WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION

Form #3

Do Not Mark In This Box

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

AGENCY: DHHR/Office of Health Facility Licensure & Certification TITLE NUMBER: 64

CITE AUTHORITY: Legislative

AMENDMENT TO AN EXISTING RULE: YES X NO ____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 11

TITLE OF RULE BEING AMENDED: Behavioral Health Centers Licensure Rule

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

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

Martha Yeager Walker
Authorized Signature

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

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

Revenue estimate for SFY2009: $250 per license - $10 per license received under old rule = $240 per license increase X 56 behavioral health centers = $13,440; 342 beds X $25 per bed = $8,550; Civil Monetary Penalties: 31 facilities X $1,000 per facility = $31,000 + 46 facilities X 8 days beyond plan of correction deadline X $50 per day = $18,400 . ($13,440 + $8,550 + $31,000+18,400 = $71,390 Total Additional Revenue)

Revenue estimate for SFY2010: $250 per license - $10 per license received under old rule = $240 per license increase X 59 behavioral health centers = $14,160; 704 beds X $25 per bed = $17,600; Civil Monetary Penalties: 10 facilities X $1,000 per facility = $10,000 + 10 facilities X 8 days beyond plan of correction deadline X $50 per day = $4,000 . ($14,160 + $17,600 + $10,000 + $4,000 = $45,760 Total Additional Revenue)

Memorandum

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

Date
7/31/09

Agency

Department of Health and Human Resources

Authorized Representative

Martha Yeager Walker

Martha Yeager Walker
Secretary

BRIEF SUMMARY OF THE RULE

BEHAVIORAL HEALTH CENTERS LICENSURE RULE

64CSR11

This repeals and replaces the behavioral health center licensure rule with the effective date July 1, 2000. It sets forth the requirements for behavioral health centers to be licensed in the state of West Virginia.

STATEMENT OF CIRCUMSTANCES WHICH REQUIRE THE PROPOSED RULE

BEHAVIORAL HEALTH CENTERS LICENSURE RULE

64CSR11

The behavioral health center licensure rule has not been updated since July 1, 2000. The proposed rule brings the licensing requirements for behavioral health centers in line with current practice and current federal Centers for Medicare and Medicaid Services and state Bureau for Medical Services practices.

FISCAL NOTE FOR PROPOSED RULES

Rule Title: BEHAVIORAL HEALTH CENTERS LICENSURE RULE

Type of Rule: X Legislative ____ Interpretive ____ Procedural

Agency: Health and Human Resources

Address: Building 3, Room 206

Capitol Complex

Charleston, West Virginia 25305

Phone Number: 558-0488 Email: roselowther-berman@wvdhhr.org

Fiscal Note Summary

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

This repeals and replaces the behavioral health center licensure rule with the effective date July 1, 2000. It sets forth the requirements for behavioral health centers to be licensed in the state of West Virginia. The rule changes bring the licensing requirements for behavioral health centers in line with current practices and federal Centers for Medicare and Medicaid Services (CMS) and WV Department of Health and Human Resources Bureau for Medical Services practices. Civil Monetary Penalties of one thousand dollars have been added for behavioral health centers that fail to correct deficiencies cited during their licensure survey and fifty dollars per day penalties for behavioral health centers that do not submit plans of correction by the deadline.

The Department of Health and Human Resources estimates that any increases in costs to the Department, associated with the proposed rule change will be negligible and can be absorbed within the current funding level. There are one hundred eighteen licensed behavioral health centers. Revenue will increase from ten (10) dollars per license to two hundred fifty (250) dollars per license along with a licensure fee of twenty-five (25) dollars per bed. Licenses are issued every two years. Fifty-Six (56) facilities will renew their licenses in 2009 and fifty-nine (59) facilities will renew their licenses in 2010.

Fiscal Note Detail

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

Effect of Proposal	Fiscal Year		
	2008 Increase/Decrease (use"-")	2009 Increase/Decrease (use"-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	0	0	0
Personal Services			
Current Expenses			
Repairs and Alterations			
Equipment			
Other			
2. Estimated Total Revenues		71,390	45,760

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: 7/29/09

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM:(*Agency Name, Address & Phone No.*) OHFLAC, 1 Davis Square, Suite 101, Charleston WV 25301-1799

LEGISLATIVE RULE TITLE: Behavioral Health Centers Licensure Rule

1. Authorizing statute(s) citation W. Va. Code §§ 27-9-1, 27-17-3, 27-1A-4(g), 27-1A-6(6), 27-1A-6(7).

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

   June 25, 2009

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

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

   July 27, 2009 @ noon.

   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)

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

Aimee Jackson, Paralegal
OHFLAC
1 Davis Square Suite 101
Charleston, WV 25301-1799
Phone: (304) 558-0687
Fax: (304) 558-5607
Email: aimeejackson@wv.gov

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

Dr. Rose Lowther-Berman, PMII
OHFLAC
1 Davis Square Suite 101
Charleston, WV 25301-1799
Phone: (304)558-0488

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

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

b. Date of hearing or comment period:

_____

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

_____

d. Attach findings and determinations and reasons:

Attached _____

Behavioral Health Comments:

All comments are from the Behavioral Healthcare Providers Association unless otherwise noted. Starlight also contributed comments and these are noted as well.

1.6. General Purpose:
Comment: The new language added to this section "traumatic brain injuries" have not been included in previous rules. The majority of behavioral healthcare providers has not served individual with traumatic brain injuries in the past, and would not know how to meet their special needs unless described elsewhere in this Rule.
Response: There are persons with traumatic brain injuries who are currently served by some behavioral health centers. No center is required to serve persons if the center does not feel capable of doing so. If the center does not serve persons with traumatic brain injury, the rule would not apply. The regulation should stand as written.

2.4.a.6. and 3.37. Exceptions and Private Practice:
Comments: 1) Mental health centers are also private practices under these definitions.
2) MENTAL HEALTH CENTERS ARE ALSO PRIVATE PRACTICES UNDER THIS DEFINITIONS, SO DO WE NEED TO FOLLOW THEM??
Response: 1) and 2) Behavioral Health Centers are not private practices under this definition because a behavioral health center does not hold a license issued by a state health regulatory board. The regulation should stand as written.

3.1.a. Abuse:
Comment: 1) This definition should be made consistent with definitions of physical abuse already in Statute under the applicable and recognized standards as set forth under DHHR protective services requirements. The appropriate definition of physical abuse is already established in the law.
2) THE `THAT WAS' AT THE END OF THE 2N0 LINE ISA TYPOGRAPHICAL ERROR OR POOR LANGUAGE.
KNOWINGLY AND INTENTIONALLY ARE SYNONYMS. I WORRY ABOUT `PSYCHOLOGICAL HARM',
ALTHOUGH I UNDERSTAND THE INTENT.
Response: 1) and 2) This definition expands the protections covered in the protective services requirements to better preserve the health and safety of vulnerable West Virginians. It is consistent with federal CMS rules for ICFs/MR and the current Behavioral Health regulations. The regulation should stand as written.

3.1.a.2. Abuse:

Comment: WHICH CAN BE INTERPRETED TO MEAN ANY TIME YOU BLOCK SOMEONE FROM STRIKING YOU, IT ISA FORM OF STRIKE AND, TO MAKE MATTERS WORSE, IF YOU TAKE A PAD OR PILLOW AND THRUST IT OUT TO PROTECT FROM BEING STRUCK, THAT IS AN "OBJECT" UNDER THIS DEFINITION AND COULD ALSO BE CONSIDERED A STRIKE. THIS COULD BE INTERPRETED TO MEAN ALMOST NO CRISIS INTERVENTION TRAINING OUT THERE WOULD BE ACCEPTABLE. STAFF WOULD SIMPLY HAVE TO `TAKE IT' OR RUN,WHICH ISN'T PROPER, EITHER. WE DON'T THINK THIS IS THE INTENT, BUT IT'S TOO EASY TO MAKE THATKIND OF POOR DECISION WITH THIS LANGUAGE.
Response: The regulation should stand as written.

3.1.a.3. Abuse:
Comment: 1) Starlight: This is in conflict with Crisis Prevention Institute (CPI) methods for performing a two person transport.
2) We think this means with fingers and includes "digging in nails". If so, the language should be clarified.
Response: 1) There is nothing in the CPI training or methods that permits shoving, pushing, pulling, tugging, or twisting any part of the consumer's body with fingers or nails.
2) The regulation is clear on this point.
The regulation should stand as written.

