inspectors to do four tasks including interviewing consumers and therefore, no inspection can be complete until each one is complied with. Consumers have the right to decide if they want to talk to inspectors. The rule infers a compulsory compliance on the part of a consumer. Suggest removing the word “shall” and substituting, “may.”

Comment: Suggest change to “Observation of service delivery with consumer consent” and “Interviews with consumers (with the consumers consent), staff and administrators.

Response: Agree. “Shall” changed to “may.” Also, since with is impossible not to observe consumers in an out-patient clinic, will change 4.3.b.4 to Interviews with consumers (with the consumers’ consent)…”

§4.3.c

Comment: Why some 2 and some 1? What is the logic behind it? No statement about other visits for fraud, drop ins, howdies, etc?

Response: We believe this is a directive from the Hartley court order which implies that a residential facility needs more monitoring than an out-patient. Under the authority of the Secretary, a regulatory body may only enter at the request of the facility, the Secretary, during a complaint investigation, or during a licensure survey. We do a lot of on-site training, but only at the request of the facility. Unfortunately, with 84 facilities and 64 ICF/MRs, we’re too busy to do “howdies.”

§4.3.d

Comment: Some services are provided in consumers’ homes and the consumer does not have to allow anyone in their home unless they re willing to open their home to the inspector. Cannot be met for every service.

Response: Will change wording to “Inspections shall include every licensed location operated by the center.

§4.3.e

Comment: Includes “consumers (with their permission). Phrase should be included anywhere in the regulation where the consumer is expected to participate. A general statement at the beginning of the standards could accomplish the same result. The definition of reasonable request must include the reasonable notice period required to access the information and the persons subject to the inspection. The exception would be a unscheduled visit.

Response: The only other place where a consumer would be expected to participate is at 4.3.b (see changes). Consideration is always given on a survey that the center needs time to gather information. This regulation is necessary for those occasions (and they have occurred) when a center has refused entry, or access to files, etc. §§

Comment: It is poor practice not to notify the person in charge or that person’s delegate of the reason for the complaint. The person in charge should always be notified due to potential liability issues. Rewrite to indicate the above. Some complaints may arise from services provided in consumer’s home and an investigation notice should only be provided to the administrator.

Response: The rule states that the administrator shall be notified. That is office protocol.

§4.4.d

Comment: Suggest each place ten(10) days occur, working or calendar days be included.

Response: Agree.

§4.c.f

Comments: Is this ten (10) working days or ten (10 calendar days)?

Response: Working days. Addition made to rule.

§4.4.b

Comment: Unannounced visits at facilities is significantly different than unannounced visits at service sites. Services are provided to families in home, to individual consumers in their residence and in other natural settings. Unannounced visits to consumers can only be considered with their permission.

Response:

§4.3.g

Comment: Why say substantial again.

Response: We have it pretty much figured out what is substantial. If we haven't had any major complaints, or surveys with negative findings.

§4.4.1

Comment: States the Secretary may suspend or revoke a license. Their code doesn't say anything about suspending a license. Their code indicates that a license may be revoked for good cause after notice and hearing.

Response: According to Regulatory, if the code gives the Secretary the power to "revoke" at license, which 27-9-1 does, then all other penalties of a lesser intensity, can be invoked. This is an original regulation from 1984 and its purpose is to protect any staff or consumer who files, or is involved, in a complaint. It is to be understood if it were invoked, a center would rather have a license suspended rather than revoked.

§4.5

-Comments: Plans of correction are required within ten days, no exception. I'd suggest the wording "except if a variance is permitted by the Secretary" be added to permit the Center and Secretary time to negotiate aspects of a Plan when that negotiation is necessary.

Response: Agree. Change made.

§4.5.b

Comment: This rule permits the Secretary to modify a Plan of Correction. This could be unilateral and unacceptable to the Center. The Secretary's only legitimate function is to approve or disapprove the License and thus her only legitimate authority for a POC should be parallel. There should be a ten (10) day requirement for the Secretary to act on the POC.

Response: This rule is in the current regs. Modifications are only done with the approval of the Center. Addition shall state: "...in writing within ten (10) working days of receipt. Additionally

sentence shall be added: "Modifications shall be made in conjunction with the center."

§4.6.c.2

Comment: Information from a medical or personnel file would appear to be more in line with the standard.

Response: The intent of the regulation is not to release any "personal" information of anyone involved in a complaint. Will change to "...consumer or personnel file..."

§5.5.1

Comment: The term "policies for effective service delivery" is too vague. Depending upon interpretation, this could be a 10 page booklet or a 100 page manual.

Response: Due to the variety and size of centers, the amount of policy will vary. However, there are specific policies required in the rule, including a basic policy to define the program, etc. at 5.2.a. The size of the policy does not dictate quality of services.

§5.2.a -

Comment: Suggest adding the "mission statement" to the list here.

Response: Agree. Shall change to read "...governing body that sets policies, develops a mission statement, defines services..." Note deletion at 5.3.b of the phrase: "...with a mission statement,"...

Comment: While most providers have through other standards an expectation of whom will comprise the governing body; it would be appropriate to indicate this here also.

Response: See definition of Governing Body at 3.20. It is not necessary to define every type to address 85 licensed entities.

§5.3.b

Comment: The administrator should work with the governing body to develop a mission statement but the mission statement is the responsibility of the governing board.

Response: See response to 5.2 a. above.

Comment: The governing body evaluates implementation of policies.- What exactly does this mean? What would be required?

Response: We would suggest reviewing the intent of 5.11.a - Quality Assurance.

§5.3.d

Comment: Suggest adding "by-laws" to this sentence.

Response: Addition will be made: "...governing body, policies, procedures and by-laws..."

Comment: When the governing body is not a board of directors what will the standards be?The Rule currently does not address a nonboard governing body.

Response: The section under governing body applies to all.

§5.3.d.3

Comment: Effectiveness is a subjective term and needs further definition. How often should the board review itself and what should it use to determine its' effectiveness. The who, what, when, why and how questions should be addressed in this standard.

Response: This section is in keeping with accreditation standards. We agree that it would be

difficult to enforce this regulation, therefore, it will be deleted.

§5.3.d.4 -

Comment: This rule requires the Center to have a policy that prevents a conflict of interest (implies a priori knowledge of the conflicting event). Because of this impossibility, suggest “the process to declare a conflict of interest and to separate and absent the Board member(s) from the decision making process.”

Comment: The governing body should have guidelines for managing situation in which conflict between board members and the center arise. Members signing a conflict of interest statement with a clear definition of what constitutes a conflict of interest would satisfy this standard.

Response: All the rule requires is a policy and suggestions can be included.

§5.4.j

Comment: The amount of the required bond should be based on some objective criteria and uniformly applied to all centers managing consumers funds.

Comment: Having to receive the approval of the secretary will be cumbersome and may delay obtaining a bond. Either set a formula in the rule or set an expected standard so that the center may know what the secretary would accept.

Response: According to counsel, the formula is already in the rule. Because the secretary includes designees, it won't be cumbersome.

§5.4.e

Comment: Insurance coverage minimum should be identified.

Response: OHFLAC does not believe this to be necessary.

§5.4.j -

Comment: Having to receive the approval of the secretary will be cumbersome and may delay obtaining a bond. Either set a formula in the rule or set an expected standard so that the center may know what the secretary would accept.

Response: According the counsel, the formula is already in the rule. Because the Secretary includes designees, it won't be cumbersome.

§5.5.b

Comment: Rule requires “a” code of ethics. Centers are comprised of professionals, each with their own code. To require only one is administratively difficult. Suggest, “The center shall demonstrate that its staff adhere to a code of ethics as evidenced by a statement which sites each staff's code of ethics. Where no such code exists, the center shall insure that staff adhere to the following provisions: 5.5.b.1,2,3,4,5 and 6.

Response: These provisions are specific to a behavioral health service, not to the different professional codes, which may or may not include them. Most centers already have a code.

Comment: The standard should read “Policies and procedures shall be developed and implemented...”

Response: A code is a set of rules or principles. Not necessarily a policy, although the code could be part of the overall policy of the center. Will add “...will develop and implement a code...”

§5.5.b.4

Comment: This implies that there are only two things care can be based upon, diagnosis and treatment needs. As this might conflict with policies of funding sources, suggest removing the term "solely" and adding "and other documented indicators of the consumers behavioral health and/or general health status."

Response: The other "documented indicators" which would be "diagnostic" as the implication are these are assessments. However, will change "diagnostic" to "assessments."

Comment: Should include "including consideration of the consumers wants and desires and other clinical documentation of the consumers health and behavioral health status."

Response: Agree. Additional wording shall be added.

§5.5.f

Comment: Precede the sentence with, "If the center utilizes volunteers..."

Response: Response: Agree. To read: "If the center utilizes volunteers, it shall implement..."

§5.5.g

Comment: "All personnel and consultants" needs to be defined so that is "all professional staff and consultants" are credentialed.

Response: Agree. Although with some variation, this regulation has been in effect since 1984. Change will be made from "personnel" to "all professional staff..."

§5.5.h

Comment: Add "procedures" to this sentence. Suggest searching the entire document to make it consistent "policy and/or procedure."

Response: Addition made at this regulation. Not necessary for all mention of policy.

Comment: There should be a reference to the "mandatory reporting laws" with which Centers shall comply.

Response: Agree. Will word to read: The center shall comply with its written policies and with Section 9.6.9 and Section 49-6A-5 of the WV state code when there is reasonable cause to suspect that a consumer is neglected or abused.

§5.5.k

Comment: This rule is unclear as to what the exception means. It implies a center has responsibility for protective services. Because this is not capitalized, it does not mean Protective Services, as in Child and Adult Protective Services. Please check the meaning and clarify.

Response: Will take suggestion of comment to read: Except in the case of abuse, neglect or exploitation, in which the center has the responsibility by law to report to protective services, a consumer..."

Comment: The consumer or legal representative as the primary source of information is a concern in that many times the consumer is not the most reliable source. Need to define when it would be the consumer and when it would be the legal representative.

Response: The purpose of this requirement is to ensure that the consumer's right to participate in his or her treatment is not violated. In cases where a legal guardian has been appointed, then this right would rest with them. It would be either the consumer, or the guardian.

§5.5.1

Comment: The rule should not require that all new personnel receive a copy, but rather that “all staff should be either given a copy or have access to policies and procedures.” The term “personnel” is not defined whereas “staff” is.

Comment: Should read “The center shall have and periodically review and revise policies for effective service delivery and protection of consumer rights and shall provide a copy or make a copy available of these policies to all new personnel.”

Response: Wording changed as suggested.

§5.5.m -

Comment: As there are so many communicable diseases, this rule is vague as to its intent and burdensome. In order for a center to construct an acceptable policy and/or procedure, please clarify which communicable diseases to be included.

Comment: Should read “The center shall implement a policy pertaining to communicable disease affecting both consumers and staff.”

Response: Wording will be changed to suggestion. According to OHFLAC RN Administrator, a competent RN would write this policy and know the intent of “communicable” disease.

Comment: States the center shall implement a policy pertaining to employees with communicable diseases. Why? Then what?

Response: This rule is being enforced by the Bureau of Public Health, and as such, it would be understandable that a health entity have policy governing employees and consumers afflicted with TB, Hepatitis B, etc. Then, they should implement the policy. See 5.2.b.

§5.6.a

Comment: This rule is vague as to how a center can be in conformance. Please re word.

Response: It is not necessary for minimum standards to prescribe ratios and qualifications of staff for a particular service, except in section 7.17. The outcome of not providing “adequate” and “qualified” staff to ensure quality care should be evident in assessing each consumer’s progress, and the center’s ability to protect the rights of the consumer.

§5.6.b

Comment: As it is impossible to know definitively, if anyone has a prior history of abuse, neglect or mistreatment (no definition of), it is impossible to be in compliance with this rule. Please reword such as, “The center shall not knowingly hire...”

Comment: With regard to abuse, neglect or mistreatment, the standard will work if it is related to conviction only. History would need substantiated proof.

Response: Wording will be changed to read: “The center shall not employ individuals with a conviction of ...”

§5.6.c -

Comment:

“Direct service staff” is undefined thus is impossible to know who the Secretary has in mind. Change “competent, responsible” to “qualifies as evidenced by academic degrees, license(s) and employment history.”

Response: Change made to “Staff providing direct care to consumers shall be” Competency and responsibility can be evidenced by outcomes.

Comment: What is the definition of competent and responsible? Mentally competent and responsible or legally competent and responsible? Suggest “Direct service staff shall be persons eighteen (18) years of age or older and capable of performing the duties assigned.”

Response: Wording will be changed to suggestion.

§5.6.d.1

Comment: Volunteers should have documentation in their record of what functions they are performing as a volunteer but a job description is not appropriate.

Response: Agree. Change made at 5.6.d. Volunteer deleted.

Comment: We maintain a master file of job descriptions. We think this should be sufficient. We do not see the necessity to have a copy in the individual personnel file.

Response: This is a better practice to have a description of what the individual does in the file.

§5.6.d.6

Comment: Although they are a good idea, Licensure should not require us to complete Employee Performance Evaluations. As long as we meet the Medicaid (and other funding source) requirements for the clinical supervision of employees, the decision to implement Performance Evaluations should be solely that of the employer.

Response: In this day and age, it would almost be inconceivable that any business did not perform some type of evaluations on their employees, the outcome being quality service or not.

§5.6.e

Comment: Why not all staff - people start in these places as clerks, aids, etc. and then move up into the other fields. They would never have had the IB. What is meant exactly by para-professional?

Comment: See changes to 5.6.b in General Comments. Regulation has been deleted.

§5.6.d.6

Comment: requiring an employee performance evaluation on a volunteer implies that the nature of what a volunteer does is the same as an employees. Volunteers should be used to augment, not supplant employees. Suggest to delete.

Response: Change made at 5.6.d: Delete volunteers. This is addressed in policy at 5.5.f.

§5.6.e

Comment - requiring CIB for all employees extends a false sense of security because the CIB does not report unreported instances of abuse nor out of state activity. Too, the CIB gives employers information that may not be directly relevant to the job and thus endanger the employment of the citizen. Suggest that the rule read, “The center protects the rights of the consumer from abuse and neglect as evidenced by a thorough investigation of staff references upon hire and through inquiry of the CIB for appropriate positions.”

Response: See changes at 5.6.b which will require the center to not employ individuals with a conviction of...5.6.e will be deleted.

Comment: Does this apply to professional contracted staff persons?

Response: See response above.

§5.7.a

Comment: The rule implies that a clerk will receive training on treatment policies. Change the wording to focus the rule to direct care staff.

Response: Agree. Change made to “professional and direct care staff.”

Comment: An anticipated period of orientation is not defined, leaving some ambiguity as to the time frames licensure would find reasonable. While is agreement that the first day should begin the training, specific training cannot be accommodated in the immediacy of time frames suggested. To assure safety, agencies generally ensure that untrained staff work with someone trained.

Comment: Staff-training piece infers that staff can be trained on the first day to all policies and procedures and restraint. Most restraint models are lengthy training, which take a minimum of 8 hours to complete. Orientation to policies and procedures is not something that could be accomplished on the first day of hire. Time frame needs defined. The Heimlich maneuver is no longer the method approved or taught by the American Red Cross.

Response: Regulation only states “beginning” on the first day. It doesn’t require all the training to be finished on one day. To say “timely” would be too vague. While the regulation doesn’t require that the training be done by the American Red Cross, a call to the organization assured us that the Heimlich maneuver is part of the training.

§5.7.b

Comment: - training on infectious disease control is vague. Change to “Blood Borne Pathogens” if this is what is meant.

Response: According to the RN Administrator in the office, this term is sufficient as it includes air borne, contact and other types of infectious disease. Also from the current regs.