3.1.a.4. Abuse:
Comments: We know it is not the intent but the language is clear: better not give shots, then.
Response: The regulation should stand as written.

3.1.a.5. Abuse:
Comments: While we agree if Joe hits someone, he shouldn't hit him back, but, there comes a point where aggression towards someone will cause the person to protect himself. Does retaliation include filing a police report in compliance with state law? This is dangerous language that could get staff hurt or not afford them protection because they couldn't protect themselves without risking an abuse complaint.
Response: The regulations are designed to protect the consumers. Staff, appropriately trained in behavioral interventions, would never have recourse to retaliate toward a consumer physically. It is abuse if the staff aggresses toward the consumer. The regulation should stand as written.

3.6. Aversive Procedures:
Comments: Not letting someone do something they want to do is undesirable; telling them 'no' is undesirable. While they are both aversive they are not necessarily aversive procedures that should be reviewed by HRC. "I want to run

into the street". If you tell me 'no', that is proper. We realize that they don't mean this, but that isn't what the language says.
Response: This regulation is limited to a 'treatment program to decrease inappropriate behavior.' The term HRC (Human Rights Committee) is not used in this regulation at all. The regulation should stand as written.

3.9. Behavior Intervention Plan:
Comments: Under positive behavioral support, this is a behavioral support plan. If they wish to use this terminology, it is confusing.
Response: This terminology is used throughout the regulations. The regulation should stand as written.

3.13. Consumer Record:
Comment: Language which allows only a written and signed record should be adjusted to reflect current, recognized practice allowing also for electronic medical and clinical records.
Response: The proposed regulation does not specify written records. It specifies that the record must be dated and signed. Both of these may be done electronically. The regulation should stand as written.

3.15. Critical Incident:
Comment: The language here should be adjusted to reflect that the requirements would be consistent with incidents occurring in a 24 hour licensed residential setting. Critical incident reporting would not be an appropriate requirement for those who access services for short period of times during the day or month on an outpatient basis. Nor is there any distinction drawn between requirements related to incapacitated individuals or individuals emancipated.
Response: Critical incidents may occur in any setting, and involve any type of individual. OHFLAC does not limit protections to certain types of individuals, but is committed to the protection of all persons receiving Behavioral Health services. The regulation should stand as written.

3.15.e. Critical Incident:
Comments: This means any behavior and requires all staff to guess as to the potential end point of a behavior. A person can pick up a chair and put it down after de-escalation. That could be a critical incident, or an incident. Which is right? This is a guessing game.
Response: Given this definition, there is no guessing. The incident would be a critical incident. The regulation should stand as written.

3.15.g. Critical Incident:
Comments: CONSUMERS ON PROBATION/PAROLE, INVOLVED IN DRUG COURTS AND SOON HAVE MAJOR INVOLVEMENT WITH LAW ENFORCEMENT REGULARLY. THESE ARE NOT CRITICAL INCIDENTS. THIS SHOULD PROBABLY

BE REFINED TO REFLECT THAT. THE PROBLEM HERE IS THAT IT COULD BE TAKEN LITERALLY AND THERE WOULD BE CITATIONS. WE KNOW THAT IT ISN'T INTENDED THAT WAY, BUT THE LANGUAGE LEAVES THAT RESPONSE AVAILABLE.
Response: The key word is 'major' . Routine involvement with probation and parole officers would be 'routine'. The regulation should stand as written.

3.15.j. Critical Incident:
Comment: 1) The word 'potential' should be removed. It is too subjective a term. A single dietary error for instance does not generally cause true harm to an individual.
2) SO EXACTLY WHO IS TO DETERMINE WHAT ISA `POTENTIAL' SERIOUS CONSEQUENCE AND WHAT IS NOT. THIS COULD BE EASILY INTERPRETED TO MEAN THAT ANY MEDICAL ERROR ISA CRITICAL INCIDENT, NO MATTER HOW MINOR BECAUSE THERE COULD ALWAYS BE A "POTENTIAL" FOR A SERIOUS CONSEQUENCE
Response: 1) and 2) The regulation should stand as written. A single medication or dietary error may cause harm or death.

3.15.k. Critical Incident:
Comments: Who are we to authorize someone to be absent? Clients have the right to refuse treatment at any time as stated later on. There is actually better language in the Guidelines that clarifies this.
Response: The treatment team should define the conditions under which a consumer would be therapeutically absent. There are no Guidelines for the proposed Behavioral Health regulations, so the comment is unclear. The regulation should stand as written.

3.20. Employee:
Comment: 1) Starlight: Under this definition, a parent is an employee. Behavioral Healthcare Providers Association 2) WHO ARE WE TO AUTHORIZE SOMEONE TO BE ABSENT? CLIENTS HAVE A RIGHT TO REFUSE TREATMENT AT ANY TIME AS STATED LATER ON
3) THERE IS ACTUALLY BETTER LANGUAGE IN THE GUIDELINES THAT CLARIFIES THIS
Response: These comments are well taken. The proposed regulation will be modified with the addition of the following at the end of the sentence: "where monetary compensation is effected thorough the center's payroll system.

3.21 and 3.41. Emergency Procedures and Psychiatric Emergency:
Comments: So medical emergencies are not a part of emergency procedures. This sounds like physical crisis intervention.

Response: Medical Emergencies are not procedures at all. They are emergency situations which require intervention. The commenter is correct. The regulation should stand as written.

3.23. Goal:
Comment: IN OTHER WORDS, A SYNONYM FOR OBJECTIVE EXCEPT FOR THE LANGUAGE SPECIFYING THAT IT SHOULD HAVE A `BROAD SCOPE'
Response: That is correct. The regulation should stand as written.

3 .26. Independent Health Contractor:
Comment: 1) Starlight - The regulation should be modified to read "A licensed, certified, and /or registered health care provider or parents who provide services under the Title XIX MR/DD Waiver Program..."
2) Behavioral Healthcare Providers Association - WE HAVE NO IDEA WHY THIS IS HERE, BUT IT WOULD COVER THE CONTRACT PERSON SCRAPING OUR PARKING LOT EXCEPT FOR THE `HEALTH' STATEMENT.
Response: 1) This comment is well taken, and the proposed regulation should be modified to reflect this language.
2) The person scraping the parking lot is not a health contractor.

3.27. Individual Support Plan:
Comment: The language here models language elsewhere in the Rule related to requirements for treatment plans. However, it does not allow for fewer documentation and record keeping requirements now recognized by the Bureau for Medical Services and APS Healthcare reviewers for what are known as 'low end services'.
Response: The proposed rule does address this issue under section 8.3.

3.28. Informed Consent:
Comments: THIS WOULD REQUIRE MODIFICATION OF THE CONSENT LANGUAGE IN CONSENT FOR TREATMENT TO ASSURE THAT A STATEMENT IS INCLUDED THAT SAYS `I HAVE LEGAL CAPACITY TO GIVE MY INFORMED CONSENT'. NOTE: CONSENT AND AGREE TO TREATMENT ARE THE SAME THING, YET THEY USE BOTH WORDS IN THE SECTION ON INFORMED CONSENT.
Response: This regulation is to assure that consumers who do not have capacity to give consent are not permitted to do so. The regulation should stand as written.

3.28.c. Informed Consent:
Comments: SINCE THIS IS ABOUT CONSENT, IT SHOULD PROBABLY SAY `CONSENTS TO THE TREATMENT, NOT
AGREES. OTHERWISE IT WOULD BE `INFORMED AGREEMENT'
Response: The point is well taken. The regulation should be modified.