Comment: First aid training if done correctly provides instruction in the Heimlich’s maneuver. The term bloodborne pathogen control is also required training.

Response: Some centers do not use the Red Cross as their training. This is to ensure these elements are included in the training.

§5.7.c

Comment: Introduces a new term, “providers.” Suggest this be deleted as it is undefined.

Response: Agree. Providers will be deleted.

Comment: Definition is too narrow and should be changed to read “Employees providing services to consumers shall be trained in the proper care of the consumers to whom they will be providing services (including special needs, health and behavioral health needs) prior to, or within ten (10) days after being assigned to work with the individual. Fully trained staff shall be present until newly hired staff are fully trained.

Response: Suggestion accepted.

Comment: Should be who are diagnosed with a Behavioral Disorder

Response: See response above.

§5.7.e

Comment: While this is a fine standard, there is no criteria by which staff will be judged. Create a sentence that contains, “as evidenced by...” so staff and centers will know what the Secretary means.

Response: The terms “demonstrate” and “provide evidence” speak to the outcome of the staff’s ability to serve the client. Same as “as evidenced by.”

Comment: The standard is vague and should be rewritten to read “Periodically staff will be evaluated based on demonstrated ability to perform their job responsibilities.”

Response: See response above.

§5.8.a.2

Comment: Centers can not “transfer” per se a person from a less to a more restrictive environment when they are dangerous to self or to others without going through the commitment process. This rule does not acknowledge this and infers the opposite.

Response: Disagree. Revised from current rule. Many times consumers are transferred to emergency rooms, and other types of in-patient facilities without commitment hearings. The rule is to safeguard all involved. Also, refer to addition of definition for psychiatric emergency, and use of restraint and seclusion at 7.6.f.

Comment: Need to clarify whether the plan would be to transfer the patient out, or to staff-up to handle the patient. This provision would allow a facility to simply transfer out a patient that was difficult, but which should be within their ability and responsibility to handle

Response: See comment above.

Comment: What is meant by “assurance” and what is meant by “adequate coverage?”

Response: Assurance is a binding statement that what one says is true. Staff need to know that they have the backup of the facility that they will not be required to contain, or control a situation that is beyond their capability. See definition of psychiatric emergency. Adequate is when coverage prevents someone from getting hurt.

Comment: A consumer can only be moved to a more restrictive environment through treatment planning or due process through the mental hygiene process. Should read “Assure that the center shall initiate proper procedures for the transfer to an acute care facility, a consumer who poses an imminent physical danger to themselves or others, or provide adequate coverage to manage a consumer at the residential facility.”

Response: Will change wording to above comment suggestion.

Comment: Adequate coverage by whose definition? Line staff should definitely not be led to believe that they determine the definition of “adequate coverage” or that the staff with low tolerance for certain clients can impact the clinical decision whether or not a commitment is necessary.

Response: See response above.

§5.9.a.2

Comment: Would recommend adding “or a standing committee of the governing body.”

Response: Wording will be added.

§5.9.a.4

Comment: The Human Rights Committee will “review internal and external investigations...”

What are internal and external investigations? If police were doing an investigation would they be expected to give information on their investigation to this committee?

Response: Internal would mean those done by the center as required at 8.2.a. External would be by APS, CPS, etc. as required to report at 5.5.h.

§5.9.a.6

Comment: The Human Rights Committee has to ensure that written consent be given prior to aversive procedures begin. Does it make sense that written consent or agreement is required before consequences are imposed?

Response: Yes. Usually the aversive procedure is either a psychotropic medication, which can alter behavior, or a restraint and should be reviewed prior to implementation. In an emergency, policy should follow Directives at Section 9.8.

§5.9.c.

Comment: Would like to suggest that the proposed standard be altered in that a parent and/or guardian of the consumer may be substituted for the consumer to sit on the human rights committee. We believe that members of the consumer's family, or his or her guardian, have a vested interest in the consumer, and they would be able to bring the concerns of the consumer to the human rights committee.

Response: A consumer is any individual, or a member of their family, who may, at any time, have reason to receive services from the center. In this respect, the consumer may be a parent, but not the guardian.

§5.10.a.2

Comment: Again what is adequate? What we determine "adequate" to be based on our knowledge of the clients, skill level of staff, and other factors may not be considered adequate by an OHFLAC Reviewer.

Response: We see no problem with requiring "adequate" insurance. Is it really necessary to outline basic coverage?

§5.11.a

Comment: The center shall monitor and evaluate service quality and effectiveness-based on what criteria?

Response: The policy that is required at 5.5.1.

Comment: How often? Effectiveness - 70% of regs? 70% of their mission, by independent study, their advisory board?

Response: Most QA systems are based on the centers own criteria, as required by policy 5.5.1. The effectiveness of their system by comparing it to a licensure review and it is very effective.

Comment: This statement is too vague and does not set some type of criteria by which we or a reviewer could make a valid assessment.

Response: Since there are so many comments about this regulation, the following will be added to the rule:

The overall scope of the quality improvement process is described in a written plan or outline which sets forth mechanisms, committees, or other means of assigning responsibility for carrying out and coordinating

quality improvement process activities, and includes:

objectives and scope of the activity; methods of monitoring; reporting of results; and follow-up mechanisms.

§6.1.b

Comment: What does adequate mean?

Response: Rather than be prescriptive, as in the old rule, in addressing issues such as “covers on clothes hampers,” this requirement became more generalized. If the setting is a “mess,” it’s not adequate. This would not be cited unless there were specific findings.

§6.1.c

Comment: At face value the rule demands that the center eliminate risks. This is an impossible standard to meet. Remove “eliminate” and reword to say, “reduces.”

Response: After identifying a risk to client safety, it would seem reasonable that a center would want to eliminate it.

§6.1.d

Comment: It is unclear what is wanted here as there is no specification of the product or outcome of evaluating the likelihood of exposure. One could say that the research shows that a person is more likely to be exposed to blood borne pathogens if they come in contact with blood than a person who doesn’t. Is this what the rule wants?

Response: RN consultant in office believes this is an essential regulation taking into consideration that in many settings, there are consumers who have IVs and other types of procedures involving the risk of contact with blood.

§6.1.f

Comment: This would be strengthened by adding “911” to the concept.

Response: Some areas may not have 911 numbers.

Comment: “post by the telephone emergency telephone numbers...” Should this be a residential requirement, or is for all phones in the agency? There are many phones that consumers would never even be near”

Response: Good point. Will change to read: The center shall post by the telephone in all direct care and residential services, ...”.

§6.1.h

Comment: The development of “a plan” to address issues of access will not deal with the issue of access. A center could develop a plan and not implement it. If the issue is access, then this should be stated.

Response: Hopefully the writer realizes this regulation was addressing ADA requirements, which exceed those in the licensure requirements for these areas. 6.4.a requires compliance with building codes and other requirements, which include components for access, etc. It is not the intent to strictly enforce ADA requirements in this rule, but to make the provider aware of their regulations.

§6.2.a

Comment: “used regularly” is not specific, vague and open for interpretation. Suggest delete it.

Response: Agree. Deleted.

Comment: The center shall comply with the State Fire Code and have evidence that facilities rented, owned or used regularly for services are in full compliance.

Response: The intent is already in the regulation. Will change to “...with the State Fire Code.”

Comment: The center regularly provides services in family homes and in other natural locations. The evidence of compliance for Center rented or Center owned would be possible. Evidence of compliance for family homes and other natural environments would not always be either possible or feasible.

Response:

§6.2.b

Comment: Should read: hold them and record.

Response: How else would they prove they had been done?

Comment: Monthly is too disruptive. Suggest every quarter.

Response: Agree, to require every quarter.

§6.4.a

Comment: Wants change to State Fire Code.

Response: Will include change: “...codes and health, and the State Fire Code.”

§6.5.b.1

Comment: “unproducing” should be “producing.”

Response: Agree. Change made.

§ 6.6

Comment: “Emergency Shelters” are not defined.

Response: Whole Change shall be made to 24 hour Residential Settings.

§6.6.a

Comment: “attractively furnished” is subjective and will be in the eye of the beholder; especially when consumer choice is exercised. Delete this.

Comment: The room dimensions requirements is clear. What is adequately and attractively furnished is highly subjective and may be contingent upon the consumer’s perception and cultural norm for the area where the facility is located.

Response: Attractively furnished has been deleted.

Comment: Specifies the amount of “floor space.” The child care reg. Identifies the same number of square feet but does not identify that as “floor space.”

Response: We can only enforce tangible space.

§6.6.c

Comment: How can the physical space (walls, rooms, etc) be arranged from one client to the next based on their “clinical needs.” The rule sounds appropriate but will be impossible to meet

as it is not specific.

Comment: Recommend “The consumers clinical space needs will be taken into consideration when bedroom is assigned.”

Response: Many client rooms are equipped with medical and/or adaptive equipment and the room should be arranged to accommodate - not be too crowded or prevent egress. Wording will be changed to read: “Each room shall be arranged...”

§6.6.d

Comment: Where was a required window mentioned? Is there a requirement for windows?

Response: While the regs don’t require a window in the bedroom, if there is one, it needs to be covered.

§6.6.e

Comment: “personalized” connotes personal ownership. In a rental facility or room, two roommates might have two identical beds, share a nightstand, have two identical dressers, one rug. Etc. This would not necessarily be “personalized.” Because the intent is unclear, please remove “personalized.”

Response: Furnishings also include posters, radios, mementos. The intent is for the room not to look like a jail cell.

Comment: Furnishings for residential treatment facilities need to be first and foremost, safe. “Homelike and personalized” may or may not meet the needs of a particular population.

Comment: Homelike? Whose home? Very subjective.

Response: 6.1.a addresses environments that are safe. See response above. While the regulations don’t contain prescriptive, or philosophical advice on how to treat consumers, we feel it important that “behavioral” health facilities be as humane as possible.

§6.6.1

Comment: What is sufficient number?

Response: A number that is observed to accommodate the residents. If it were observed that there was an obvious lack of facilities based on the number of resident, that would be insufficient.

§6.6.f

Comment: Nothing here about keeping them separate.

Response: Appropriate would be separate. 6.6.g requires “locked” storage.

§6.6.h

Comment: It should be made clear the lavatories, bath tubs and showers need to meet this requirement. The water temperature required for sanitizing dishes and clothes may be different and thus the need for a mixing faucet or another form of control to keep the delivery temperature within the specified limits.

Response: The regulation requires all of this.

§6.6.m

Comment: All plumbing shall meet the requirements of BOCA International.

Response: Wording will be changed to: "...in the absence thereof, the requirements of BOCA International.

§6.6.p

Comment: What about a variety of foods?

Response: Good idea. Add to 6.6.p.3: "Provide a variety of well-balanced meals and snacks...?"

Comment: What is included under dietary service? Does this include meals provided youth in residential or day treatment programs/ If so, I would recommend that the programs be required to conduct regularly scheduled and documented consultation with a dietician. Are meals to be prepared "prior" to?

Comment: All meals that are provided, in any setting. Wording will be changed to "Food" services. Also change to "Be planned with the regularly, documented assistance of a dietitian;..."

§6.7.a

Comment: Within programs, group settings for services should be appropriate for the individual consumer's needs.

Response: This requirement is included in the regulation.

§6.7.a.2

Comment: What is adequate:

Response: Again, it is impossible to dictate ratios due to the variety of settings and services the rule addresses. If it were observed, or, there were findings, that a consumers health and safety had been at risk in any way due to lack of staffing, this regulation would be violated. Many times, there are "numbers" meeting ratios, and, yet the safety of a consumer not be met.

§6.7.b Clarification. Also against WV State Code.

Response: Deleted.

§6.9.c.5

Comment: There is a word or phrase missing between the words "applicable" and "of."

Response: Thanks. Will be changed to "To staff of the center for treatment or internal review purposes.

§7.1

Comment: This standard needs to allow for the child care licensing standards with regard to supervision. The standard does not currently differential between clinical and administrative supervision.

Response: The standard is not specific to child care. See change at 7.1.c.

§7.1.b

Comment:...written procedures will be established..." the "for what" is not specified.

Response: Addition of "...written procedures outlining each provider's responsibility" will be added.

§7.1.c.

Comment: Our agency does not require supervisors to have or to obtain a masters degree. If such was enacted, it would create a major financial hardship on our Center.

Comment: The standard needs to reflect child care licensing requirement for supervision. The standard should differentiate between clinical and administrative supervision. A bachelor's degree in human services or education under the direct supervision of a master's degree in a human service or related field and two (2) years experience can administratively supervise a program.

Response: The intent of the regulation is to ensure that those individuals with the responsibility to supervise staff in a clinical, or therapeutic setting has a master's degree, except for skills training. Regulation will be changed to read:

Program staff shall be supervised by a person with a master's degree in a human service or a health related field. Directors/supervisors of services for children/families shall also have two years post-masters degree experience in the delivery of family services. Program administrators shall have at least a bachelor's degree and be supervised by a person with a masters degree in a human service or health related field.

Comment: Supervisor's have two years experience in the delivery of family services. This must be a mistype. Change to remove the two year requirement and add, "post masters experience in a human service or health related field." The concept of "skills training" is not contained int eh definition section.

Response: See above comment.

Comment: How does the Department define "human services or health related field?"

Response: There is no definition.

Comment: It should be up to the center itself to determine who supervises its programs. Not all of the services we provide have to be provided by staff with a Master's degree. Licensure should not arbitrarily set this kind of a standard. Degrees and clinical skills do not always reflect nor insure that a person has the skills and ability to successfully manage resources and people or insure that services are delivered in compliance with State, Federal and agency guidelines. The implementation of this regulation without, at a minimum the safe guard of a "Grandfather Clause" or behavioral health experience substitutions for education, would eliminate a number of skilled, experienced and dedicated individuals from the behavioral health system.

We understand that supervisors should be knowledgeable about service provision but we feel that there are staff qualified to supervise who may not have a master's degree or two years post-master's degree experience in the delivery of family services. Some of the services we provide are not "family services." Is this saying you cannot be a supervisor unless you have provided "family services?"

We also do not understand what the last part of this regulation means. "...except for skills training which must be done by a registered nurse or a person with a bachelor's degree in human services or education." Does this mean that training will now have to be done by a degreed individual rather than high school level staff?

Response: Because of the number of new centers that are reviewed for compliance prior to issuing a license, we believe there has to be some standard of qualifications for administrative and clinical staff. See response above and change to the regulation.

7.2.a

Comment: What are the “criteria for admission” referred to in this rule?

Response: See 5.5. a. That’s up to the center.

§7.2.c

Comment: Does this replace the current rule of having the master treatment plan in place within 30 days of the admission? This seems to be an unrealistic time line in that there generally would not be enough time to complete recommended evaluations and to use those results in defining a comprehensive service plan.

Response: The plan, as currently, has to be initiated within seven days. See 7.3.b. Wording at “implemented” shall be changed to “finalized.”

§7.3.e.3.B

Comment: Not all goals and objectives of a treatment plan are designed to lead to discharge. This rule expects them to be so. Repword to delete, “for discharge.”

Comment: Although all services should have measurable objectives related to goals and have achievement date and include expected outcomes, all services do not have discharge. Should change to “...and when appropriate outcomes for discharge.”

Response: Agree. Change will be made.

§7.3.g.2

Comment: “Educational services” needs defined. Is it intended to mean that youth are doing something educational or that the youth is placed in an approved school placement? If should not specify that it applies only to youth in residential programs. “Promptly” should be defined in terms of a day limit. How will the state Board of Education assist us with this?

Response: Again, in keeping with regulatory directives, definitions that are found in Webster’s and used in that context needn’t be defined. This term appears to us to be self-definitive. The service may be a day program or a certified school. The regulations only apply to those services that occur under the licensed umbrella, thus would not apply to out-patients. Too prescriptive to mandate day or hour limits. The assumption is the center has already been assisted by the Board of Education if the service is a certified school.