3.33. Neglect:
Comments:
1) The definition here is not consistent for neglect as found elsewhere in Code related to DHHR protective services requirements.
2) This definition of neglect is too subjective, and will result in undue hardship for agencies and staff. A proper definition of neglect should include mention that the wrongful act or acts resulted in placing the consumer at risk for injury or for death.
3) In addition, neglect should not apply only to a single incident, but rather should be applicable to 'intent,' to 'repeated instances,' or to a 'pattern' of findings.
4) AS A CAREGIVER, IF SOMEONE FAILS TO BUY A COAT FOR A GUY WHO MAKES $ 100,000 A YEAR, THAT IS NEGLECT UNDER THIS LANGUAGE. ALSO, STATE LAW USES THE TERM INCAPACITATED OR FACILITY RESIDENT NOT VULNERABLE. ANYONE CAN BE VULNERABLE. WE THINK THIS IS AN UNWARRANTED EXPANSION OF WHAT THE STATE LAW SAYS. THIS WOULD MAKE TWO KINDS OF NEGLECT. NEGLECT BY STATE LAW AND NEGLECT UNDER LICENSURE WHERE AN INDIVIDUAL IS NOT INCAPACITATED OR IS NOT A FACILITY RESIDENT. SOUNDS TO US LIKE IF SOMEONE NEGLECTED A VULNERABLE PERSON (WHO IS NOT INCAPACITATED) IT WOULD NOT NEED TO GO TO ADULT PROTECTIVE SERVICES.
Response: 1) -4) This definition expands the protections covered in the protective services requirements to better preserve the health and safety of vulnerable West Virginians. It is consistent with federal CMS rules for ICFs/MR. The regulation should stand as written.

3.33.a. Neglect:
Comment: A pattern of findings should be required to support the determination that suggests "neglect" rather than isolated instances of failure to carry out an individual support plan.
Response: Any one instance may constitute neglect, based on its severity. The regulation should stand as written.

3.33.d. Neglect:
Comment: 1) A pattern of 'willful' acts should be required before rising to the level of neglect, rather than isolated instances of failure to follow written policies and procedures.
2) WE ALSO DON'T THINK STATE LAW SAYS THIS. WE THINK IT IS WELL-INTENTIONED, BUT IF OUR PROCEDURES SAY YOU WILL OPEN DOORS FOR ALL CLIENTS AND FAIL TO DO SO, IT IS NOT NEGLECT UNDER STATE LAW. BUT IT IS UNDER LICENSURE.

Response: 1) and 2) Any one instance may constitute neglect, based on its severity. For example, leaving a consumer in a closed vehicle in midsummer need only occur once to constitute neglect, and possibly kill the consumer. The regulation should stand as written.

3.37. Private Practice:
Comment: WE ARE A PRIVATE PRACTICE AND NOT SUBJECT TO THESE RULES UNDER THIS DEFINITION
Response: The regulation should stand as written. If you are a 'private practice', then the regulations do not apply to you.

3.41. Psychiatric Emergency:
Comment: REDUNDANT WITH 3.21. Emergency Procedures
Response: Procedures are not emergencies. Both 3.21 and 3.41 are Definitions. The regulation should stand as written.

3.44. Residential Facility:
Comment: 1) Starlight - Agencies have no control over the private homes of consumers and do not feel it is appropriate for agencies to be penalized for the condition of consumer homes.
2) Behavioral Healthcare Providers Association - IE: GROUP HOMES, TRANSITIONAL HOMES (MAYBE), CSU ETC.
Response: 1) This regulation does not deal with the condition of homes, it only defines residential facilities.
2) This is correct.
The regulation should stand as written.

3.45.b. Physical Restraint:
Comment: Why do they specify these? (therapeutic or basket holds and prone or supine containment)
Response: They are examples. The regulation should stand as written.

3.48. Self Administration of Medication:
Comment: SO, THE QUESTION IS HOW DO WE TELL IF THEY ARE FOLLOWING THE HIGHLIGHTED SECTION WITHOUT WATCHING THEM, WHICH ACTUAL MAKES THEM `NOT SELF-ADMINISTRATION', BUT RATHER MONITORED ADMINISTRATION. IF WE DON'T WATCH, IT'S SELF-ADMIN (BUT COULD BE INTERPRETED AS NEGLECT). IF WE DO, IT'S NOT SELF-ADMINISTRATION. ODDLY, WHY IS `PREPACKAGED' INCLUDED?
IS THIS CONSIDERED DIFFERENTLY THAN A PILL BOTTLE? ALTHOUGH WE COULD CONSIDER A PILL BOTTLE AS A PRE-PACKAGING, WE WONDER IF LICENSURE WILL?
Response: This regulation does not address the observation of a consumer at all. The regulation should stand as written.

3.51. Staff
Comment: 1) INTERESTINGLY, REDUNDANT WITH 3.20. Employee WITH EXTRA LANGUAGE THAT MAKES PEOPLE NOT PAID BY US STAFF. WE ARE CONCERNED THAT THIS MIGHT BE CONSTRUED TO MEAN THAT IF A CAREGIVER (UNPAID) WAS HELPING A CLIENT AS WE DIRECT THEM (IE, GETTING THEM TO A TREATMENT PLANNING MEETING, DR. APPOINTMENT AND SOON), THEY ARE STAFF. WE DON'T THINK THAT IS TRUE.
2) Individuals paid under contract through the accounts payable system are not staff. In addition this definition differs from the definition for employee found in 3.20.
Response: 1) This applies to persons paid by the center. 2) This is true. The regulations define Employee and Independent Contractor for this reason. The regulation should stand as written.

3.52.b. Substance Abuse:
Comment: Why is this particular part of the DSM IV being used, and not all of it?
Response: This was modified in consultation with Bureau for Behavioral Health and Health Facilities. The regulation should stand as written.

3.56. Treatment Plan
Comment: Treatment plans should not be generically the same for all individuals in a center's service. Treatment plan requirements should differ for those who are enrolled in 24 hour services or those with developmental disabilities who would have specific habilitation requirements tied to accomplishing measureable goals and objectives. This language does not make accommodation for those who receive a limited set of services such as medication management (maintenance), or other 'low end' services on a limited, outpatient basis.
Response: Treatment plans are not generic since each is based on the identified needs of the consumer. If the consumer needs many services (residential, day treatment, etc) the plan would reflect this. Likewise if the consumer needs medication management quarterly only, then the plan would reflect this as well. The regulation should stand as written.

4.2. License Application:
Comment: The process is more complicated and expensive.
Response: The proposed rule codifies the current procedures for Construction and Renovation used at OHFLAC. OHFLAC recognizes that the expense of the license itself is more. This is an attempt to make the licensure process more cost neutral for the state. The regulation should stand as written.

4.2.a. License Application:

Comment: It would be impossible for a new, not for profit agency seeking licensure to have six months' of operating expenses are on hand, when in fact most if not all revenue will be derived on a fee for service basis.
Response: Financial viability must be in a form as listed to provide credible evidence of financial resources. To ensure the health and safety of consumers, OHFLAC must have evidence that the center is fiscally viable. This information must be provided to the Health Care Authority, and so would not pose a hardship. The regulation should stand as written.

4.2.a. Licensing Application:
Comment: Licensing staff should not address these issues as found listed here. These are requirements already with the Health Care Authority application process to make a determination before finding that a service is needed or necessary. It is duplicative of HCA requirements.
Response: See previous comment. The regulation should stand as written.

4.2.e.3. License Application:
Comment: 1) Renovations or conversions of facilities are already subject to Department of Health rules under the Certificate of Need through the Health Care Authority. This is duplicative.
2) INCLUDES SITE CHANGE, BED CAPACITY CHANGE, EXTENSIVE REMODELING IN EXCESS OF $ 5000 WITH A FINE OF $500 IF WE DON'T TELL THEM. $5000 REMODELING ISA PITANCE ANYMORE, SO WHEN WE DO MOST FORMS OF REMODELLING, WE'LL HAVE TO FILE ANOTHER APPLICATION.
Response: 1) This regulation clarifies the term "extensive renovations" used in the current regulations (4.2.b.).
2) This is correct.
The regulation should stand as written.

4.2.f. License Application:
Comment: The $500 penalty here should be the purview of the Health Care Authority, which issues Orders to close or to cease operations if healthcare entities have exceeded the terns of the service being offered or the sites providing those services.
Response: This penalty is designed to deter centers from making changes in sites and services without notifying OHFLAC. It has nothing to do with the Health Care Authority, but could affect the health and/or safety of consumers. The regulation should stand as written.

4.2.h.4. License Application: ok
Comment: We have to provide OHFLAC with our policies and procedures. We wonder if it is even necessary for them to have our policies and procedures as long as we provide them to them when asked.

Response: This regulation only requires that the application includes policies and procedures amended since the last survey. This is covered as a part of the survey process and there is only a question of OHFLAC obtaining a copy prior to the onsite inspection or during the onsite inspection. It was added to reduce surveyor time at the facility and the inherent costs of the survey process. The regulation should stand as written.