Comment: While agencies promptly seek educational services for their youth, access may be another matter and one entirely dependent on the county educational system. I would encourage the rule to be revised to place the center’s responsibility to ensuring that appropriate educational services are promptly sought.

Response: while we are aware that this might be difficult at time, that’s why we opted not to define “educational services.” If the school cannot accommodate the individual right away, there should be some form of programming, even if its at the facility.

§7.3.g.4

Comment: We think this is unclear. It appears to be a duplication of what occurs in the physician’s documentation, which is the generally accepted practice for reviewing drug dosages and types and explaining the rational for changes or continuation of psychotropic drug regimens. If each medication change must be included in the treatment plan, this will e a nightmare, especially in the case of medications that must be titrated up or down according to schedule

(sometimes weekly) such as Clozapine.

Response: This is only requiring that at the time of a treatment plan review, the drug regimen is included, since, in many cases, medications are the only intervention. What is occurring now in most cases, the treatment plan is in the file and is not looked at for months, even though the consumer's treatment is undergoing changes.

§7.4.c.

Comment: Where clients or guardians do not have the capacity to read or write the documentation of participation should be in line with the individual's abilities. If written consent is not obtained, the record should reflect why.

Response: Addition made. If written consent is not obtained, the record shall indicate why the written consent was not obtained.

7.5.b.4

Comment: Discharge summary should include a plan developed in conjunction with the consumer for care after discharge and for follow-up - how do we do this for consumers who take them selves out of treatment (do not return)? There is no provision for discharge summaries when the consumer does not return for treatment.

Response: Addition will be made as follows: "...with the consumer, when available,..."

§7.6.a

Comment: This regulation says that "center staff" shall be trained in behavior management-does this mean all staff or all staff who work directly with clients? It should specify what staff would need this training.

Response: Wording shall be changed to: "Program and direct care staff shall be trained..."

§7.6.b

Comment: This might better be worded: "The center shall develop and implement policies and procedures for the management of behaviors that are socially or personally nonproductive by means of aversive techniques such as restraints, seclusion and time-out. All such techniques shall be used in the context of a behavior intervention plan that:

Comment: Suggest "The center shall develop and implement policies and procedures, such as time-out, seclusion and restraints, for intervention in working with behaviors that are interfering with the consumers ability to function socially or personally. All behavior intervention plans shall..."

Response: Wording will be changed to conform to second suggestion.

§7.6.b.1

Comment: Again a better description of what OFLAC means by functional analysis is very

important.

Response: See change at 3.18.

§7.6.f

Comment: Seclusion and Physical restraint should be regulated separately. The use of physical restraint certainly needs to be closely monitored by administrators. However, the use of physical restraint should not require a physician or other licensed professional and/or a team to determine use. The use of physical restraint is only used to the point of client readiness.

Comment: Mechanical restraint should only be used as a last resort and this standard would be appropriate for mechanical restraint.

Comment: Mechanical restraint should only be used as a last resort and this standard would be appropriate for mechanical restraint. Consumers are, at times, restrained using CPI, TCI or other techniques that require the short term use of physical restraint. The standard would not be appropriate for standard crisis intervention physical restraint holds such as the basket hold and four point restraint. CPI or TCI may be a part of consumers treatment as behavioral intervention or in the case of an emergency may be used on a very limited basis to protect the consumer and those in the immediate vicinity of the consumer. Suggest defining the term physical restraint better in this standard.

Response: Refer to the definition of Restraint at 3.39 and Physical Restraint at 3.39. They are different procedures. However, to prevent confusion, regulation shall be changed to: "...placed in seclusion or a mechanical device used as a physical restraint..." since mechanical device is described in the definition of physical restraint.

Comment: Seems to preclude the use of any immediate restraint of an individual until a discussion is held with others who may not be immediately available. What is the child is attacking someone?

Response: Note definition of Psychiatric Emergency. Also, change in regulation as noted above.

Comment: Our agencies employ passive physical restraint in situations where a youth is a danger to self or others, and only after verbal de-escalation techniques have been ineffective. Such a crisis situation does not permit a staffing or authorization as this rule stipulates, nor is it necessary. It would be appropriate for situations of seclusion or mechanical restraints.

Response: See response above. Also, see addition to 8.1.a.8.

§7.6.g

Comment: Very confusing to read. If a client is restrained during the three hours before release, perhaps this is justification enough not to release him.

Response: Phrase "...during the three (3) hour before release..." shall be deleted and "the interdisciplinary team shall review the consumer's status and, subsequently, revise the individual treatment plan to address his or her needs".

§7.6.1

Comment: Need to define "ensure" in section 7.6.1.

Response: Ensure means to "ensure the quality of." We believe the wording meets the intent of the regulation.

§7.6.n

Comment: While behavior intervention may cause severe emotional stress; they may also be the most effective and least intrusive method to address problem behaviors. Agencies should have established behavior intervention protocols, and mechanisms for identification and review of interventions. "Likely to occur" needs to be defined.

Response: 7.6.b require that the center have policies and procedures for the management of inappropriate behaviors. We believe that if any behavior intervention, whether it be a formal plan, or center protocol, causes any emotional stress, this is abuse (see definition of psychological abuse). The status of an individual may change, either physically, or mentally. We see behavior plans that have been in effect for several years, while very serious changes have taken place in areas of the consumer's status and no change to the plan, which makes them ineffective. This regulation also addresses psychopharmacological behavior interventions which necessitates monitoring for side effects.

§7.7.c

Comment: No limit, no permission fo director when going to other methods. What are those methods? At some point a director should be notified if this staff intervention continues at length.

Response: Look at Section 7.6 and also the definition of psychiatric emergency at 3.37.

§7.8

Comment: Emergency procedures should have general policy guidelines and specific procedures appropriate for the location of the facility or the service.

Response: Change made at 7.8.a: "The center shall have policy and procedures for handling psychiatric and medical emergencies that ensures:

§7.10.a

Comment: The center shall be responsible for medication that the center prescribes or administers or stores. The center cannot be responsible for medication prescribed by other providers. Suggest adding to the process ""medications the center controls.

Response: The center still has to have a process and be responsible.

§7.10.b 1

Comment: This standard precludes a physician from ordering and reviewing medications on a 180 day cycle. This is a common practice and the rule should accommodate it.

Comment: It is unrealistic to hold us accountable for insuring that all medications are reviewed every 90 days when not prescribed by our physician and are being ordered for lifelong medical conditions such as diabetes that is under control with current medication regimens.

Response:

6.8.b.9 requires the record include all signed and dated physician's orders. Addition will be made: "orders, prescribed by the center's physician." This would preclude any other orders then being reviewed quarterly. Refer to 7.4.a. If it is documented with good reason, the 180 days would be ok.

§7.10.b.2

Comment: This is unclear and we do not understand the meaning.

Response: Wording will be changed: "...treatment plan and with documentation ..."

§7.10.b.3

Comment: This should be adequate to cover 7.10.b.2.

Response: Disagree. The requirements are different. b2 has to do with ordering medications, b.3 with the administration.

§7.11.a

Comment: Should state - "non-prescription" as staff should not give the least amount of all medications. Certainly this would be harmful in the case of many drugs such as antibiotics.

Response: This right is addressed at 8.1.a.19. Regulation will be deleted.

§7.11.c

Comment: Medication administration should be based on a client's ability to safely self-administer. Self-administration should include some language about the client's understanding of what he/she is taking, when to take it, and the side effects to notice.

Response: Commas will be added: "A consumer, to the extent, ..." In settings where the consumer's goal is to be independent, this ability should be assessed and allowed. See 7.11.e for informed consent.

§7.12.a

Comment: This rule if promulgated by the Secretary will require "supportive services" that she has not to date determined how she will pay for. This is the requirement of a service not based on the treatment plan and potentially an unfunded mandate. Delete this item until resolved. Needs defined.

Response: If the service is semi-independent, the assumption is there are a few services going on, otherwise it would be independent. The issue is any service, no matter how humble, should be noted on the treatment plan, otherwise it hasn't been assessed as needed. However, since this is already required in Section 7, this section will be deleted.

§7.13

Comment: Would an agency operating a residential treatment program for minors need to comply with 7.13 and 7.14?

Response: Since the implication evidently isn't understood, addition made: "Residential Treatment Services (Adult and Minors).

§7.13.a

Comment: The rule alluded to in this standard should be specified. The phrase, "and that are available upon request" is misplaced and awkward.

Comment: For staff? For residents? Specific to Residential Services or the Whole Rule. Currently we maintain a policy manual specific to Residential Services not the whole rule.

Response: Agree this makes no sense, and this is in the current regulations. Change to "The service shall have rules of conduct for consumers to follow while in residence.

§7.13.b

Comment: Consumers have the right to choose and may not always want foods that promote healthful living.

Response: Will change “provided” to “offered.”

§7.13.d

Comment: Who are residents who require 24 hour staffing?

Response: Those whose treatment plans require this level.

§7.13.e

Comment: It is a Case Management function to refer and maintain a record of referrals.

Residential staff are not always the consumer’s case manager.

Response: In this case, wouldn’t the case manager then be staff in a group home? Will change to read: “Residents shall be referred for ongoing mental health services and assisted in keeping appointments...”

§7.14

Comment: If the issue is concern over family involvement, then define that is a separate section which is applicable to all client populations which have family involvement, not simply applicable to minors. Should agencies dealing with an adult population have any less of a focus on involving families?

Comment: Recommend “The level of the family or guardian or legal representative involvement expected.”

Response: What the regulations can require needs to be based on realistic outcomes. If it has been assessed that an adult needs to be involved in his or her families, that should be noted on the treatment plan. This section was added to the regulations due to the addition of the child care facilities. There were no precedents to follow, therefore, we consulted the Council On Accreditation for A behavioral Health Care Services, U.S. Edition, 1997. However, will change to “The level of the family or guardian or legal representative involvement expected...”

§7.14.b

Comment: Recommend “...child and family/guardian or legal representative...”

Response: Will make addition.

§7.15.a

Comment: The “open facility...” terminology contradicts the earlier language of “can be locked.” Need to define “an organized program of activities and counseling.” There should be a standard of assessment, treatment and discharge.

Response: Note the response for 6.7.b above. The requirement does not preclude adherence to section 7.

Comment: Is there a minimum number of clients?

Response: Not unless the code at 27-17-1 applies.

Comment: Nothing is mentioned of Fire Code Requirements.

Response: Refer to 6.2.a and 6.4.a.

§7.16

Comment: The clinical supervisor of a partial hospitalization program, monitor or adults, should be on site.

Response: We have only had this difficulty with children's program. However, we will delete "minors."

§7.17

Comment: If the issue is supervision or oversight, then this needs defined. If the issue is having staff who are qualified to provide the service, then perhaps you need to define staff qualification for this service. In 7.17 there is only reference to ratios for staff, not qualifications for staff. If this issue is intensity of service, then perhaps you need to define what is required for a program to be licensed as such.

Response: Issues of oversight and staff qualifications are addressed at 5.5.g, 5.6.a, 5.6.b, 5.6.c, 5.6.d, and 5.7. Assessments and treatment planning and implementation are found in section 7. There are several of these services licensed across the state. Staff ratios and adequate educational components are areas we have had concern with and needed to address them. These regulations are similar to the Council On Accreditation, US Edition 1997.

§7.18

Comment: There is no definition of the term "Educational Programs."

Response: Some terms can define themselves. Directive from the regulatory division advised only defining those phrases that are not used in context as defined in Webster's.

Comment: Teacher qualifications should be further defined. The standard otherwise will be interpreted as a licensed teacher.

Response: 7.18.a.1 requires that staff meet state requirements. Assumedly, that is a teacher's certificate. It's up to the State Board of Education to define the qualifications. Addition will be made to add "staffing ratios."

§7.18. D

Comment: What is an appropriate teacher to consumer ratio:

Response: This whole section was adapted from the Council On Accreditation, US Edition 1997 as there was no precedent in the current regulations. 7.18.a.1 requires staffing to meet the requirements of the department of education.

§7.18.e

Comment: What is an adequate number of classrooms? How is this measured?

Response: This would be up to the department of education and observable determination.

§64-11-8

Comment: This section should be deleted as there is a proposed Consumer Rights Rule that will amply take care of all West Virginians. Any variation from that Rule to this one will cause confusion. The Secretary has proposed the Rights Rule and as that Rule satisfies her concerns about consumer rights. That furthers my suggestion that section should be deleted as it is now duplicative and redundant.

Comment: Recommend that this standard refer to compliance with the Behavioral Health Consumer Rights Rule 64CSR74. Common definition will allow for less chance for confusion and more opportunity for compliance. Need full list of the consumer rights made into a Bill of Rights.

Response: OHFLAC strongly disagrees with this suggestion. The Consumer Rights Rule is not imperative to whether a center is, or remains, licensed. Furthermore, complaints investigated by the agency will be based on this rule, not the Consumer Rights Rule as OHFLAC has no authority to enforce the latter.

§8.1.a.17

Comment: “The rights to referral” poses a problem for those services paid a bundled rate for all treatment. If a client wishes to see a particular therapist in the community, this is not covered if the client is receiving Residential Treatment.

Response: See 8.1.c. The assumption is the Department would be the legal representative.

§8.1.a.23.C

Comment: The right to “constant access” needs clarified.

Response: A individual’s right to his own possessions should never be curtailed, unless the provisions at 8.1.b are invoked. Constant means consistent, access means the right to retrieve, or enter.

§8.1.a.23.D -

Comment: The right to private communication with others needs clarified. The parent/guardian may wish to limit contact with others. The legal guardian may wish to limit contact with the parent. Are these rights to be at agency or consumer expense?

Response: See 8.1.b. Not sure what expenses are indicated? Need to clarify.

§8.1.b

Comment: The right to limit the client’s rights and personal liberties should require either the signature of the physician or the administrator.

Response: The requirement is for “policy” to established addresses this issue, which, we assume, should be approved by the administrator. We don’t see the physician’s play in this, unless its a restrictive health procedure, which would then be a physician’s order.

§8.1.c

Comment: -The legal representative if “hostile or adverse to the best interests of a consumer” should be removed as the legal representative. What mechanism will be in place for agencies to implement this?

Response: Since the representative has been appointed legally, you would need to pursue this through the courts.

§8.2

Comment: The complaint process should be kept in place in this standard in that it augments the provisions of 64CSR74.

Response: OHFLAC will not be enforcing 64CSR74.

§8.2.a

Comment: An employee of a center is required to report abuse or neglect immediately, this clause should not be limited to physical abuse.

Response: Disagree. If a consumer has been physically abuse at 3:00 am, by anyone, it should be immediately reported. The time-frame is acceptable for other types of abuse.

§8.2.b

Comment: Those agencies licensed also under Chapter 49 are not permitted to conduct in-house investigations and must report all instances of suspected abuse to the Institutional Investigative Unit within the Office of Social Services. Clarification in this rule for such dually licensed would be appreciated.

Response: Agencies can continue reporting abuse to the IIU.

Comment: what is considered as a “reasonable time?”

Response: Probably the next meeting of the Human Rights Committee.

§8.3

Comment: Most of or consumers are outpatient and have lives outside of treatment. Would we be expected to investigate their injuries? This would make more sense for injuries or death that would occur in day treatment or residential programs but not for consumers seen here for therapy or medication maintenance kinds of services.

Response: Since the rule is directed towards the services of a behavior health center, the interpretation seems clear that only those incidents that occur at the behavior health center, at any service site.

§8.3.a

Comment: The criteria for what rises to be a “serious injury” is not defined.

Response: Again, some terms are self defined.

§9.1.c

Comment: At times the magistrate does not want the consumer released until he has appeared before the magistrate. The definition of a responsible adult needs clarification.

Response: Can add “judged to be responsible,” but then “judged” would need to be defined. Assumedly, the criteria would be someone else who is not inebriated.

§10.1.a

Comment: Need to define “fraud or illegal action”. Need to define how the secretary will make this determination. Need to define to what extent violation of federal, state or local laws would impact the decision. For example, an agency violates a health department regulation and this is evident by getting less than 100 points or a review. To what extent will this allow the secretary to deny renewal.

Response: The first sentence says that “the secretary makes...” not the secretary’s designee shall.

Fraud and abuse should be determined by facts of each case, i.e., provider track records, etc.

§10.1.d

Comment: Need to define reports.

Response: Plans of corrections.

§10.2 If a license is revoked, can the agency apply for a renewal during the stay (of effective date) as identified in 10.2?

§64-11-10

Comment: None of these are defined in WV Code Chapter 27

Response: The intent is in the code.

Comment: The center does not control access to private homes and locations it does not own or control. This could infer a penalty if access is denied where the center does not have control.

§64-11-10

Comment: Penalties None for these are defined in WV code chapter 27.

Response: According to counsel, 64-11-10 clarifies what constitutes good cause as mentioned in the code.

§64-11-11

Comment: The Administrative Due Process needs to be defined. Time frames to request should be included, as should time frames for response. The hearing process needs to be defined.

Apparently the process is already defined in "Rules of Procedure for Contested Case Hearings and Declaratory Rulings" however, these should either be included or provided to centers.

Response: Counsel believes this to be adequate wording.

SUMMARY OF CHANGES AFTER PUBLIC COMMENTS

8.1.a.8. Addition: The right to freedom from restraint or seclusion. "Restraint and seclusion may only be used in situations where there is imminent danger to the consumer or others and all other less restrictive methods of control have been utilized." Addition made due to comments concerning restraints pointing out the omission of how an inappropriate restraint would be defined.

To avoid confusion, 4.1.e.2, application submission, will be deleted.

In reviewing comments, it was apparent that all the components of a behavior intervention program were not included. Therefore, 7.6.c will include the data to be collect **Ged** to assess progress toward the objectives.

6.8.b.9 will add the words: "...prescribed by the center's physician.

7.3.b - Changed implemented to finalized.

7.6.c Added "...the data to be collected to assess progress towards objectives.

An additional regulation shall be added at 7.6.f to read: "When a psychiatric emergency exists and less restrictive measures are not effective, the center may utilize intrusive measures such as the administration of medication, seclusion or mechanical restraints until the crisis is resolved or the client can be transported to an inpatient facility." This addition is necessary as it was not clear under what circumstances restraints or seclusion could be

A definition of psychiatric emergency will be added at 3.34 which states: "An incident when a consumer loses control and behaves in a manner that poses substantial likelihood of physical harm to himself or herself or to others." This addition is made based on comments questioning when a restraint may be used.

Consequently, at 7.8, the wording shall be changed to "Medical and Psychiatric Emergency Services."

**F
M
R
S**

MENTAL HEALTH COUNCIL, INC.

ADMINISTRATIVE OFFICE

**Telephone: 304-256-7100
101 S. Eisenhower Drive
BECKLEY, W. VA. 25801**

July 30, 1999

Beth Marquart, Director
Regulatory Development
Department of Health and Human Resources
Capitol Complex – Building 3, Room 265
Charleston, West Virginia 25305

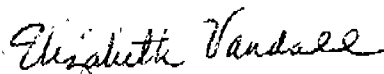
RECEIVED
JUL 30 11:11 AM
1999

Dear Ms. Marquart:

Please find attached our comments on Proposed Legislative Rule – Behavioral Health Centers Licensure.

Thank you for taking our comments and concerns into consideration.

Sincerely,



Elizabeth Vandall, M.A.
Quality Improvement Director

COMMENTS

PROPOSED SERIES II BEHAVIORAL HEALTH CENTERS LICENSURE

General Comment – Overall, we found the proposed regulations to be somewhat vague, leaving a lot to personal interpretation.

3.1 Abuse and 3.27 Neglect - Definitions are not consistent with Chapter 49 of the West Virginia Code. Should not licensure definition be the same for consistency?

5.5.1 - The term “policies for effective service delivery” is too vague. Depending upon interpretation, this could be a 10 page booklet or a 100 page manual.

5.2.b. - “The governing body evaluates implementation of policies” – what exactly does this mean? What would be required?

5.3.d.3. - “Policies and procedures shall provide for the process to evaluate the effectiveness of the governing body”. What does this mean, and who would be responsible for evaluating the effectiveness of the governing body?

5.6.d.1. - We maintain a master file of job descriptions. We think this should be sufficient. We do not see the necessity to have a copy in the individual personnel file.

5.6.d.6. - Although they are a good idea, Licensure should not **require** us to complete Employee Performance Evaluations. As long as we meet the Medicaid (and other funding source) requirements for the clinical supervision of employees, the decision to implement Performance Evaluations should be solely that of the employer.

5.6.e. - What does regular contact mean? Does this include the receptionist, switchboard operator, billing clerks, etc., all of whom have regular contact or just those people who have hands-on clinical contact such as instructors, case managers, therapists, etc.

5.7.c. - Should be who are **diagnosed** with a Behavioral Disorder.

5.8.a.2 - Adequate coverage by whose definition? Line staff should definitely not be led to believe that they determine the definition of “adequate coverage” or that the staff with low tolerance for certain clients can impact the clinical decision whether or not a commitment is necessary.

5.9.a.4 - The Human Rights Committee will “review internal and external investigations of complaints and consumer grievances”. What are internal and external investigations? If the police were doing an investigation would they be expected to give information on their investigation to this committee?

Comments on Behavioral Health Centers Licensure

Page 2 of 3

5.10.a.2. - Again, what is adequate? What we determine "adequate" to be based on our knowledge of the clients, skill level of staff, and other factors may not be considered adequate by an OHFLAC Reviewer.

6.1.f - "Post by the telephone emergency telephone numbers ..." Should this be a residential requirement, or is for all phones in the agency? There are many phones that consumers would never even be near.

7.1.b. - Procedures for what?

7.1.c - It should be up to the center itself to determine who supervises its programs. Not all of the services we provide have to be provided by staff with a Master's degree. Licensure should not arbitrarily set this kind of a standard. Degrees and clinical skills do not always reflect nor insure that a person has the skills and ability to successfully manage resources and people or insure that services are delivered in compliance with State, Federal and agency guidelines. The implementation of this regulation without, at a minimum the safeguard of a "Grandfather Clause" or behavioral health experience substitutions for education, would eliminate a number of skilled, experienced and dedicated individuals from the behavioral health system.

We understand that supervisors should be knowledgeable about service provision but we feel that there are staff qualified to supervise who may not have a master's degree or two years post-master's degree experience in the delivery of family services. Some of the services we provide are not "family services". Is this saying you cannot be a supervisor unless you have provided "family services"?

We also do not understand what the last part of this regulation mean. "...except for skills training which must be done by a registered nurse or a person with a bachelor's degree in human services or education". Does this mean that training will now have to be done by a degreed individual rather than high school level staff?

7.3.g.4 - We think this is unclear. It appears to be a duplication of what occurs in the physician's documentation, which is the generally accepted practice for reviewing drug dosages and types and explaining the rationale for changes or continuation of psychotropic drug regimens. If each medication change must be included in the treatment plan, this will be a nightmare, especially in the case of medications that must be titrated up or down according to schedule (sometimes weekly) such as Clozapine.

7.5.b.4 - "Discharge summary should include a plan developed in conjunction with the consumer for care after discharge and for follow-up" - how do we do this for consumers who take themselves out of treatment (do not return)? There is no provision for discharge summaries when the consumer does not return for treatment.

Comments on Behavioral Health Centers Licensure

Page 3 of 3

7.6.a - This regulation says that "center staff" shall be trained in behavior management -- does this mean all staff or all staff who work directly with clients? It should specify what staff would need this training.

7.10.b.1 - It is unrealistic to hold us accountable for insuring that **all** medications are reviewed every 90 days when not prescribed by our physician and are being ordered for lifelong medical conditions such as diabetes that is under control with current medication regimens.

7.10.b.2. - This is unclear and we do not understand the meaning. See 7.3.g.4

7.10.b.3 - This should be adequate to cover 7.10.b.2.

7.13.a. - For staff? For residents? Specific to Residential Services or the Whole Rule. Currently we maintain a policy manual specific to Residential Services not the whole rule.

7.13.e. - It is a Case Management function to refer and maintain a record of referrals. Residential staff are not always the consumer's case manager.

8.3.a - "The center shall investigate any incident that results in serious injury or death..."
Is this injury or death while receiving services? Most of our consumers are outpatient and have lives outside of treatment. Would we be expected to investigate their injuries? This would make more sense for injuries or death that would occur in day treatment or residential programs but not for consumers seen here for therapy or medication maintenance kinds of services.

THE
Pressley Ridge
 SCHOOLS OF WEST VIRGINIA

Scott Hasselman
 Southern Regional Director
 2580 Grant Gardens Road
 Oma, WV 25545
 (304) 743-4439 Fax (304) 743-1147

Robert C. Knittle
 State Director
 400 Capitol Street, 2nd Floor
 Charleston, WV 25301
 (304) 345-0525 Fax (304) 344-1394

Lisa M. Shepard
 Northern Regional Director
 Route 5, Box 697
 Charlesburg, WV 26301
 (304) 624-9875 Fax (304) 624-9871

July 29, 1999

Ms. Beth Marquart, Director, Regulatory Development
 Department of Health and Human Resources
 Capitol Complex - Building 3, Rm 265
 Charleston, WV 25305

OFFICE OF HEALTH AND HUMAN RESOURCES
 DEPARTMENT OF HEALTH AND HUMAN RESOURCES
 CHARLESTON, WV 25305
 99 JUL 30 PM 3:10
 RECEIVED

Dear Ms. Marquart,

Thank you for the opportunity to comment on the Proposed Rules for Behavioral Health Center Licensure, Title 64.

My first comment is that I had a difficult time identifying what was new or different in the regulations. Usually when proposed changes occur the reader can identify those changes by the way they are highlighted or otherwise identified. It was difficult to leaf through copies of OFJAC and Child Caring regulations at the same time and identify if there was a change or not.

I'd like to mention the other questions or concerns I have by naming the reg. number.

3.18. Functional Analysis: This term may need to be further explored and more specific in explanation. Functional Analysis means different things to different people especially to the Office of Medical Services. That office makes reference to an antiquated method of behavioral analysis, but refers to it as functional analysis. I think this could cause confusion.

3.31. Positive Programming: A wonderful idea with no method of reimbursement. Medicaid regulation is very specific about what is reimbursable if providing behavior management.

4.2a Identifies the Secretary (not her/his designee) as having to inspect new locations for all residential treatment facilities. Will it always be the Secretary?

6.6a The regulation specifies the amount of "floor space". The child caring reg. identifies the same number of square feet but does not identify that as "floor space".

6.7.b.2 and 6.7.b.3 This may be in violation of a child caring regulation and WV Chapter 49.2b. If a child is in a group home or emergency shelter we are not permitted to "lock" children in, regardless of the issues that may be present.

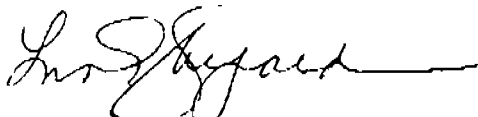
7.1.c. Supervisors are not required by anyone else to have a Master's degree and 2 years post masters degree experience. What type of Supervisor are you referring?

7.6.b.1 Again a better description of what OFI.AC means by functional analysis is very important.

64.11.10 Penalties. Is this consistent with WV Code 27 ?

Once again thank you for this opportunity. I look forward to your response. If you have any question about the responses please do not hesitate to contact me at: 624-9875.

Sincerely,



Lisa M. Shepard M.A.,LPC
Deputy State Director

Cc: Robert Knittle, Deputy Executive Director

THE
Pressley Ridge
SCHOOLS OF WEST VIRGINIA

Scott Hasselman
Southern Regional Director
2580 Grant Gardens Road
Ona, WV 25545
(304) 743-4439 Fax (304) 743-1147

Robert C. Knittle
State Director
100 Capitol Street, 2nd Floor
Charleston, WV 25301
(304) 345-0525 Fax (304) 344-1394

Lisa M. Shepard
Northern Regional Director
Route 5, Box 897
Clarksburg, WV 26301
(304) 624-9875 Fax (304) 624-9871

FROM: Lisa Shepard

TO: Beth Marquart

PHONE #: 624-9875

NUMBER OF PAGES: 3

COMMENTS: Comments for proposed Behavioral
Stand Reg changes.

The Children's Home of Wheeling, Inc.

Improving the quality of family life since 1870

1 Orchard Road • Wheeling, W.Va. 26003-6674
(304)233-2367 • Fax: (304)233-3246

July 27, 1999

Ms. Beth Marquart
Director
Office of Regulatory Development
Building 3, Room 265 Capitol Complex
Charleston, WV 25305

REC'D
WV
CHILDREN'S HOME
OF WHEELING
JUL 28 1999
11:05 AM
0000000000

Dear Ms. Marquart:

Please find attached my comments on proposed Behavioral Health Regulations Title 64, Series 74 and Title 64, Series 11. I trust that you will understand the comments which I have made, and I have cited the page number of the regulation as a reference.

I am mailing a hard copy of my comments to you at this time, in the event that the facsimile transmission is not adequate. Should you have any questions about my comments, please do not hesitate to contact me at **233-2367 extension 251**.

Sincerely,



Melanee W. Sinclair, ACSW
Executive Director

Comments on Proposed Behavioral Health Licensing Regulations 64 CSR 11

Pg. 2 The definition of physical and verbal abuse should be the same as in the WV Code. If the "higher level of care" is to be defined here, then that standard needs to be clearly identified. "Unnecessary or improper use of physical restraint" is vague. "Use of unnecessary force" is vague. "Inappropriate removal from a treatment program" needs deleted. Treatment programs may determine that a client is not appropriate for the program, and need immediate discharge. This should not be defined as physical abuse. "Restriction of communication or withdrawal of privileges" should not be defined as physical abuse. If you wish to make it an issue of concern, perhaps you need to include in psychological abuse.

Pg. 4 Critical Incidents definition of "behavior that will likely lead to..." needs parameters.

Pg. 5 "Major involvement with law enforcement" needs defined. "Serious consequence resulting from an apparent error in medication or dietary administration" need clarified. (Both serious consequence and apparent need defined). Medication errors as defined on pg. 7 may assist in this definition.

Pg. 7 "Inappropriate application of behavior intervention" needs deleted. If there is a concern about hand on approaches, then that is really a physical abuse issue. If the issue is other than that then it needs to be reflected accordingly.

Pg. 10 Volunteers may not meet "employment qualification", but the agency may have "volunteer qualifications". If there is a concern that volunteers need to be screened in the manner of employees, then can't we identify that?

Pg. 11 Amended applications would allow for changes in location, intensity and capacity with only notification to the secretary. While new providers would need to go through the certificate of need process? This will allow a lot of flexibility to current providers to expand throughout the state and provide whatever service was desired. The license should expire when indicated, and be re-issued after application and review. The ability to grant a waiver should be defined more clearly than "application would be impractical" and "not detrimental".

Pg. 15 While most providers have through other standards an expectation of whom will comprise the governing body; it would be appropriate to indicate this here also.

Pg. 16 Insurance coverage minimums should be identified.