4.3.a. Fees:
Comment: The licensing fee of $100 is not justified compared to the current $ 10 fee.
Response: The proposed rule originally had a fee of $500, which was modified based on comments to $250, then $100. Fees have not increased in at least 17 years. The changes were calculated to address some of the cost of inflation. The regulation should stand as written.

4.3.c. Fees:
Comment: The renewal fee of $250 plus $ 25 per bed is excessive. In addition it may cause those with existing licensed beds to consider closing community based beds in which case individuals will end up in state hospitals or in diversionary beds in private hospitals.
Response: This fee parallels similar fees charged by the Assisted Living Program and brings the Behavioral Health Program in line with similar programs within OHFLAC. The regulation should stand as written.

4.5. Site Selection:
Comment: 1) Some of the requirements in this section are already regulated by existing rule under the Health Care Authority. The added cost implied for contracting architectural, structural and engineering services, not previously required in this Rule, particularly for renovations, will all but preclude small, not for profit licensed behavioral health centers and agencies from renovation or improving any existing properties.
2) NO MODIFICATIONS WITHOUT EXTREMELY EXPENSIVE ARCHITECT DRAWINGS AND WE HAVE TOSUBMIT EVERYTHING TO THEM FOR THE WORK. WE ARE CONFUSED AS TO WHY LICENSURE SHOULD HAVE ANYTHING TO DO WITH OUR REMODELING OF OUR BUILDINGS? ON TOP OF THIS, WHO IS RESPONSIBLE FOR THIS? THE BUILDER? THE OWNER? THE CENTER? THE RENTER? THIS ASSUMES CONTROL OF THE BUILDINGS THAT CENTERS MIGHT NOT ALWAYS HAVE AND IS REMARKABLY EXPENSIVE AND TIME-CONSUMING TO ASSURE.
Response: 1) and 2)OHFLAC is charged with the health and safety of behavioral health consumers. The cost is not additional, but is covered in 4.2.b of the current rule. This regulation does not expand, but clarifies the current regulation. The regulation should stand as written.

4.5.b. Site Selection:
Comment: 1) Conducting a safety risk assessment or an infection control assessment prior to renovations such as installing new carpeting in offices or in the building is excessive.
2) MORE EXPENSE JUST TO PUT UP A NEW WALL OR PAINT A WALL.
Response: This regulation brings the OHFLAC regulation in compliance with the Guidelines for Design and Construction of Hospital and Healthcare Facilities. The regulation should stand as written.

4.5.c Site Selection:
Comment: For new sites. All of this is new and includes compliance with all kinds of rules including this one: "Guidelines for Design and Construction of Hospital and Health Care Facilities other than in the last iteration of these rules, we never heard of that and don't know that we should be required to follow it. Especially, since it is just a set of guidelines. Besides, placing it here gives the Guidelines force of rule. They are just Guidelines and not framed in statute.
Response: The regulation should stand as written.

4.5.c. Site Selection:
Comment: 1) It is fine to require licensed agencies to conform to existing state or local zoning requirements or to state Code requirements. It is not practical in a rural state such as ours to locate needed services in approved sites dose to centers of population or near medical staff or facilities, or existing transportation services. Many licensed centers have satellite offices in very small communities in their rural counties in addition to the main center office and service sites.
2) FOR NEW SITES. ALL OF THIS IS NEW AND INCLUDES COMPLIANCE WITH ALL KINDS OF RULES, INCLUDING THIS ONE: "GUIDELINES FOR DESIGN AND CONSTRUCTION OF HOSPITALS AND HEALTHCARE FACILITIES." OTHER THAN IN THE LAST ITERATION OF THESE RULES, WE NEVER HEARD OF THAT AND DON'T KNOW THAT WE SHOULD BE REQUIRED TO FOLLOW IT. ESPECIALLY, SINCE IT IS JUST A SET OF GUIDELINES. BESIDES, PLACING IT HERE GIVES THE GUIDELINES FORCE OF RULE. THEY ARE JUST GUIDELINES AND NOT FRAMED IN STATUTE.
Response: 1) This is not in the proposed regulation. It is unclear what the commentator means.
2) The 'Guidelines" are through the American Institute of Architects Academy of Architecture for Health. They have been applied by the OHFLAC Life Safety Program for Hospitals, Nursing homes, and Behavioral Health Centers. This regulation simply clarifies an existing practice.
The regulation should stand as written.

4.6.f. Inspections:
Comment: New, but probably proper
Response: This is correct. The regulation should stand as written.

4.6.g. Inspections:
Comment: 1) Inspectors sometimes seek to inspect private residences. This Rule should specify that private residences are not to be considered licensed sites operated by the centers.
2) What does 'if feasible' mean?
Response: 1) and 2) The comment regarding 'if feasible' is well taken. When it is removed, this regulation is verbatim from the current rule. The regulation only applies to licensed locations. The regulation should stand as amended, taking out the words 'if feasible'.

4.6.k. Inspections:
Comment: 1) Clear rules should exist in writing in this section regarding the informal dispute resolution process: Providers need to know, for instance, who can be present for each side, if lawyers may participate, if a statement of deficiencies or plan of correction must be agreed upon before the proceedings can be initiated, and timelines for all of the appeals and required documentation at each step.
2) INTERESTINGLY, THE LANGUAGE SUPPORTS A CENTER DISAGREEING AT ANY TIME, YET THEY WANT US TO DISAGREE AT THE END OF THE INSPECTION BEFORE THE SURVEYOR LEAVES AND BEFORE WE HAVE HAD AN OPPORTUNITY TO LOOK INTO THE MATTER. WE THINK THIS LANGUAGE PERMITS US TO NOT FILE A DISAGREEMENT WHEN THEY LEAVE, LOOK INTO THE MATTER AND FILE AFTERWARD WITHOUT PREJUDICE. SUPPORTING DOCUMENTATION IS MENTIONED 1WICE, WHICH PROBABLY CAN BE RESOLVED IN AN EDIT BY SAYING IT ONLY ONCE.
Response: 1) These issues are covered in OHFLAC procedures that encompass not only behavioral health centers, but also ICFs/MR, and nursing homes. They are based on federal guidelines.
2) No changes are proposed to the regulation.
The regulation should stand as written.

4.7.c. Complaint investigations:
Comments: 1) Providers are not always advised of the general nature of the complaint being investigated. This violates their due process right to know the concern rather than to be subjected to something little more than a fishing expedition. In earlier Rules this section required Health Facilities staff to specify the actual reason for the complaint so that the scope of the review remained focus on that circumstance, and that the review of operations did not become a fully involved licensure review.
2) There are no timelines for OHFLAC's investigation of a complaint.
Response: 1) The current rule does not require the actual reason for the complaint, nor did the previous rule. The proposed rule does require that the general nature of the complaint be identified.

2) OHFLAC complaint intakes are prioritized with those involving the Health and Safety of consumers given first priority. Therefore it is possible that issues involving finance or treatment plan implementation would be investigated later. The regulation should stand as written.

4.9.a. Plans of Correction:
Comment: The Rule should delineate what is meant by variance, and on what basis, or under what circumstances, the provider might request one and the Secretary to grant one.
Response: This is covered in the proposed rule under 3.5.7. Variance should remain the prevue of the Secretary. Current and previous OHFLAC practice has been to implement the directed plan of correction as a last resort when the center, after repeated attempts, did not submit an acceptable plan of correction. The regulation should stand as written.

4.9.d. Plans of Correction:
Comment: Directed Plans of Correction are sometimes made a requirement in this section of the rule. However, the Rule previously, as well as the proposed Rule, does not provide detail about the nature of the Directed Plan of Correction. (timelines, occasions under which it would be warranted, rights to appeal its use).
Response: A Directed Plan of correction is used to assure that plans of correction are timely and that a center cannot postpone implementation of a plan simply by refusing to submit an approved plan. The regulation should stand as written.