Pg. 18 "All personnel and consultants" needs to be defined so that it is "all professional staff and consultants" are credentialed. The consumer or legal representative as the

primary source of information is a concern in that many times the consumer is not the most reliable source. Need to define when it would be the consumer and when it would be the legal representative,

Pg. 19 The center will not necessarily have information of "prior history of" abuse, neglect or mistreatment. If there is to be some central mechanism to track this for our use, then this should be indicated. The staff-training piece infers that staff can be trained on the first day to all policies and procedures and restraint. Most restraint models are lengthy trainings, which take a minimum of 8 hours to complete. Orientation to policies and procedures is not something that could be accomplished on the first day of hire. The time frame for "staff orientation" needs defined. The Heimlich maneuver is no longer the method approved or taught by the American Red Cross.

Pg. 22 The development of "a plan" to address issues of access will not deal with the issue of access. A center could develop a plan and not implement it. If the issue is access, then this should be stated.

Pg. 23 Furnishings for residential treatment facilities need to be first and foremost, safe. "Homelike and personalized" may or may not meet the needs of a particular population.

Pg. 25 Need to define if Shelters Residential Treatment Centers and Group Homes "may be locked". Is this to prevent people from coming in or residents from going out? Facilities would need to have some plan for safety as it relates to fire etc if residents are locked in. There needs to be clarification if the entire following list applies or any one of the following list applies. "Need of protection" and "danger to self or others" needs defined. What does Internal Investigation Unit and Licensing think of this regulation?

Pg. 29 "Education services" needs defined. Is this intended to mean that youth are doing something educational or that the youth is placed in an approved school placement? It should not specify that this applies only to youth in residential programs. "Promptly" should be defined in terms of a day limit. How will the state Board of Education assist us with this?

Pg. 31 Seclusion and Physical restraint should be regulated separately. The use of physical restraint certainly needs to be closely monitored by administrators. However, the use of physical restraint should not require a physician or other licensed professional and/or a team to determine use. The use of physical restraint is only used to the point of client readiness.

Section 7.6.g is very confusing to read. If a client is restrained during the three hours before release, perhaps this is justification enough not to release him.

Need to define "ensure" in section 7.6.1.

Pg. 32 While behavior intervention may cause severe emotional stress; they may also be the most effective and least intrusive method to address problem behaviors. Agencies

should have established behavior intervention protocols, and mechanisms for identification and review of interventions. "Likely to occur" needs to be defined.

Pg. 33 Medication administration should be based on a client's ability to safely self-administer. Self-administration should include some language about the client's understanding of what he/she is taking, when to take it, and the side effects to notice.

"Semi-Independent Living Facilities" needs to be defined. There is not adequate definition in the one standard listed that indicate that supportive services are provided based on a treatment plan. There should be further definition as to self-administration of medication, staffing needs nutritional oversight, habits of personal care, hygiene and grooming, and mental health assessment and participation in treatment.

Pg. 34 Would an agency operating a residential treatment program for minors need to comply with 7.13 and 7.14? If the issue is concern over family involvement, than define that in a separate section which is applicable to all client populations which have family involvement, not simply applicable to minors. Should agencies dealing with an adult population have any less of a focus on involving families?

Pg. 35 The "open facility that ensures a safe living environment" terminology contradicts the earlier language of "may be locked". Need to define "an organized program of activities and counseling". There should be a standard of assessment, treatment and discharge.

The clinical supervisor of a partial hospitalization program regardless of whether the program serves minors or adults should be on site enough to ensure that services meet the needs of the consumers. If the issue is supervision or oversight, then this needs defined. If the issue is having staff who are qualified to provide the service, then perhaps you need to define staff qualifications for this service. In 7.17 there is only reference to ratios for staff, not qualifications of staff. If this issue is intensity of service, then perhaps you need to define what is required for a program to be licensed as such.

Pg. 36 Teacher qualifications should be further defined. The standard otherwise will be interpreted as a licensed teacher.

Pg. 37 "The right to referral" poses a problem for those services paid a bundled rate for all treatment. If a client wishes to see a particular therapist in the community, this is not covered if the client is receiving Residential Treatment.

Pg. 38 The right to "constant access" needs clarified.

In regard to minors, the right to private communication with others needs clarified. The parent/guardian may wish to limit contact with others. The legal guardian may wish to limit contact with the parent. Are these rights to be at agency or consumer expense?

The right to limit the client's rights and personal liberties should require either the signature of the physician or the administrator.

The legal representative if "hostile or adverse to the best interests of a consumer" should be removed as the legal representative. What mechanism will be in place for agencies to implement this?

Pg. 39 An employee of a center is required to report abuse or neglect immediately, this clause should not be limited to physical abuse.

The Internal Investigation Unit of the WVDHHR has not allowed organization to complete any investigation, let alone a "thorough investigation" The standards for all agencies involved in regulating this business, need to agree on the approach to take. Time frames for reporting need to be clearly identified. In this draft, the administrator is not required to report this to anyone except the agency's Human Rights Committee unless there is a grievance or serious injury or death. The standard should require notification to a state licensing body. This standard does not imply that first and foremost, the center needs to ensure the client's safety.

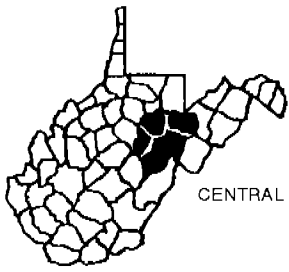
Pg. 41 Need to define "fraud or illegal action". Need to define how the secretary will make this determination. Need to define to what extent violation of federal, state or local laws would impact the decision. For example, an agency violates a health department regulation and this is evident by getting less than 100 points on a review. To what extent will this allow the secretary to deny renewal?

Need to define the reports, which may lead to denial, revocation, suspension, admission ban or reduction in census.

If a license is revoked, can the agency apply for a renewal during the stay (of effective date) as identified in 10.2?

The Administrative Due Process needs to be defined. Time frames to request should be included, as should time frames for response. The hearing process needs to be defined. Apparently the process is already defined in "Rules of Procedure for Contested Case Hearings and Declaratory Rulings" however; these should either be included or provided to centers.

The issue of dual licensing though a reality is not defined in this document. The issue of operating with different standards from two state bodies in of great concern.



THE APPALACHIAN COMMUNITY HEALTH CENTER

CENTRAL OFFICE • 725 YOKUM STREET • ELKINS, WV 26241 • PHONE 304-636-3232 • FAX 304-636-9243

Participating: BARBOUR, RANDOLPH, TUCKER, and UPSHUR COUNTIES

July 28, 1999

Beth Marquart, Director Regulatory Development
Department of Health and Human Resources
Building 3, Room 265
State Capitol Complex
Charleston, WV 25305

Handwritten notes and stamps on the right side of the page, including a date stamp 'JUL 29 1999' and some illegible text.

Dear Ms. Marquart:

The Appalachian Community Health Center has reviewed the Behavioral Health Centers' Licensure Rule 64CSR11 and offers the following:

General Comment: The Rule as proposed needs to be further modified to add clarification to a number of sections. The potential for contested findings is significant with the Rule as it now stands. Further, the Rule should be more integrated with other rules and regulations, specifically the Behavioral Health Consumer Rights Legislative Rule 64CSR74. The use of common definitions for abuse and neglect would allow for uniform implementation of both Rules. There is a need for common consumer rights requirements that are either reported in both rules or are cited in one rule referencing the other. An example would be for the Behavioral Health Licensure Consumer Rights to cite the Behavioral Health Consumer Rights Rule 64CSR74 as the standard for compliance with 64-CSR-11-8 of the licensure rule. It is further recommended that a complete list of consumers' rights in the form of a Bill of Rights be developed that would meet the standards of both 64CSR11 and 64CSR74.

The 64CSR11 as proposed mixes services, locations and facilities together and assumes that services will be reviewed wherever they may be provided. Services provided at a Center owned facility are assessable but review of individual consumers or groups of consumers are contingent upon the consumer's willingness to participate. Consumers have the right not to participate in reviews. Services provided in private homes are also subject to the consumer willingness to participate in the review process. The rules and regulations will need to assure that the consumer's rights are protected even during a licensing review process.

It is suggested that the Department withdraw the Rule and establish a committee consisting of consumers, providers and the Department to review and suggest modifications of the Rule. The committee process was successfully used in rewriting 64CSR74 to include providers, consumers and the Department.

64-11-3. Definitions.

General Comment: The definitions used for Abuse, Neglect and other terms in common with consumer rights should have the same definitions in order to avoid confusion and misinterpretation.

3.4. Adversive Procedures.-- Restrictive procedures that impose consequences a consumer finds undesirable in a treatment program to decrease inappropriate behaviors. What is undesirable varies with each consumer but generally includes such measures as fines or loss of privileges. Aversive procedures include, but are not limited to, physical and chemical restraint, time-out and seclusion.

Comment: The consequences that are indicated in this standard are narrow in scope and do not reflect the full range of therapeutic alternatives that may be appropriate. The standard should state that any adverse procedure utilized to decrease inappropriate behaviors must be included as a part of the consumer's treatment plan except in the case of an emergency.

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

Comment: Protective devices are more than the current definition indicates. Suggest a language change to "Protective Device- any appliance or device that helps protect a consumer from injury or that is used to aid in the healing of an injury. Appliance used may include a brace, pad, helmet, covering, bandage, etc."

3.42. Semi-Independent Living Facility.-- An apartment or home that houses consumers with disabilities, providing staff as needed.

Comment: A private home is not a facility yet services may be provided in apartments or private homes. A facility as defined in the section should be defined as an apartment or home owned by the center.

3.44. Staff -- Personnel paid by the center to provide services.

Comment: All persons paid by the center are not staff. Employees paid by the center are staff. Recommend changing the language to reflect "Staff -- Employees paid by the center to provide services"

3.48. Treatment. -- A broad range of planned habilitative services, including diagnostic evaluation, counseling, medical, psychiatric, psychological, training, education, and social service care, that are provided to enable a consumer to meet identified goals and objectives.

Comment: Consumers receive either or both habilitative and rehabilitative services. Suggest rewording to reflect the option. Suggest, " Treatment. -- A broad range of planned habilitative and/or rehabilitative services..."

3.49. Treatment Plan.-- A written design based on the assessment of a consumer's needs and strengths that identifies problems, sets client-centered goals and objectives and describes all services, programs and activities required to support the achievement of the goals and objectives.

Comment: The treatment plan should reflect all the services, programs and activities currently being implemented. The definition should read " Treatment Plan. -- A written design based on the assessment of a consumer's needs and strengths that identifies problems, sets client-centered goals and objectives and describes services, programs and activities currently required to support the achievement of the goals and objectives agreed to by the client.

3.50. Volunteer. -- A person who provides services for no direct financial remuneration, and who meets the center's employment qualifications for health, safety and training.

Comment: Volunteers should be afforded the opportunity to receive health, safety and training appropriate to the services that are providing. Suggest rewording to " Volunteers should meet all the qualifications for the services they are providing and should be afforded the opportunity to receive health, safety and training appropriate to their functions.

64-11-4. State Administrative Procedures.

4.1.e.2.A. Initial applications shall be received by the secretary not less than thirty (30) days and not more than sixty (60) days prior to initiative of services.

Comment: The process for initial application will need to be outlined further. The time line for site review and initial provisional license should be made clear.

4.1.e.2.C.1. A change in the geographic location of a service or facility;

4.1.e.2.C.2. A change that increases the intensity of services at a location (e.g. home-based to day program);

Comment: There will need to be clear guidelines as to what constitutes the changes indicated in this standard. The change a of location is clear while the change of location of service may be subject to interpretation. Change as to intensity of service at a location needs more explanation then the e.g. given.

4.1.e.2.D. An application for an initial or renewal license shall identify the governing body, administrator and senior management of the center.

Comment: The identification of the governing body and the administrator are appropriate information for an application. The identification of senior management staff should not be a part of initial or renewal license. If there is a reason that identification needs to go beyond the governing body and the administrator, then a definition of senior management staff will need to be developed.

4.1.e.3.b.B.1 An initial six (6) month license shall be issued to centers establishing a new program or service for which there is insufficient consumer participation to demonstrate substantial compliance with this rule.

Comment: There is not a definition of consumer participation. Does this mean consumers participating in the planning for the program or does it mean participation of consumers receiving the program? The Rule will need to be clear as to what consumer participation means and what constitutes sufficient.

4.2. Construction and Renovation.

General comment: The governing body must determine the appropriate services and must be responsible for center owned facilities. The purchase of land, the design and construction are the responsibility of the governing body. Establishing standards for construction, mechanical requirements and safety is the state's responsibility. Pre-site approval goes beyond the current licensing standards and may offer a barrier to the propriety purchase of property within the community.

4.2.a. The secretary shall inspect new locations for all residential treatment facilities and locations of additions to existing residential treatment facilities prior to the architect's beginning work on final drawing and specifications.

Comment: Is this necessary for licensing? The secretary actually going to all proposed sites all sites being renovated seems burdensome and time consuming. Such a standard may delay an already cumbersome process. The secretary inspecting any site or renovation being funded directly or with a majority of funding coming from the state would be more appropriate.

4.2.d. Residential treatment facilities shall be located as conveniently as possible with access to necessary services.

Comment: The standard is subjective and needs to be either eliminated or reworded to indicate that residential facilities shall meet all appropriate standards for accessibility and residents shall have accessibility to other services as needed.

4.3. Inspections.

General comment: Inspection by authorized representatives is appropriate as long as consumer's rights are respected and observed. Consumers have the right not to be observed at their request. Consumers have the right not to be interviewed.

4.3.b. Inspections shall include, but are not limited to:

Comment: This standard indicates that all 4 of the elements of the section shall be included even though the consumer has the right not to be observed and the consumer has the right not to be interviewed.

4.3.b.1. Could read, "Observation of service delivery with consumer consent"

4.3.b.4. Could read " Interviews with consumers (with the consumers consent), staff and administrators.

4.3.d. Inspections shall include every service and location operated by the center.

Comment: Some services are provided in consumers' homes and the consumer does not have to allow anyone in their home unless they are willing to open their home to the inspector. The Standard cannot be met for every service. Some services are provided in natural setting that may involve persons that are non-consumers and may not wish to be observed or interviewed.

4.3.e. The Center shall comply with any reasonable request from the secretary to have access to the service, staff, consumers (with their permission) and records.

Comment: This standard includes the phrase " consumers (with their permission)", this phrase should be included anywhere in the regulation where the consumer is expected to participate. A general statement at the beginning of the standards could accomplish the same result. The definition of reasonable request must include the reasonable notice period required to access the information and the persons subject to the inspection. The exception would be a unscheduled visit.

4.3.f. Within ten (10) days of completion of an inspection the secretary issues a report.

Comment: Is this ten (10) working days or ten (10) calendar days?

4.4. Complaint Investigation:

4.4.b. The secretary may conduct unannounced inspections of centers or services involved in a complaint and any other investigations necessary to determine the validity of a complaint.

Comment: Unannounced visits at facilities is significantly different then unannounced visits at service sites. Services are provided to families in home, to individual consumers in their residence and in other natural settings. Unannounced visits to consumers can only be considered with their permission.

4.4.c. At the time of the investigation the investigator shall notify the person responsible for the center's operation or person in charge of the location involved in the complaint the reason for the complaint.

Comment: It is poor practice not to notify the person in charge or that person's delegate of the reason for the complaint. The person in charge or his/her delegate should always be notified due to potential liability issues. The standard should be rewritten to indicate the above. Some complaints may arise from services provided in a consumer's home and an investigation notice should only be provided to the administrator or the administrator's delegate.

4.4.d. Within ten (10) working days of the investigation, the secretary shall provide to the center a written report of the results of the investigation, along with any violations.

Comment: Suggest that each place ten (10) days is indicated that working or calendar days be included.

4.5 Plans of Correction:

4.5.a. Within ten (10) days after receipt of the inspection report, the center shall submit to the secretary for approval a written plan to correct all deficiencies that are in violation of this rule.

Comment: Again is this ten (10) working days or calendar days? The standard also does not allow for an extension . The clause "accept where variance is allowed by the secretary under special circumstance" should be added.

4.5.b. The secretary shall approve, modify or reject the proposed plan of correction in writing.

Comment: The secretary can approve or reject a plan of correction. The secretary can suggest modifications to the submitted plan. The center would have to modify the submitted plan based on the secretary's recommendation.

4.5.d. When the secretary rejects a plan of correction, a revised plan shall be submitted within ten (10) days.

Comment: Please specify ten (10) working days or calendar days.

4.6. Reports and Records.

4.6.c.2. Information of a personal nature from medical or personal file;

Comment: Information from a medical or personnel file would appear to be more in line with the standard.

64-11-5. Governance.

5.2. Governing Body.

5.2.a. The center shall have a governing body that sets policies, defines services, guides development and ensures the accountability of the center.

Comment: The governing body should also be responsible for developing a mission statement.

5.3. Administration.

5.3.b. The administrator shall develop a plan of operation with a mission statement, program goals and a description statement.

Comment: The administrator should work with the governing body to develop a mission statement but the mission statement is the responsibility of the governing board not the administrator.

5.3.d. When a board of directors is the governing body, policies and procedures shall provide for:

Comment: By-laws often appropriately define and outline board committee structure and responsibilities. Thus this section should be rewritten to state "When a board of directors is the governing body, by-laws, policies and procedures shall provide for:"

Comment: When the governing body is not a board of directors what will the standards be? The Rule currently does not address a non board governing body.

5.3.d.3. The process to evaluate the effectiveness of the governing body:

Comment: Effectiveness is a subjective term and needs further definition. How often should the board review itself and what should it use to determine its' effectiveness. The who, what, when, why and how questions should be addressed in this standard.

5.3.d.4. The prevention of a conflict of interest between board members and the center;

Comment: The governing body should have guidelines for managing situations in which conflict between board members and the center arise. Members signing a conflict of interest statement with a clear definition of what constitutes a conflict of interest would satisfy this standard.

5.4. Financial.

5.4.j. If the center handles consumer funds in excess of twenty-five dollars (\$25) per consumer and in excess of five hundred dollars (\$500) for all consumers per month, the center shall obtain a bond in an amount approved by the secretary sufficient to cover all consumer accounts and the amount shall not be less than two thousand five hundred dollars (\$2,500). When the amount of any bond is insufficient to adequately protect the funds of consumers, the center shall obtain an additional bond in such amount as necessary to adequately protect the funds of consumers.

Comment: The amount of the required bond should be based on some objective criteria and uniformly applied to all centers managing consumers funds.

5.5 Center Responsibility.

General comment: Policies and procedures regarding the operation of the center should be developed to operationalize the center's functions.

5.5.b. The center shall implement a code of ethics that includes, but is not limited to provisions regarding the following:

Comment: The standard should read "Policies and procedures shall be developed and implemented by the center that include but are not limited to provision regarding the following:

Comment: The ethical standards of each profession will be the standards the professionals are required to follow. The centers should have a general ethical standard policy that all staff not covered by another professional standard are required to follow.

5.5.b.4. That decisions are made about care solely on the diagnosis and treatment needs:

Comment: This standard should include "including consideration of the consumers wants and desires and other clinical documentation of the consumers health and behavioral health status."

5.5.h. When a consumer is a threat to self or others, the center shall comply with its written policies and mandatory reporting laws.

Comment: The center should follow its' "policies, procedures and mandatory reporting laws."

5.5.k. Except in cases of abuse, neglect or exploitation in which the center has responsibility for protective services, a consumer or his or her legal representative shall be the primary source of information about the consumer's service needs.

Comment: Should read " Except in the case of abuse, neglect or exploitation, in which the center has the responsibility by law to report to protective services, a consumer or his legal representative shall be the primary source of information about the consumer's service needs.

5.5.l. The center shall develop and revise policies for effective service delivery and protection of consumer rights and shall provide a copy of these policies to all new personnel.

Comment: Should read " The center shall have and periodically review and revise policies for effective service delivery and protection of consumer rights and shall provide a copy or make a copy available of these policies to all new personnel."

5.5.m. The center shall implement a policy pertaining to employees with communicable disease.

Comment: Should read " The center shall implement a policy pertaining to communicable disease effecting both consumers and staff."

5.6. Personnel.

5.6.b. The center shall not employ individuals with a conviction of, or prior history of, abuse, neglect or mistreatment.

Comment: With regard to abuse, neglect or mistreatment of individuals or persons, the standard will work if it is related to conviction of one abuse, neglect or mistreatment. History of abuse, neglect or mistreatment would need substantiated proof to withstand a legal challenge.

5.6.c. Direct service staff shall be competent, responsible persons eighteen (18) years of age or older.

Comment: What is the definition of competent and responsible? Mentally competent and responsible or legally competent and responsible? Suggest " Direct service staff shall be persons eighteen (18) years of age or older and capable of performing the duties assigned."

5.6.d.1. The job description and application:

Comment: Volunteers should have documentation in their record of what functions they are performing as a volunteer but a job description is not appropriate.

5.6.d.6. Employee performance evaluation:

Comment: Volunteers are not employees. Periodic reports on the volunteers activities, training and progress would be appropriate to maintain in the volunteer's file.

5.7.b. As part of staff orientation, all direct care staff shall be trained in emergency care, first aid, infectious disease control, cardiopulmonary resuscitation and Heimlich's maneuver.

Comment: First aid training if done correctly provides instruction in the Heimlich's maneuver. The term bloodborne pathogen control is also required training.

5.7.c. Employees and providers shall be trained in the proper management of consumers with seizures or behavioral disorders prior to, or within ten (10) days after being assigned to work with individuals with these types of disorders. Fully trained staff shall be present until newly hired staff are fully trained.

Comment: Definition is too narrow and should be changed to read " Employees providing services to consumers shall be trained in the proper care of the consumers to whom they will be providing services including special needs including health and behavioral health needs prior to, or within ten (10) days after, being assigned to work with the individual. Fully trained staff shall be present until newly hired staff are fully trained.

5.7.e. Staff shall be able to demonstrate the skills and techniques necessary for their jobs and provide evidence that they are qualified to perform the functions associated with them.

Comment: The standard is vague and should be rewritten to read " Periodically staff will be evaluated based on demonstrated ability to perform their job responsibilities."

5.8. Requirements for Residential Staff.

5.8.a.2. Assurance that the center shall transfer to an appropriate acute care facility, a consumer who poses an imminent physical danger to themselves or others, or provide adequate coverage to manage a consumer at the residential facility.

Comment: A consumer can only be moved to a more restrictive environment through treatment planning or due process through the mental hygiene process. Should read "Assure that the center shall initiate proper procedures for the transfer to an acute care facility, a consumer who poses an imminent physical danger to themselves or others, or provide adequate coverage to manage a consumer at the residential facility."

5.9. Human Rights Committee

5.9.a.2. Report activities and recommendations, if any, at least annually to the governing body:

Comment: Would recommend adding “or a standing committee of the governing body.”

64-11-6. Health Safety.

6.2. Fire Code

6.2.a. The center shall have evidence that facilities rented, owned or used regularly for services are in full compliance with applicable fire safety codes.

Comment: The center regularly provides services in family homes and in other natural locations. The evidence of compliance for Center rented or Center owned would be possible. Evidence of compliance for family homes and other natural environments would not always be either possible or feasible.

6.2.b. The center shall conduct monthly fire drills in its residential and daytime group setting locations, some of which shall be during rest or sleeping periods.

Comment: Some residential facilities are short term facilities and the staff need to be aware of the fire drill procedures and new residents need to be instructed in fire drill activities. In longer term residential facilities and in daytime group settings monthly drill may be disruptive to the normal service pattern. Quarterly fire drills would be more appropriate and less disruptive.

6.5. Lighting, Ventilation, Heating.

6.5.b.1. Unvented, fume-producing heating devices; and

Comment: “Fume-producing” should be changed to “fume-producing”

6.6. Requirements for Group Homes, Residential Treatment Facilities and Emergency Shelters (24 Hour).

6.6.a. Bedrooms shall be adequately and attractively furnished and provide a minimum of eight (80) square feet of floor space per person for one (1) person occupancy and a minimum of sixty (60) square feet of floor space per person for two (2) or more person occupancy.

Comment: The room dimensions requirements is clear. What is adequately and attractively furnished is highly subjective and may be contingent upon the consumer’s perception and cultural norm for the area where the facility is located.

6.6.c. Space shall be arranged in consideration of the occupants' clinical needs.

Comment: Recommend "The consumers clinical space needs will be taken into consideration when bedroom is assigned."

6.6.h. A facility shall provide safe, comfortable and clean lavatories, bathtubs and showers equipped with hot and cold running water and a mixing faucet to ensure a water temperature not to exceed one hundred ten (110) degrees Fahrenheit.

Comment: It should be made clear the lavatories, bath tubs and showers need to meet this requirement. The water temperature required for sanitizing dishes and clothes may be different and thus the need for a mixing faucet or another form of control to keep the delivery temperature within the specified limits.

6.7 Consumer Grouping

Comment: Consumers should be served in the environment that is most appropriate for their need. If group activities are appropriate then the consumer should receive service in the group setting that does not interfere with the consumers' progress on a regular basis.

6.7.a. Within Programs, groupings shall occur that:

Comment: Within programs, group settings for services should be appropriate for the individual consumer's needs.

64-11-7. Consumer Services.

7.1. Program Description.

Comment: The standard needs to allow for the child care licensing standards with regard to supervision. The standard does not currently differentiate between clinical and administrative supervision.

7.1.c. Supervisors shall be persons with a master's degree in human services or a health related field and two (2) years post master's degree experience in the delivery of family services, except for skills training which may be done by a registered nurse or a person with a bachelor's degree in human services or education.

Comment: The standard needs to reflect child care licensing requirement for supervision. The standard should differentiate between clinical and administrative supervision. A bachelor's degree in human services or education under the direct supervision of a master's degree in a human service or related field and two (2) years experience can administratively supervise a program.

7.3. Treatment Plan.

7.3.e.3.B. Measurable objectives shall be related to the goals, have an expected achievement date and include expected outcomes for discharge.

Comment: Although all services should have measurable objectives related to goals and have achievement date and include expected outcomes, all services do not have discharge as the expected outcome during the course of treatment. Should read “ Measurable objectives shall be related to the goals, have achievement date and include expected outcome and when appropriate outcomes for discharge.

7.4. Treatment Plan Review.

Comment: Where clients or guardians do not have the capacity to read or write the documentation of participation should be in line with the individual’s abilities. If written consent is not obtained, the record should reflect why the written consent was not obtained.

7.4.c. Written consent by a consumer, or his or her legal representative shall be obtained and recorded in the treatment plan.

Comment: If written consent is not obtained, the record shall indicate why the written consent was not obtained.

7.6. Behavior Intervention.

7.6.b. The center shall develop and implement policies and procedures, such as restraints, seclusion and time-out, for management of behaviors that are socially or personally nonproductive. All behavioral intervention plans shall:

Comment: The term nonproductive is subjective. Suggest “ The center shall develop and implement policies and procedures, such as time-out, seclusion, restraints for intervention in working with behaviors that are interfering with the consumers ability to function socially or personally. All behavior intervention plans shall:”

7.6.f. A consumer shall not be placed in seclusion or a physical restraint until he or she is either: examined by an attending physician or other licensed professional, and a discussion is held between a member of the professional staff and available interdisciplinary team members; or a physical or other licensed professional has ordered by telephone these interventions after a member of the professional staff has discussed the situation with the available interdisciplinary team members.

Comment: Mechanical restraint should only be used as a last resort and this standard would be appropriate for mechanical restraint. Consumers are, at times, restrained using CPI, TCI or other techniques that require the short term use of physical restraint. The standard would not be appropriate for standard crisis intervention physical restraint holds such as the basket hold

or four point restraint. CPI or TCI may be a part of consumers treatment as behavioral intervention or in the case of an emergency may be used on a very limited basis to protect the consumer and those in the immediate vicinity of the consumer. Suggest defining the term physical restraint better in this standard.

7.8. Emergency Medical and Psychiatric.

Comment: Emergency procedures should have general policy guidelines and specific procedures appropriate for the location of the facility or the service.

7.10. Medication Service.

General comment: The center shall be responsible for medication that the center prescribes or administers or stores. The center cannot be responsible for medication prescribed by other providers.

7.10.a. The center shall develop a process for the administration, storage and accountability of all medications, that includes provisions for a medication administration record procedure and is in compliance with state and federal requirements.

Comment: Recommend “ The center shall develop a process for the administration, storage and accountability of all medications the center controls, that includes provisions for a medication administration record procedure and is in compliance with state and federal requirements.

7.13. Group Homes and Residential Services:

7.13.b. The residents shall be provided foods that promote healthful living.

Comment: Consumers have the right to choose and may not always want foods that promote healthful living. Healthful living foods should be offered and encouraged but the consumer should also have other options available. Consider the school lunch program currently being offered.

7.14. Residential Treatment Services for Minors (24 Hour).

General Comment: Circumstances may not always make family involvement appropriate especially when the consumer is in the custody of the state. The standard needs to allow for such circumstances.

7.14.a.3. The level of the family involvement expected.

Comment: Recommend “ The level of the family or guardian or legal representative involvement expected”.

7.14.b. The discharge process includes; child and family involvement, personnel responsible for discharge decision and provisions for aftercare.

Comment: Recommend “ The discharge process includes; child and family/ guardian or legal representative , personnel responsible for discharge decision and provisions for aftercare.”

64-11-8. Consumer Rights.

General comment: Recommend that this standard refer to compliance with the Behavioral Health Consumer Rights Legislative Rule 64CSR74. Common definition in 64CSR11 and 64CSR74 will allow for less chance for confusion and more opportunity for compliance. A full list of the consumer rights made into a Bill of Rights would benefit both consumers and providers.

8.2. Violation of Consumers Rights.

Comment: The complaint process should be kept in place in this standard in that it augments the provisions of 64CSR74.

64-11-9. Substance Abuse.

9.1.c. A shelter shall not discharge a consumer to a responsible adult until after an evaluation is complete, unless there are unusual circumstances, e.g. transfer for medical or security reasons.

Comment: At times the magistrate does not want the consumer released until he as appeared before the magistrate. The definition of a responsible adult needs clarification.

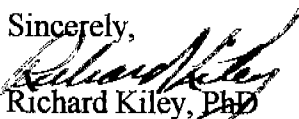
64-11-10. Penalties.

10.1.e. A facility has refused to provide access to its location or records as requested by the secretary.

Comment: The center does not control access to private homes and locations it does not own or control. Earlier standards indicate reviewing services where they are provided and this standard carried to its logical conclusion could infer a penalty if access is denied where the center does not have control.

The center would like to thank you for the opportunity to comment on 64CSR11. If you have any questions or concerns regarding the Center's comments please do not hesitate to contact me.

Sincerely,


Richard Kiley, PhD
Executive Director



RECEIVED

The Department of Military Affairs and Public Safety

WALTER SMITTLE III
State Fire Marshal
L. DARL CROSS
Chief Deputy Fire Marshal

CECIL H. UNDERWOOD, GOVERNOR
STATE FIRE MARSHAL'S OFFICE
1207 Quarrier Street, 2nd Floor
Charleston, West Virginia 25301

Phone (304) 558-2191
FAX (304) 558-2537

Handwritten notes and stamps, including a date stamp: JUL 29 1999

July 29, 1999

Beth Marquart, Director, Regulatory Department
Department of Health & Human Resources
Capitol Complex – Building 3, Room 265
Charleston, West Virginia 25305

Ms. Marquart

The following changes and comments are offered in regards to Legislative Rule 64CSR11.