4.9.g. Plans of Correction:
Comment: 1) It is fine to require centers to post notice that official records are available for review upon request. However, results of investigations, particularly internal investigations, are not public record and should not be posted for review. This would create an undue liability issue.
2) INTERESTINGLY, THE LANGUAGE SUPPORTS A CENTER DISAGREEING AT ANY TIME, YET THEY WANT US TO DISAGREE AT THE END OF THE INSPECTION BEFORE THE SURVEYOR LEAVES AND BEFORE WE HAVE HAD AN OPPORTUNITY TO LOOK INTO THE MATTER. WE THINK THIS LANGUAGE PERMITS US TO NOT FILE A DISAGREEMENT WHEN THEY LEAVE, LOOK INTO THE MATTER AND FILE AFTERWARD WITHOUT PREJUDICE. SUPPORTING DOCUMENTATION IS MENTIONED 1WICE, WHICH PROBABLY CAN BE RESOLVED IN AN EDIT BY SAYING IT ONLY ONCE
3) While we have nothing to hide, where are we going to post such things?
Response: 1) and 3) This regulation is for survey and complaint results only, not internal investigations. The regulation shall be amended to distinguish that the results of OHFLAC surveys, inspections and investigations should be available. Where the posting occurs is up to the facility.

2) No changes are proposed to the regulation.
The regulation should stand as written.

4.10 Plans of Correction:
Comment: This is new and permits by rule waivers of the rule language.
Response: This is correct. The regulation should stand as written.

5.2.a. Governing Body:
Comment: The governing body should not 'set policy' as stated in this portion of the Rule. The Governing body should hire an administrator who is required to carry out the day to day operations as specified by the Board. Boards should govern only, and this role should be distinguished from the operations role which is given to center management. In the previous Rule, this description of Governing Body responsibilities was instead found under the section entitled "Administration' which we believe is where it rightfully belongs.
Response: This is covered in the current rule under 5.2.a. The language is identical. The regulation should stand as written.

5.2.e.7. Governing Body:
Comment: Governing bodies should not have to see to it that a policy and procedure is maintained. That is the role of 'administration'.
Response: The governing body could delegate this to the administration, as they delegate other tasks. Assigning it to the administration, would limit the authority of the governing body. The regulations should stand as written.

5.2.e.8. Governing Body:
Comment: Governing bodies should not have to see that policies and procedures are available to all staff in all programs. That is the role of' administration.
Response: The governing body could delegate this to the administration, as they delegate other tasks. Assigning it to the administration, would limit the authority of the governing body. The regulation should stand as written.

5.2.e.9. Governing Body:
Comment: ALL ARE NEW BOARD REQUIREMENTS. 5.2.e.2 IS SOMETHING ADMINISTRATION WOULD HAVE TO ASSURE. 5.2.E.3 I CAN HELP WITH; 5.2.E.4 RELATES TO REPORTS LATER. IT'S VERY VAGUE HERE, WHICH IS PROBABLY OK. 5.2.e.7 IS AN ISSUE RE: POLICIES. IT MEANS WE NEED TO HAVE ALL OUR POLICIES REVIEWED BY THE BOARD AND SOMEHOW OR OTHER SIGNED OFF. 5.2.e.8 WE'VE BEEN TALKING ABOUT MECHANISMS, INCLUDING INTRANET, SO IT'S PROBABLY ALREADY OK; 5.2.e.9 HAS TO DO WITH CORPORATE COMPLIANCE, WHICH IS COVERED UNDER THE ACCOUNTING MANUAL CORPORATE COMPLIANCE PROCEDURES. CORPORATE COMPLIANCE IS INCLUDED UNDER THE RISK MANAGEMENT POLICY.

Response: This is true. The regulation should stand as written.

5.3.b. Administration:
Comment: The board doesn't have to do this now
Response: This is correct. The regulation should stand as written.

5.5. Fiscal Protections:
Comment: Centers should be protected from being placed in the position of being accused of 'abuse' as has happened with licensure visits in instances where incidents occurred related to writing checks on behalf of clients, or otherwise managing their funds are labeled abuse. The Rule fails here to distinguish that properly disciplined staff can constitute an 'incident' but did not rise to the level of 'abuse'.
Response: The rule addresses abuse and incidents under 3.1 and 5.12, not under 5.5. The regulations should stand as written.

5.5.a. Fiscal Protections:
Comment: Centers should not be required to purchase automotive liability. Centers instead should be required to assure that those who drive vehicles on behalf of work, and as related to their job functions, are in compliance with state vehicular licensing laws.
Response: This regulation applies only to company owned or leased vehicles.

5.6.b. Consumer Funds:
Comment: 1) A COUPLE OF COMMENTS: "If the Center handles consumer funds or disburses non-fee-for service funds. "CAN THIS BE CLARIFIED? WE PROBABLY DO DISBURSE NON-FEE-FOR-SERVICE FUNDS WHICH HAVE NOTHING TO DO WITH CONSUMER FUNDS. "... such as allowance funds, the Center is a fiduciary for the funds ..." WE AREN'T LAWYERS, BUT DOES DISBURSING A CONSUMER'S ALLOWANCE REALLY REACH THE LEVEL OF "FIDUCIARY RESPONSIBILITY"? COMMON SENSE WOULD SUGGEST THAT IT HAS SOME RELATIONSHIP TO FIDUCIARY RESPONSIBILITY, BUT IS THIS LEGALLY CORRECT?
Response: This is covered in the current rule under 5.4.h. The language is identical. The regulation should stand as written.

5.6.f. Consumer Funds:
Comment: 1) The Rule should require only that bonding is obtained in an amount sufficient to handle client funds. To specify 'in an amount not less than $2500" is overly prescriptive.
2) WE DON'T RECALL THE $25/CONSUMER IN THE PREVIOUS RULE. IS THIS NEW? IT CERTAINLY RAISES THE BAR FOR HAVING A BOND. IF YOU HAVE ONE GUY WHO YOU HANDLE $26 FOR, YOU HAVE TO BE BONDED.

Response: This is covered in the current rule under 5.4.h. The language is identical. The regulation should stand as written.

5.7.b Center Responsibility:
Comment: SEE SECTION 9. REQUIRES MODIFICATION OF OUR CODE OF ETHICS TO ASSURE WE HAVE MET ALL THESE REQUIREMENTS AND REQUIRES TRAINING STAFF IN THE CHANGES. ALL AT A COST IN TIME AND MONEY
Response: Section 9 is the Consumer Rights Section. It is possible that some providers may have to modify their individual Codes of Ethics in response to this regulation. The regulation should stand as written.

5.7.e. Center Responsibility:
Comment: The Rule's language should reflect the same language as is currently required by Federal definition of protections being afforded under 'equal employment opportunities.'
Response: This regulation covers the Federal definitions when it references "any other category protected by applicable law". The regulation should stand as written.

5.7.g. Center Responsibility:
Comment: 1) Reporting should be limited to reports as required by state law. This section of the Rule has been over-interpreted to the extent that 'everything' is reported, leaving providers to guess what is reasonable to report and what is excessive when having to report.
2) ISN'T NEW, BUT WE ARE NOT FAMILIAR WITH A STATE LAW THAT REQUIRES US TO REPORT INJURIES OF UNKNOWN ORIGIN TO ANYONE. WE BELIEVE THAT THIS MAY BE IN SNF AND HOSPITAL REGS. ITS NO PROBLEM TO REPORT THEM TO THE ADMINISTRATOR AND THE LANGUAGE DOESN'T REQUIRE OTHER REPORTS EXCEPT AS REQUIRED BY STATE LAW
Response: 1) and 2) The rule is a state law. This is covered in the current rule under 5.5.h. The language is identical. The regulation should stand as written.

5.8. Relationships with Other Providers:
Comment: The Rule here should require that centers 'demonstrate' good faith effort to obtain written agreements or contracts. In some instances centers cannot compel external organizations to enter into signed agreements.
Response: Centers have the option of refusing to honor agreements that are not written. If the agreement is not in evidence or vague, a situation where neither provider actually serves the consumer may exist. This regulation is designed to protect the consumer from such occurrence. The regulation should stand as written.