Proposed Changes:

- 6.2.a. The center shall comply with the State Fire Code and have evidence that facilities rented, owned or used regularly for services are in full compliance.
- 6.4.a. All structures, grounds, and equipment shall comply with applicable building codes and health, State Fire Code requirements.
- 6.6.m. All plumbing shall meet the requirements of BOCA International.

Comments:

- 7.13 Group Homes and Residential Treatment Services
- 7.14 Residential Treatment Services for Minors (24 Hours)
- 7.15 Shelter Services for Minors
 - Is there a minimum number of clients?
 - Nothing is mentioned of Fire Code requirements

Sincerely

Walter Smittle III
State Fire Marshal



235 S. Water Street • Martinsburg, WV 25401 • 304-263-8954

July 27, 1999

Beth Marquart, Director
Regulatory Development
Department of Health and Human Resources
Capitol Complex – Building 3, Room 265
Charleston, WV 25305

Dear Ms. Marquart:

Having reviewed the draft document of the Behavioral Health Center Licensure, we wish to provide you with the following comments:

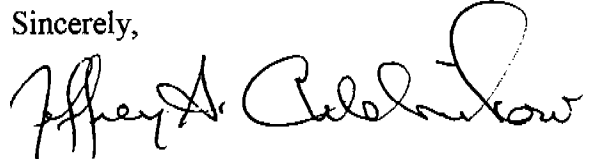
- 1.) Re: 5.5.h.: There should be a reference to the “mandatory reporting laws” with which Centers shall comply.
- 2.) Re: 5.6.b.: It is not clear to us how we would learn if a potential employee has a prior history of abuse, neglect, or mistreatment unless they have a criminal record. We can not afford to conduct background checks on those who have no criminal records.
- 3.) Re: 5.8.a.2.: What is meant by “assurance” and what is meant by “adequate coverage?”
- 4.) Re: 5.11.a.: This statement is too vague and does not set some type of criteria by which we or a reviewer could make a valid assessment.
- 5.) Re: 6.6.p.2: How often should a dietician be involved in the planning of meals?
- 6.) Re: 6.7.a.2.: How are staff to consumer ratios for adequate protection and supervision defined?
- 7.) Re: 6.9.c.5.: There is a word or phrase missing between the words “applicable” and “of.”
- 8.) Re: 7.1.c.: How does the Department define “human services or health related field?”
- 9.) Re: 7.2.a.: What are the “criteria for admission” referenced in this rule?
- 10.) Re: 7.2.c.: Does this replace the current rule of having the master treatment plan in place within 30 days of the admission? This seems to be an unrealistic time line in that there generally would not be enough time to complete recommended evaluations and to use those results in defining a comprehensive service plan.
- 11.) Re: 8.2.b.: What is considered as a “reasonable time?”
- 12.) Re: 9.3.b.: What is considered to be “sufficient” for onsite nursing staff?

COPIES OF THIS DOCUMENT
DATE: 08/11/99 TIME: 09:00
CLEARANCE: 0000

Our primary concern in bringing these issues to your attention is that the various rules listed above are vague in content. They can lend themselves to a broad range of interpretations, most of which are purely subjective. Having gone through many licensure reviews, we are aware of the difficulty for us and reviewers to come to agreement on the interpretation of such rules. Clarifying these rules by including specific criteria would allow Centers to assess their own compliance and improve internal processes on a regular basis, rather than waiting for the bi-annual reviews.

Thank you for your kind attention to these comments. We are available for any inquiries you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey A. Chlebnikow". The signature is fluid and cursive, with a large loop at the end.

Jeffrey A. Chlebnikow, MA
CQI Coordinator

A handwritten signature in black ink, appearing to read "Fred Donovan". The signature is cursive and somewhat stylized.

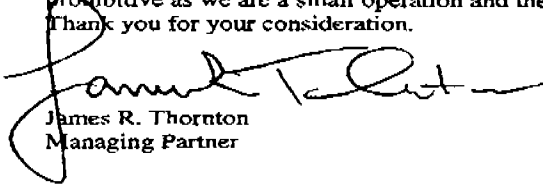
Fred Donovan, Psy. D.
Executive Director

Handwritten notes and stamps in the top right corner, including a date stamp "59 JUL 30 11 40 AM '99" and other illegible markings.

Serenity Valley Residential Board and Care Homes

To Whom It May Concern:

This letter is to serve notice that Serenity Valley would like to see the rule 4.1.b under Title 64 of the Legislative Rules to be amended from 10 beds to 16. This is due to the fact that 10 would be cost prohibitive as we are a small operation and the cost to upgrade for that number simply does not make sense. Thank you for your consideration.


James R. Thornton
Managing Partner

WVCCA West Virginia Child Care Association

P.O. Box 3403, Charleston, WV 25334-3403 • One United Way Square • 304/340-3611 • FAX: 304/340-3612

July 28, 1999

Ms. Beth Marquart, Director, Regulatory Development
Department of Health and Human Resources
Capitol Complex-Building 3, Room 265
Charleston, WV 25305

Re: Behavioral Health Centers Licensure 64CSR11

Dear Ms. Marquart:

In reference to the aforementioned , the following issues either require further clarification or consideration:

- 1) Page 19, 5.7a re: *staff training*: An anticipated period of orientation is not defined, thereby leaving some ambiguity as to the time frames licensure would find reasonable in completing training in restraint and first aide. While we are in agreement that an appropriate orientation for new staff should commence on the first day of employment, agencies will find it impossible to ensure that training on passive physical restraint, first aide and CPR will be accommodated in the immediacy of time frames suggested in the rule. To ensure child safety, agencies generally ensure that untrained staff in restraint or first aide are always on shift with appropriately trained and certified staff until these staff are trained.
- 2) Page 24, 6.6 What is included under *dietary services*? Does this include meals provided youth in residential or day treatment programs? If so, I would recommend that the programs be required to conduct regularly scheduled and documented consultation with a dietician. However, the rule as it reads to me, suggests that all meals would be planned and prior "approved" by a dietician, which is not necessary in most cases unless the youth would require special dietary needs.
- 3) Page 24, 6.7b re: *facilities that may be locked*. This particular rule is confusing in that it is unclear if the intent is to prevent elopement of residents or to prevent intrusion upon the facility by outsiders. For juveniles, placement in a hardware secure facility would require order of the circuit court. Moreover agencies who would choose to develop such programs for juveniles would need to be certain that their programs meet applicable licensing requirements for Secure Care as defined under Chapter 49. Such a provision would also suggest that the Office of Health Facility, Licensure and Certification may want to consider additional regulations of such facilities to assure client safety, client rights, etc.
- 4) Page 26, 7.1c It is unclear what the licensing regulations define as a *supervisor*. Those individuals who are responsible for programmatic/administrative oversight may not be

RECEIVED
99 JUL 30 AM 9:35
OFFICE
WV DEPT OF HEALTH
AND HUMAN RESOURCES

WVCCA Comments on Behavioral Health Licensure

July 28, 1999

Page 2.

the same individuals who perform clinical supervision, and the former may not have the required credentials.

- 5) Page 29, 7.3g.2 re: prompt availability of educational services. While agencies promptly seek educational services for their youth, access may be another matter and one entirely dependent on the county educational system. I would encourage the rule to be revised to place the center's responsibility to ensuring that appropriate educational services are promptly sought.
- 6) Page 31, 7.6f re: restraint. Our agencies employ passive physical restraint in situations where a youth is a danger to self or others, and only after verbal deescalation techniques have been ineffective. Such a crisis situation does not permit a staffing or authorization as this rule stipulates, nor is it necessary. It would be appropriate for situations of seclusion or mechanical restraints.
- 7) Page 39, 8.2b Those agencies licensed also under Chapter 49 are not permitted to conduct in-house investigations and must report all instances of suspected abuse to the Institutional Investigative Unit within the Office of Social Services. Clarification in this rule for such dually licensed facilities would be appreciated.

We appreciate the work that has gone into these rules, and the overall quality of that effort. Thank you for the opportunity to provide additional input into that effort. Should you have any questions, please do not hesitate to contact me at 340-3611.

Sincerely,



Nickie James
Executive Director

/vj

cc: WVCCA Administrators



July 21, 1999

Beth Marquart, Director, Regulatory Development
Department of Health and Human Resources
Building 3 Room 265
State Capitol Complex
Charleston, WV 35305

REC'D
WV
7/21/99
99 JUL 26 11:11:51
PHS

Dear Ms. Marquart:

Thank you for allowing us the opportunity to respond to the Behavioral Health Centers Licensure Rule 64CSR11 as follows:

General Comment: This Rule in many places is vague and non-specific and consequently will permit subjectivity on the part of the Secretary. This opens the door for potential contested findings. I do not believe there was any provider input into this Rule to assist the Department in such matters. Therefore, I suggest the Department withdraw the Rule and establish a committee to include providers so that meaningful input may be given.

Fiscal Note 4B. The Department claims no economic impact. With the CIB requirements alone, there is a minimum charge of \$10.00 per person checked. We had over 200 new employees last year. Thus, I suggest the Department request input on the potential financial impact per a committee process suggested above.

§64-11-3 Definitions

3.1.b. Psychological Abuse – Because this is a new licensure definition, is this a term-of-art? Could the types of abuse included here be put under “verbal abuse” as effectively?

3.22.a – Informed Consent. This appears to call for an assessment and a judgment to be rendered at the time of informed consent about the capacity of an individual to give consent. Suggest – “That a consumer has or does not have the legal capacity to give informed consent.”

3.29 – Partial Hospitalization – This is a definition that presumes one knows what a PH program is like in an inpatient setting. I’d suggest the following as adapted from Medicare, “A comprehensive structured program that uses a multi-disciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders. A Partial Hospitalization program is designed to treat consumers who exhibit severe or disabling conditions related to an acute psychiatric/psychological condition or an exacerbation of a severe and persistent mental disorder.

3.42 Semi-Independent Living Facility – This definition does not make any distinction between a Center owned facility and a non-center owned facility. I suggest adding the phrase, “An apartment or home owned by the Center that . . .”

3.44 Staff – This definition is vague. Centers use a variety of means to secure and provide services. Some people delivering services are direct employees, some are independent contractors, some are full time, some are part time, some are agents of other agencies or employment agencies, and some are Mothers and Fathers of the consumers. The center in some form or the other pays all of these. I suggest, “Individuals hired directly by the center and placed on the Center’s payroll system to provide Behavioral Health Services”

The concept of “variance” needs to be included and its definition, “A declaration that a rule may be accomplished in a manner different from the manner set forth in the rule.” This is especially important as this rule is contains much more general and vague language. Note that at 4.1.e.3.B.4, Variance and Waiver (see below) are referenced.

The concept of “waiver” needs to be included and its definition, “A declaration that a certain rule is inapplicable in a particular circumstance.” See above.

3.49 – The word “all” connotes an exhaustive, definitive, all-inclusive list of services. Please delete it as a treatment plan is not for this purpose. It is to identify only those specific, limited services that will meet the goals and objectives.

4.1.e.2.C.2 – Of the three changes, this is the least specific. There is no guidance as to what change in intensity reaches the threshold of a “change”. For example, would adding evening hours be a change in the intensity of services? Would adding group therapy or medication groups be a change in the intensity? Because I do not know the intent, I can not suggest the wording and thus recommend deleting this rule.

4.2 - Taken as a whole this section allows the Secretary to substitute her judgment on the siting of a residential treatment facility for that of the Board. This rule expands the Secretary’s authority beyond this scope of the authorizing legislation and should be modified to remove substituted judgment. The Secretary’s authority does not give her the right to intervene or assert an interest in a Center before it is established. Her Scope and Authority all arrive after a Center files for a license. In § 64-11-2, Application it states that the rule, “. . .applies to a center . . .that offers services . . .” The tense is present, not future. Thus, 4.2 should be deleted or modified to conform to the Secretary’s more limited authority.

4.2.a Notwithstanding the above, taken literally, the Secretary shall inspect

the addition of a storage building to a residential treatment facility.

4.2.d – This language is too subjective and taken literally causes the Secretary to substitute her judgment for that of the Board before purchase of property and before a License is applied for. Delete this requirement.

4.3.b – This section uses the term “shall” and thus requires inspectors to do four tasks including interviewing consumers and therefore, no inspection can be complete until each one of the four elements are complied with. One or more of the elements may not be relevant and consumers have the right to decide if they want to talk to inspectors. This rule infers a compulsory compliance on the part of a consumer. I’d suggest removing the word “shall” and substituting, “may”.

4.5 – Plans of correction are required within ten days, no exception. I’d suggest the wording “except if a variance is permitted by the Secretary” be added to permit the Center and Secretary time to negotiate aspects of a Plan when that negotiation is necessary.

4.5.b – This rule permits the Secretary to modify a Plan of Correction. This could be unilateral and unacceptable to the Center. The Secretary’s only legitimate function is to approve or disapprove the License and thus her only legitimate authority for a POC should be parallel. There should be a ten (10) day requirement for the Secretary to act on the POC.

4.5.d – see comments for 4.5 above.

5.2.a – I suggest adding the “mission statement” to the list here.

5.3.d – I suggest adding “by-laws” to this sentence.

5.3.d.4 – taken literally this rule requires the Center to have a policy that prevents a conflict of interest (implies a priori knowledge of the conflicting event). Because of this impossibility, I suggest, “The process to declare a conflict of interest and to separate and absent the Board member(s) from the decision making process.”

5.4.j – Having to receive the approval of the secretary will be cumbersome and may delay obtaining a bond. Either set a formula in the rule or set an expected standard so that the center may know what the secretary would accept.

5.5.b – This rule requires “a” (read one) code of ethics. Centers are comprised of physicians, social workers, psychologists, etc. Each has their own code. To require only one is administratively difficult. I’d suggest, “The center shall demonstrate that its staff adhere to a code of ethics as evidenced by a statement which sites each staff’s code of ethics. Where no such code exists, the center shall

insure that staff adhere to the following provisions: 5.5.b.1,2,3,4,5 and 6.

5.5.4 – This implies that there are only two things care can be based upon, diagnosis and treatment needs. As this might conflict with policies of funding sources, I suggest removing the term “solely” and adding “and other documented indicators of the consumers behavioral health and/or general health status.”

5.5.f – I’d precede the sentence with, “If the center utilizes volunteers, . . .”

5.5.h – Add “procedures” to this sentence. I’d suggest searching the entire document to make it consistent “policy and/or procedure”.

5.5.k – This rule is unclear as to what the exception means. It implies a center has responsibility for protective services. Because this is not capitalized, it does not mean Protective Services, as in Child and Adult Protective Services. Please check the meaning and clarify.

5.5.1 The rule should not require that all new personnel receive a copy but rather that “all staff should be either given a copy or have access to policies and procedures.” The term “personnel” is not defined whereas “staff” is.

5.5.m – As there are so many communicable diseases, this rule is vague as to its intent and burdensome. In order for a center to construct an acceptable policy and/or procedure, please clarify which communicable diseases are to be included.

5.6.a – This rule is vague as to how a center can be in conformance. Please re word.

5.6.b – As it is impossible to know definitively, if anyone has a prior history of abuse, neglect or mistreatment (no definition of), it is impossible to be in compliance with this rule. Please reword such as, “ The center shall not knowingly hire . . .”

5.6.c – “Direct service staff” is undefined thus it is impossible to know who the Secretary has in mind. Change “competent, responsible” to “qualifies as evidences by academic degrees, license(s) and employment history.”

5.6.d.6 – requiring an employee performance evaluation on a volunteer implies that the nature of what a volunteer does it the same as an employee. This should not be the case. Volunteers should be used to augment, not supplant employees. Thus delete this requirement for volunteers.