5.8.a Relationships with other Providers

Comment: WE HAVE NO PROBLEM WITH AGREEMENTS, BUT WE ARE CONCERNED ABOUT THE MANDATE FOR IT. HERE'S THE THINKING: WHY WOULD WE NEED TO HAVE AN AGREEMENT WITH ALL THE SPECIFICATIONS JUST TO ARRANGE FOR PROVISION OF SERVICES BY SOMEONE ON THE OUTSIDE? A CENTER SHOULD BE ABLE TO MAKE REFERRALS (WHICH ISA SYNONYM WITH `ARRANGE EXTERNALLY') TO OUTSIDE SERVICE PROVIDERS WITHOUT THIS INTRUSIVENESS. WE THINK WHAT THEY ARE DRIVING AT IS IF WE ARE GOING TO WORK OUT A DEAL WITH SOMEONE ELSE TO DO OUR THERAPY FOR US, THERE SHOULD BE AN AGREEMENT OF SOME SORT, BUT WE DON'T THINK THAT NEEDS TO BE REGULATORY. IT MAY ALSO BE A REGULATORY WAY TO TRY TO LEGISLATE AND MONITOR MOU'S AND ALSO, THIS MAY BE THE WAY THEY ARE TRYING TO ADDRESS THE WAIVER PROVIDER ISSUE. NO MATTER WHAT, IT IS MORE COST AND WILL PROBABLY HAVE LITTLE ACTUAL IMPACT ON SERVICES, BUT WILL GIVE SOMEONE SOMETHING TO ASK FOR AND CITE IF ITS NOT AVAILABLE. AND ON TOP OF THAT, CENTERS HAVE NO AUTHORITY TO COMPEL OTHERS TO COMPLETE AN AGREEMENT. IF SOMEONE ELSE DOESN'T DO THAT, EVEN IF WE HAVE DOCUMENTATION THAT THEY FAILED TO GET WITH US, IT'S A CITATION POINT.
Response: The current regulation only specified that an agreement be completed. This regulation was modified to address the specific requirements of such agreements. When agreements are vague or not in evidence, we have found that the service simply isn't provided by either provider, and the consumer is left with no service provision. The regulation should stand as written.

5.8.a.8. Relationships with other Providers:
Comment: AND WE HAVE WHAT KIND OF CONTROL OVER THEM? OTHER THAN TERMINATE AN AGREEMENT,THAT IS ALL WE CAN DO. AND WE'D HAVE TO LOOK INTO EXACTLY WHAT THE STATE/FED REQUIREMENTS GOVERNING THE PROVISION OF CONTRACT SERVICES MEANS. WHICH OF COURSE MEANS ATTORNEY TIME AT HUNDREDS OF DOLLARS / HOUR
Response: This regulation only specifies that the agreement contain language with assurances that the contractors adhere to state and federal requirements governing the provision of the contracted services. The regulation should stand as written.

5.8.b. Relationships with other Providers:
Comments: 1) This regulations (sic) required that we maintain personnel records on Independent Health Contractors who provide direct service to Center consumers including all information that we maintain on regular employees/staff. 2) THIS SEEMS TO MEAN WE HAVE TO HAVE PERSONNEL RELATED FILES ON ALL EXTERNAL HEALTH CONTRACTORS, INCLUDING THOSE WHO WORK FOR OTHER COMPANIES. WE THINK THIS COULD BE AN UNWARRANTED INTRUSION INTO PERSONNEL RELATED PROCEDURES. AN INDEPENDENT

HEALTH PROVIDER WHO WORKS FOR SOME OTHER COMPANY ALREADY HAS ALL OF THIS IN THE PERSONNEL FILES OF THE OTHER COMPANY. WE WOULD HAVE NO CONTROL OVER THEIR PERSONNEL PROCEDURES.
Response: 1) and 2) The regulation does not require a personnel file for Independent Health Contractors. A record related to the specific information and function of the Independent Health Contractor is required. The regulation should stand as written.

5.8.b.10. Relationships with other Providers:
Comment: Starlight - Adding this requirement circumvents the individual's right to due process by creating a 'list' of persons [DHHR] arbitrarily determines to be guilty of abuse or neglect, thus excluding those individual from potential employment.
Response: APS and/or CPS investigations have a due process mechanism whereby the accused has the right to contest findings and have them overturned. The regulation should stand as written.

5.8.c.3. Relationships with other Providers:
Comment: The proposed language in this section of the Rule fails to recognize that individuals sometimes engage in what is known as 'doctor shopping.' Refusal to provide additional services would be appropriate.
In addition, some consumers receive services at other agencies as authorized by the APS Healthcare authorization process under Medicaid. If consumers have received the maximum allowable amount of service under the authorization at another center, there should not be an expectation that they can continue to approach other centers to receive care which would not be reimbursed by Medicaid at all.
Response: If doctor shopping is identified in the assessment process, and is a legitimate problem, the issue would be addressed in the treatment plan. OHFLAC does not regulate consumer's attempts to gain additional services from other centers. The regulation should stand as written.

5.8.c.3. Refusal to Provide Services:
Comment: Starlight - Section 5.8.c.3 mandates that an agency may not refuse to serve a consumer based upon the involvement of another agency. We do not feel that WVDHHR has the authority to mandate who an individual agency chooses to do business with.
Response: This regulation was written to prevent agencies from effectively mandating that a consumer receive all services from one agency, as opposed to having the choice of differing agencies for differing services. The regulation should stand as written.

5.9.a. Personnel:

Comment: Licensure staff should not be regulating workers comp and unemployment rules. This is the purview of other state agencies overseeing unemployment law in West Virginia with their own audits and reviewers.
Response: OHFLAC does not regulate workers compensation and unemployment. The rule only requires the center to have policies that address these issues. The regulation should stand as written.

5.9.c. Personnel:
Comment: 1) Centers should It is unreasonable to expect background checks from all 50 states. There is no known mechanism for doing a national background search. In WV the State Police background check is limited to WV residents. The cost of checking with 50 states would be prohibitive.
2) CIB FOR INDEPENDENT HEALTH CONTRACTORS ISSUES. WE ARE CONCERNED ABOUT THE "WITHIN 30 DAYS". ONCE THE REQUEST IS MADE, WE ARE SUBJECT TO SOMEONE ELSE'S FAILURE, OVER WHICH WE HAVE NO CONTROL.
Response: 1) There are several mechanisms for doing national background checks for about $50 each. This regulation is designed to address only staff who have worked and lived in other states as well as West Virginia. It protects consumers from convicted felons, whatever the state in which the offence occurred.
2) The decision to utilize an Independent Health Contractor is a center decision. Whether the center continues to utilize the Contractor after 30 days without evidence that he/she is not a felon is the center's decision.
The regulation should stand as written.

5.9.c.1. Personnel:
Comments: 1) Centers should not be asked or expected to conduct criminal background checks on independent health contractors who also happen to be the parents of individuals for whom they receive state funds to delivery care or oversight. If a parent does have a past conviction, what then would the center be expected to do?
2) Some items on the list of offences do not prohibit of individuals for instance in a billing office for instance without having client contact.
3) Some items on the list of offences, if the offence occurred 10-20 years ago, would no longer be relevant, such as 'domestic battery' or "DUI' for instance.
Response: 1), 2) and 3) The regulation allow for waivers if the center feels that a prospective employee or contractor should be hired in spite of issues raised by a background check. It is the responsibility of Bureau of Public Health to protect the health and safety of vulnerable West Virginians, and to assure, to the best of its ability, that these consumers are not subject to abuse or neglect. The regulation should stand as written.

5.9.c.4 Personnel:

Comment: NOTE THE TERM INCAPACITATED (APS/STATE LAW TERM) AND NO `VULNERABLE' THIS TIME. AS SUCH, THIS WOULD APPLY TO ONLY THOSE DETERMINED BY STATE LAW TO BE INCAPACITATED
Response: This is correct. The regulation should stand as written.

5.9.d. Personnel:
Comment: There is no national registry.
Response: This is available on line at http://www.fbi.gov/hq/cid/cac/registry.htm and is referenced as a Sex Offender Registry. The regulation will be modified to omit the term Abuse and add Offender but should otherwise stand as written.

5.9.e.3. Personnel:
Comment: This proposed Rule is too restrictive. Some agencies may not require references for every level of staff. The Rule should propose that each center have and follow its own policies as regards references.
Response: This is covered in the current rule under 5.6.d.3. The language is identical. The regulation should stand as written.

5.9.e.5. Personnel:
Comment: The Rule here is too prescriptive. Being qualified to do one's job should be not the role of internal and external peer review, or payer requirements. The Rule here is outdated and does not reflect state of the art practice.
Response: This is covered in the current rule under 5.6.d. This regulation clarifies the existing regulation. The state is not dictating the individual's qualifications, but is requiring that center abide by its own job descriptions. The regulation should stand as written.

5.10.a. Personnel Training:
Comment: The words 'training shall be kept current' should be omitted. Orientation only occurs on a one-time basis.
Response: This is covered in the current rule under 5.7.a. The language is identical. The regulation should stand as written. While orientation is a one-time occurrence, training should be ongoing.