5.6.e – requiring CIB for all employees extends a false sense of security because the CIB does not report unreported instances of abuse nor out of state activity. Too, the CIB gives employers information that may not be directly relevant

to the job and thus endanger the employment of the citizen. I'd suggest that the rule read, "The center protects the rights of the consumer from abuse and neglect as evidenced by a thorough investigation of staff references upon hire and through inquiry of the CIB for appropriate positions."

5.7.a – the rule implies that a clerk will receive training on treatment policies. Change the wording to focus the rule to direct care staff.

5.7.b – training on infectious disease control is vague. Change to "Blood Borne Pathogens" if this is what is meant.

5.7.c – introduces a new term, "providers." Suggest this be deleted as it is undefined.

5.7.e – While this is a fine standard, there is no criteria by which staff will be judged. Create a sentence that contains, "as evidenced by . . ." so staff and centers will know what the Secretary means.

5.8.a.2 – Centers can not "transfer" per se a person from a less to a more restrictive environment when they are dangerous to self or others without going through the commitment process. This rule does not acknowledge this and infers the opposite.

6.1.c – At face value the rule demands that the center eliminate risks. This is an impossible standard to meet. Remove "eliminate" and reword to say, "reduces".

6.1.d – It is unclear what is wanted here as there is no specification of the product or outcome of evaluating the likelihood of exposure. One could say that the research shows that a person is more likely to be exposed to blood borne pathogens if they come in contact with blood than a person who doesn't. Is this what the rule wants?

6.1.f – This would be strengthened by adding "911" to the concept.

6.2.a – "used regularly" is not specific, vague and open for interpretation. Suggest delete it.

6.5.b.1 – "unproducing" should be "producing"

6.6 – "Emergency Shelters" are not defined.

6.6.a – "attractively furnished" is subjective and will be in the eye of the beholder; especially when consumer choice is exercised. Delete this.

Valley HealthCare System
Centers Licensure Rule Comments
Page 6 of 7

6.6.c – how can the physical space (walls, rooms, etc) be arranged from one client to the next based on their “clinical needs.” The rule sounds appropriate but will be impossible to meet as it is not specific.

6.6.e – “personalized” connotes personal ownership. In a rental facility or room, two roommates might have two identical beds, share a nightstand, have two identical dressers, one rug, etc. This would not necessarily be “personalized.” Because the intent is unclear, please remove “personalized.”

7.1.b – “. . .written procedures will be established. . .” the “for what” is not specified.

7.1.c – No where else is it a requirement that the center have a supervisor with 2 years experience in the delivery of family services. This must be a mistype. Please change to remove the two year requirement and add, “ post masters experience in a human service or health related field”. The concept of “skills training” is not contained in the definition section.

7.3.e.3.B – Not all goals and objectives of a treatment plan are designed to lead to discharge. This rule expects them to be so. Reword to delete, “for discharge.”

7.6.b - This might better be worded: “The center shall develop and implement policies and procedures for the management of behaviors that are socially or personally nonproductive by means of aversive techniques such as restraints, seclusion and time-out. All such techniques shall be used in the context of a behavior intervention plan that:

- 7.6.b.1. Is based on a functional analysis of the behavior;
 - 7.6.b.2. Includes positive programming to teach a consumer adaptive, more effective behavior;
 - 7.6.b.3. Ensures that a consumer does not discipline another consumer;
- and
- 7.6.b.4. Ensures that seclusion and physical restraints are used only as a last resort and are used only as long as necessary to manage behavior.”

7.6.f – The definition for physical restraint includes physically holding a consumer. This rule prohibits such a “hold.” Reword to allow physically holding a consumer.

7.10.b 1 – This standard precludes a physician from ordering and reviewing medications on a 180 day cycle. This is a common practice and the rule should accommodate it.

7.12.a – This rule if promulgated by the Secretary will require “supportive

services” that she has not to date determined how she will pay for. This is the requirement of a service not based on the treatment plan and potentially an unfunded mandate. Delete this item until resolved.

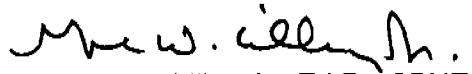
7.13.a –The rules alluded to in this standard should be specified. The phrase, “and that are available upon request” is misplaced and awkward.

7.18 – There is no definition of the term “Educational Programs”

§64-11-8 – This section should be deleted as there is a proposed Consumer Rights Rule that will amply take care of all West Virginians. Any variation from that Rule to this one will cause confusion. The Secretary has proposed the Rights Rule and as that Rule satisfies her concerns about consumer rights, that furthers my suggestion that section should be deleted as it is now duplicative and redundant.

8.3.a – The criteria for what rises to be a “serious injury” is not defined.

Sincerely,


George W. Lilley Jr., Ed.D., CBHE
Chief Executive Officer

ls

DAVID EAKLE
EXECUTIVE DIRECTOR

GREEN ACRES REGIONAL CENTER, INC.

POST OFFICE BOX 240 - ROUTE 2
LESAGE, WEST VIRGINIA 25537

RECEIVED
99 JUL 20 AM 9:37
PHONE 762-2522



July 16, 1999

OFFICE OF THE ATTORNEY
GENERAL
WEST VIRGINIA DEPARTMENT OF HEALTH
AND HUMAN RESOURCES

Beth Marquart, Director
Regulatory Development
Department of Health & Human Resources
Capitol Complex - Building 3 - Room 265
Charleston, West Virginia 25305

RE: Proposed Behavioral Health Center Licensure

Dear Ms. Marquart:

I have reviewed the proposed licensing requirements, and I have two major concerns with said proposal.

The first concern I have is with 7.1.c. Green Acres currently does not require supervisors to have or to obtain a masters degree. If such was enacted, it would create a major financial hardship on our Center.

The second concern I have is with 5.9.c. Green Acres would like to suggest that the proposed standard be altered in that a parent and/or guardian of the consumer may be substituted for the consumer to sit on the human rights committee. We believe that members of the consumer's family, or his or her guardian, have a vested interest in the consumer, and they would be able to bring the concerns of the consumer to the human rights committee.

In the event you should have any questions or concerns regarding my comments, please do not hesitate to contact me.

Sincerely,

GREEN ACRES REGIONAL CENTER, INC.

David Eakle
Executive Director

DE:pgt



RECEIVED

99 JUL 29 PM 2:23

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF SOCIAL SERVICES

Cecil H. Underwood
Governor

P.O. Box 6165
Wheeling, WV 26003
Telephone: (304) 232-4411 - FAX: (304) 232-4773

Joan E. Ohl
Secretary

MEMORANDUM

TO: Beth Marquart, Director, Regulatory Department

FROM: Peggy Cartus, Supervisor, Licensing and Institutional Investigative Units

DATE: July 27, 1999

RE: Comments on Proposed Rules Entitled:
BEHAVIORAL HEALTH CENTERS LICENSURE

I am forwarding to your attention copies of e-mail correspondence which have been provided to me by Cora Childers, Lloyd O'Brien and Terri Cook, Residential Child Care Licensing Specialists. These comments were solicited by me with the intention of compiling and editing them before forwarding to you. A physical injury prevents me from providing this compilation.

I believe you are aware WV Code, Section 49-2B requires that all settings wherein children reside must be licensed as child care facilities. The present draft regulations then would be superimposed only on licensed child care facilities which desire to participate in Medicaid funding. I believe the proposed regulations should in some manner address this statutory requirement as a 'threshold to eligibility for a Behavioral Health Center License.'

Further, I believe you are also aware that West Virginia Code mandates the reporting of child abuse/neglect and adult abuse/neglect. Although the regulations governing residential group care facilities (child care) addresses this requirement, these child care regulations do not pertain to such settings as Inpatient Psychiatric Units. I, therefore, would recommend that the proposed rule governing behavioral health centers should address this (reporting) mandate.

Thank you for the opportunity to provide you with these comments on this proposed rule.

PC/jc

cc: Jim Boggs
Cora Childers
Lloyd O'Brien
Paula Hinzman
Terri cook

From: Cora Childers
To: Lloyd O'Brien, Paula Hinzman, Peggy Cartus, Ter...
Date: Mon, Jul 19, 1999 2:13 PM
Subject: Re: OHFLAC Regs-Comments Period

I am certainly glad that I don't have to enforce these rules. Many are vague and unclear. My comments (revise, delete, or ignore as you see fit):

- 3.7.g What is a specialized family care home?
 - 3.7.k Does this exempt WV Childrens Home?
 - 3.24 Legal Representative- Where is DHHR defined? If it is under (j) a parent or guardian of a minor, it is not clear who would make the decision.
 - 3.39.b What is the difference between a mechanical device and mechanical support. One is allowed and one is not.
 - 4.1.a type of license should be defined
 - 4.1.d States that an expired or otherwise invalid license shall be surrendered... What is an otherwise invalid license and why should an expired license be surrendered? 4.1.e.2.E states that existing license shall not expire if an application is completed and the required fee has been received. What fee?
 - 4.1.e.3.B.2 Indicates that a provisional license can not be reissued but does not indicate what should happen if a center is not in substantial compliance.
 - 4.2.c States that all renovated and new structures shall meet current ADA standards. What if it is just a partial renovation or physically handicapped costumers are not appropriate placements?
 - 4.2.d States tat residential treatment facilities hall be located as conveniently as possible with access to necessary services-What does conveniently as possible mean?
 - 4.4.1 States the Sect. may suspend or revoke a license- Their code doesn't say anything about suspending a license. Their code indicates that a license may be revoked for good cause after notice and hearing.
 - 5.5.m States the center shall implement a policy pertaining to employees with communicable diseases. Why? Then what?
 - 5.6.e Does this apply to professional contracted staff persons?
 - 5.9.a.6 The Human Rights Committee is to ensure that aversion procedures are used only with the written consent of a consumer or his or her legal representative. Aversion procedures are restrictive procedures that impose consequences a consumer find undesirable in a treatment program to deceased inappropriate behaviors. (could include loss of privileges). Does it make sense that written consent or agreement is required before consequences are imposed?
 - 5.11.a The center shall monitor and evaluate service quality and effectiveness-based on what criteria?
 - 6.1.b What does adequate mean?
 - 6.1.h What if physically impaired individuals are not treated in the residential setting?
 - 6.5.a What does adequate mean?
 - 6.6.i What is a sufficient number
 - 6.7.a.2 What is adequate?
 - 6.7.b Allows doors to emergency shelters, group homes, and residential treatment facilities to be locked. I believe this is against state code.
 - 7.1.c Requires **all** supervisors to have a masters degree and 2 years post masters degree experience. This seems excessive.
 - 7.6.f Seems to preclude the use of **any** immediate restraint of an individual until a discussion is held with others who may not be immediately available. What is the child is attacking someone?
 - 7.13.d Who are residents who require 24 hour staffing?
 - 7.18.d What is an appropriate teacher to consumer ratio?
 - 7.18.e What is an adequate number of classrooms? How is this measured?
- 64-11-10 Penalties None of these are defined in WV Code Chapter 27

CC: Jim Boggs

From: Lloyd O'Brien
To: Peggy Cartus
Date: Thu, Jul 15, 1999 10:45 AM
Subject: OHFLAC Regs

I've reviewed the proposed regs for OHFLAC. Not being fully aware of all that they do I can't tell if they have covered everything real well or not, but my general take is that I like the simplicity of their regs. We may want to consider responses to the following points:

4.2.b Drawings and specifications for architectural work are usually quite massive. Plus they take architectural expertise to read, interpret, and understand. This is not with in the skills of OHFLAC staff. I think this is an unnecessary regulation because of this.

5.8.a.2 Need to clarify wether the plan would be to transfer the patient out, or to staff - up to handle the patient. I think this provision would allow a facility to simply transfer out a patient that was difficult, but which should be with in their ability and responsibility to handle.

6.7.b This provision, as I read it, would allow the locking of level III facilities as well as shelters.

4.7.6.f I think they mean mechanical restraints here, rather than "physical restraints".

Those are all the comments that I see that we might consider responding to. Beyond that however, a number of their policies are ones that we whould adopt into our regulations. Such as: (7.6), (7.7), (7.8), (7.9), (7.10), (7.11), (7.18), (9.3). Plus the sections 64-11-10, and 64-11-11. -----Also, just as a comment, notice that 7.17.a.1 limits caseload size. We need this in our Child Placing regs.

-----END

CC: Cora Childers, Paula Hinzman, Terri Cook

From: Terri Cook
To: Cartus, Peggy
Date: Tue, Jul 20, 1999 4:04 PM
Subject: OFLAC

3.1.1.5 - Seems to be an oxymoron to me because I don't think that inappropriate physical horseplay is not abuse. I think they mean, horseplay that became abusive, otherwise it is accidental and not physical abuse.

4.1.e.3B.3 substantial needs identified. How much compliacne is substantial?

Renewal and amended are vastly different. Should these be defined somewhere?

It appears that their belief is that a provisional is issued when a center seeks an amended license. I don't believe that is always the case, at least, not for us.

Observation that OFLAC is making the distinction that two consecutive provisional cannot occur unless the provisional recommendation is that of the state fire marshal. Does this mean that if the non-compliance was due to the fire marshall's report we could issue another provisional? or We could issue another provisional if the only thing that had been preventing it was an issue of health and saftey sited by the fire marshall?
I thought it was confusing.

4.1.e3.B.4 A waiver or variance. At whose determination is one or the other used? Surely one is for some things and the other for others. Need defined and situations explained or examples telling the difference.

4.2.c We need something in our regs regarding Americ. w/ Disabilities Act also.

4.3.c Why some 2 and some 1? What is the logic behind it? No statement about other visits for fraud, drop ins, howdies, etc.?

4.3g - Why say substantial again, why not, once a regular license has been issued another inspection for an amended is not required. I think it should specify, unless the amendment has to do with the capcity allowed, allocation of beds, remodelings, etc.
One might state , not needed to revisit if visit has ocured within the last 6, 9 months and changes are only programatic.

5.6.b What about if they have already employed them? Maybe after a review it is found a check was never done, now it is, so then what?

5.6.e Why not all staff. I think this is really bad - so many people start in these places as clerks, aids, etc. and then move up into the other fields. They would never have had the CIB. What is meant exactly by para-professional? The agency determines this???

5,7.a I like this one.

5.7.b. I like this one. We need to speak of blood antigens, infectious disease control, etc. (Lots of disposing of needles, med, etc. but little rules regarding handling, etc.)

5.8.a.1 - We need this. Stuff is spread out everywhere. We imply that we want it by saying keep in employee's records, etc. but this statement would tell why.

5.11.a How often? Effectiveness - 70% of regs? 70% of their mission, by independent study, their advisory board????

6.2.b - Hold them and record.

6.6.d Where was a required window mentioned? Is there a requirement for windows??????????

6.6.e. Homelike???? Whose home? Very subjective. I like ours better . . . should allow for individualization and personalization.

6.6.f. Nothing here about keeping them separate. Yes, in 6.6.g poisons and hazardous items are stated to keep separate but who wants cleaning supplied kept with foodstuffs?

6.6.i What is sufficient? Are they aiming at showering, privacy, commode use, or full baths with sink, commode and all?

6.6.p What about a variety of foods? One place I heard about just rotated the menus every three weeks. I think kids have a to thrive with various foods, salads, foreign foods, home-cookin, southern food, hamburgers, etc.

6.7.b Stronger language than ours. Many of these kids will go to Independent living, no locks.

7.7.c No limit, no permission of director when going to other methods. What are those methods? At some point a director should be notified if this staff intervention continues at length.

7.11.a Sould state - in from of medication, "non-prescription" as staff should not give the least amount of all medicines. Certainly this would be harmful in the case of many drugs such as antibiotics.

My "two cents worth."

CC: us3