5.10.b. Personnel Training:
Comment: APPARENTLY, AS A RESULT OF A LAWSUIT, THE HEIMLICH MANEUVER IS NO LONGER CALLED THIS. THE NAME SHOULD BE CHANGED TO WHATEVER IT IS CALLED NOW
Response: The point is well taken. The Terminology should be changed to 'Abdominal Thrusts".

5.10.f.2. Personnel Training:

Comment: 1) The Rule here is overly prescriptive. It is in conflict in some regards with other standards already in place under WV Medicaid rules regarding those permitted to conduct clinical evaluations, or those permitted to offer supportive counseling.
2) CAN THIS BE CLARIFIED? IT SOUNDS LIKE WE CAN ONLY HIRE MR/DD STAFF WHO ARE IN COMPLIANCE WITH STANDARDS. NO TRAINING APPARENTLY ALLOWED. MH/SA CAN BE HIRED LICENSED OR PURSUING LICENSURE, BUT NOT MR/DD...
Response: 1) and 2) This language was entered at the request of the Office of Behavioral Health Services and is designed to improve the quality of services to consumers. We believe it is clear.
The regulation should stand as written.

5.10.f.3. Personnel Training:
Comment: It would be sufficient here to say 'qualified'. It is not necessary to say 'or fully credentialed.'
Response: 'Qualified' is a lesser criterion that 'fully credentialed'. The regulation should stand as written.

5.11.b.3. Records Management:
Comment: WHAT VALUE WOULD IT BE TO HAVE A STATEMENT IN A RECORD THAT SAYS `HERE IS HOW WE ASSESS PEOPLE'? WE THINK THEY MEAN A SUMMARY OF ANY COMPLETED ASSESSMENTS WILL BE PRESENT, WHICH IS RATHER DIFFERENT
Response: The point is well taken. The regulation should be changed to read "a summary of the assessments".

5.11.c. Records Management:
Comment: The Rule should reflect medical records' retention requirements elsewhere already in WV Statute, or else by national HIPPA requirements governing records.
2) BUT, MEDICARE JUST CAME OUT WITH A NEW RULE THAT CERTAIN MEDICAL DOCUMENTS MUST BE RETAINED FOR 7 YEARS. THEY PROBABLY SHOULD INCLUDE THAT, AS WELL
Response: 1) and 2) The point is well taken. The regulation should be changed to 7 (seven) not 6 (six) years.

5.11.g. Records Management:
Comment: RELEASE, CONSENT AND AUTHORIZATION ARE ALL USED INTERCHANGEBLY IN THESE SECTIONS.
Response: The point is well taken. The regulation should be modified to read "every person signing a consent, release, and/or authorization shall be given a copy."

5.11.i. Records Management:
Comment: Until electronic records are fully permitted in WV, there remains the possibility of loss due to fires, explosions, and flooding.
Response: There is, of course, always the possibility of loss, even with electronic records. This regulation states "The Center shall ensure reasonable safety and protection of records, including service and organizational records, from...." The regulation should stand as written.

5.12.a. Quality Assurance:
Comment: 1) The proposed Rule is too prescriptive when requiring peer review, health and safety review of all facilities, and reviews of outcomes. The Rule should allow individual centers latitude to interpret 'quality assurance' measures. 2) WHY IS THIS BEING MONITORED BY LICENSURE?
Response: 1) and 2) This is covered in the current rule under 5.11.a. The new Rule clarifies the existing rule. The regulation should stand as written.

5.12.b. Quality Assurance:
Comments: Definitions are not usable in outpatient clinics and don't follow APS/CPS definitions.
Response: This regulation is verbatim from the current rule. The regulation should stand as written.

5.12.b.1.A. Quality Assurance:
Comment: GUIDELINES CALL THIS MANDATORY REPORTING, SO THERE ISA LANGUAGE ISSUE STILL. AND JUST TO KEEP THINGS MESSY, ABUSE AND NEGLECT ARE STILL CALLED CRITICAL INCIDENTS, TOO(SEE 3.15). THERE NEEDS TO BE SOME CONSISTENCY BETWEEN THESE VARIOUS NAMES.
Response: The regulation specifies that there is a difference between allegations of abuse/neglect and critical incidents (see 5.12.b.1.A) The regulation should stand as written.

5.12.b.1.C. Quality Assurance:
Comment: IS THIS A SIMPLE INCIDENT? THERE IS AN ISSUE WITH THE LANGUAGE OF `REQUIRING MONITORING AND FOLLOWUP'. THIS WOULD SUGGEST THAT IF JOE TRIPPED OVER HIS OWN FEET AND FELL AGAINST A WALL WITH NO INJURY OR DAMAGE, WE DON'T HAVE TO DOCUMENT THAT ANYMORE BECAUSE IT `MIGHT NOT REQUIRE MONITORING AND FOLLOWUP'. WE HAVE SOME SUSPICION THAT IF WE STOP TRACKING THESE, THERE WILL BE AN ISSUE FOLLOWING WHERE LICENSURE MIGHT BE ABLE TO ARGUE THAT THEY DO NEED MONITORING AND FOLLOWUP AND A CITATION COULD FOLLOW.
Response: This regulation simply lists the types of incidents that require monitoring. 5.12.b.1.C is one portion of this list. If Joe trips that would require

monitoring of Joe's possible injury and therefore would be tracked. The regulation should stand as written.

5.12.c.2. Quality Assurance:
Comment: Not all allegations of abuse and neglect should be reported to Health Facilities. Only those substantiated upon internal review or those substantiated by external review such as by Adult Protective Services staff should be reported.
Response: The Centers are required by Adult Protective Services documentation to report allegations of abuse and neglect immediately to OHFLAC, not when the allegation has been substantiated by the center's internal investigation. The regulation should stand as written.

5.12.d. Quality Assurance:
Comment: 1) This section of the Rule is too prescriptive. Health Facilities has prepared, in its own words, guidelines for investigating incidents. Therefore they are not in any Rule, and exist only as a tool for training and technical assistance. It is unrealistic therefore for Health Facilities to then expect agencies to develop policies and to carry out procedures which follow items offered up as guidelines.
2) THIS GIVES REGULATORY SUPPORT TO THE GUIDELINES AND MOVES GUIDELINES OUT OF THE STATUS OF `GUIDELINE' AND GIVES IT THE FORCE OF REGULATION. GUIDELINES ARE JUST THAT. THEY ARE NOT REGULATION. IF THEY WANT TO DO THAT, THEN THE GUIDELINES NEED TO BE REVIEWED, LANGUAGE CHANGED TO REGULATORY LANGUAGE AND THEY NEED TO BE ADDED TO THESE REGULATIONS AS PART OF THE RULES. ALSO, WHAT ABOUT THE VARIOUS TRACKING METHODS... CAN THERE BE A COOPERATION BETWEEN WAIVER AND OTHERS TO REDUCE REDUNDANCY OF MULTIPLE TRACKING SYSTEMS?
Response: 1) and 2) The OHFLAC guidelines do not prescribe policies and procedures, only practices that protect consumers and comply with the existing rule. The regulation should stand as written.

5.12.e. Quality Assurance:
Comments:
1) This section is overly prescriptive. It should suffice to say that clients are to be advised of their rights, including the right of appeal, and the right to avail themselves of the center's grievance policy.
2) Centers currently must follow the WV Code requirements regarding notices and the grievance processes under client rights.
3) Governing bodies govern, and do not become involved in day to day operations. It is not appropriate that consumers can take appeals directly to the governing body.

Response: 1) through 3) There must be a paper trail to verify center compliance. Governing body references are from the current regulation. The regulation should stand as written.

5.12.g.2 Quality Assurance:
Comment: THIS IS BETTER
Response: The point is well taken.

5.12.g.7. Quality Assurance:
Comments: We do not agree. This requirement is excessive. If a center provides "low end services" only for instance to 30 individuals or fewer, it is required to maintain a Human Rights Committee?
Response: This is covered in the current rule under 5.9.b. The language is identical. The regulation should stand as written.

5.12.g.8. Quality Assurance:
Comment: For small agencies it would be helpful if family members as well as consumers themselves could be allowed to serve on a Human Rights Committee.
Response: Family members may comprise the remaining 1/3 of the Human Rights Committee not specified by the rule. The regulation should stand as written.

6.1.a Transportation Services:
Comment: REDUNDANT WITH INSURANCE REQUIREMENTS
Response: This regulation requires centers to maintain adequate insurance coverage, if they transport consumers. The regulation should stand as written.

6.1.b. Transportation Services:
Comment: The Rule is too prescriptive. It is already a requirement under WV Law that drivers be licensed and have insurance coverage. Centers cannot constantly monitor employees for continued evidence of insurability.
Response: This regulation is designed to protect consumers who ride in employee vehicles. If the center provides transportation services, it must ensure that those services are provided safely. The regulation should stand as written.

6.2. Physical Environment:
Comments:
1) Although the standards prescribed herein may be applicable in the current year, they are sure to change in future years. It would be better not to prescribe use of 200 I Guidelines, and rather to say only 'the applicable Code or Guideline.
2) Applying these Rules to renovations may be cost prohibitive and result in a decision not to make future renovations.

3) It would be more desirable rather than to be so prescriptive, for the Rule to say instead, meets the applicable State building, zoning, fire and environmental codes.
4) WHAT IS THIS AND WHY WOULD WE NEED TO FOLLOW IT? IT IS LIKELY THAT THESE GUIDELINES, WHILE PERHAPS REASONABLE, WILL REQUIRE EXPENSIVE AND TIME CONSUMING WORK.
Response: 1) through 4) The point is well taken. The regulation was changed in the current proposed regulation. The proposed regulation lists the specific applicable codes.

6.2.a.3. Physical Environment:
Comment: NEW STANDARDS FOR BUILDINGS ARE BEING BUILT INTO THE RULE
Response: The new regulations reflect the current requirements under state and federal building codes. The regulation should stand as written.

6.2.a.3.A. Physical Environment:
Comment: RE: THE ARCHITECTURAL GUIDELINES.AGAIN, WHAT IS THIS?
Response: The new regulations reflect the current requirements under state and federal building codes. The regulation should stand as written.

6.2.a.5. Physical Environment:
Comment: REDUNDANT
Response: The new regulations reflect the current requirements under state and federal building codes. The regulation should stand as written.

6.2.a.8. Physical Environment:
Comment: THIS APPEARS TO BE AN ICF/MR RULE PORTED OVER TO OUT-PATIENT SITES. THIS WAS IN THE LAST DRAFT RULE AND SEEMED INAPPROPROPRIATE THERE, TOO. WE RECOGNIZE THAT IT IS APPROPRIATE IN RESIDENTIAL SETTINGS; HOWEVER, THIS LANGUAGE WILL REQUIRE EMERGENCY NUMBERS, FIRE, POLICE NUMBERS BY `THE TELEPHONE' (WHICH IN THIS CASE MEANS ALL PHONES IN EVERY BUILDING). AND THAT WOULD MEAN A WHOLE LOT OF PHONES. ON TOP OF THAT, WE CANNOT TRAIN EVERY CLIENT WHO CAN DO SOON HOW TO USE A PHONE. THIS WILL ALSO REQUIRE SOME FORM OF DOCUMENTATION ABOUT HOW WE TRAINED THEM AND ALL THAT. THIS IS AN UNWARRANTED EXPENSE PLUS INAPPROPRIATE MERGING OF RESIDENTIALLY-CREATED RULES INTO OUTPATIENT SERVICES.
Response: This is in the current regulation under Section 6.1.f. The regulation should stand as written.

7.3. Consumer Screening:
Comment: 1) The Rule is too prescriptive. Centers do not currently maintain records of screenings for two years' time because it is not required by any

federal or state law. Centers would have no way to access records of screenings conducted two years ago.
2) We only keep records on persons who become consumers.
Response: 1) The regulation requires retention of screening records for 180 days.
2) The regulation requires retention of all screening records for 180 days.
The regulation should stand as written.

7.4.b. Consumer Admission:
Comment: THIS IS NEW LANGUAGE THAT APPEARS TO BE TAKING THE PLACE OF A GRIEVANCE PROCESS LANGUAGE. WE THINK THIS PLACES OHFLAC IN AN INAPPROPRIATE OVERSIGHT ROLE AND BY INCLUSION, SUGGESTS THAT THE PROPER WAY TO EXPRESS YOUR DISSATISFACTION IS TO CONTACT LICENSURE, NOT FILE A GRIEVANCE WITH US AND ADDS ANOTHER LAYER OF BUREACRACY AND EXPENSE. BY LEAVING OUT THE GRIEVANCE PROCESS, IT SUGGESTS THAT THE GRIEVANCE PROCESS IS NOT THE BEST WAY TO HANDLE DISSATISFACTION, WHICH WE THINK IS INAPPROPRIATE. WHILE WE DON'T THINK THAT IS THE INTENTION, IT DOESN'T TAKE MUCH TO SEE A CONSUMER SAYING "WHY SHOULD I TRY TO HAVE THE CENTER RESOLVE MY PROBLEM (NO MATTER HOW BIG OR LITTLE IT IS) THROUGH A GRIEVANCE; I'LL TAKE IT DIRECTLY TO THEIR AUTHORITIES. WE COULD SEE LICENSURE GETTING A SLEW OF FRIVILOUS COMPLAINTS AND WISHING THIS WAS NOT INCLUDED.AND WE'D PROBABLY SEE OHFLAC ALL THE TIME MANY OF WHICH WOULD BE A WASTE OF EVERYONE'S TIME. AND, WHAT ARE THE ROLES OF ALL THE OTHER ADVOCACY GROUPS IFOHFLACTAKESOVER FOR EVERYONE?
Response: This is reflected in the current regulation (Section 8.1.a.23). It is no different than what is currently practiced and surveyed. The regulation should stand as written.

7.4.c. Consumer Admission:
Comment: The Rule is too prescriptive. It should require only that the center have an approved grievance procedure which would bring matters eventually to the attention of the Administrator. Centers should not be required to offer the external remedy only of Health Facilities to the exclusion of other bodies such as the WV Advocates, legal representation of their own choosing, and the like.
Response: The regulation is in the current rule under 11.1 and is verbatim from that rule. OHFLAC sees no need to revise. The regulation should stand as written.

7.5.b.3. Consumer Discharge:
Comment: Not all consumers will have a treatment plan in accord with current policy and practice in recognition of 'low end' services. The language should simply state "Progress toward the consumer's needs."
Response:. The regulation was revised to reflect this language.

7.6. Medical Information:
Comment: Most of the information listed in this section is not appropriate for outpatient behavioral health settings and records. The rule should require only necessary health information as prescribed by HIPAA.
Response: These items are necessary to maintain a continuum of care and ensure proper treatment procedures are being utilized. They protect the health of vulnerable West Virginians and are in compliance with HIPAA. The regulation should stand as written.

7.6.a.2.J. Medical Information:
Comment: THE STATUS IS REQUIRED AS PART OF THE MEDICAL HISTORY. WE WONDER WHO WOULD BE THE ONE TO MAKE THIS DETERMINATION BESIDES THE CONSUMER, HIM/HERSELF? AND WHAT VALUE THAT MIGHT BE REGARDING OUR REQUIREMENT TO ASSESS THIS SKILL?
Response: This is covered in Sections 8.8.b and 3.48. Self medication is assessed by the center, not the consumer. The regulation should stand as written.

8.2 Assessment and Planning for Multiple Extensive Services:
Comment: WHAT ARE THESE? THE PHRASE IS NEW AND SUGGESTS SOMETHING DIFFERENT. IS IT?
Response: All these terms are defined in the dictionary. The regulation should stand as written.

8.2.b. Assessment and Planning for Multiple Extensive Services:
Comment: 1) Not every client seen on an outpatient basis will require all of these items listed to be assessed. The language should be changed to 'clients/consumers will be assessed according to the consumer's particular needs'.
2) What is the difference between a preliminary assessment and an initial assessment?
Response: 1) There is no list of assessments in this regulation. The comment is unclear.
2) The comment is well taken. The word 'preliminary' should be changed to 'initial'. The regulation should stand with this revision.

8.2.d. Assessment and Planning for Multiple Extensive Services:
Comment: 1) Assessments may differ from screenings. The Rule should make a distinction between requirements for in depth assessments and for routine

screenings. Assessments are expensive and should be geared to consumer needs and preferences.
2) 30 DAY ASSESSMENT COMPLETION
Response: 1) and 2) Screening is not mentioned in this regulation. It is unclear what the commenter meant. The regulation should stand as written.

8.2.f. Assessment and Planning for Multiple Extensive Services:
Comment: Assessments or screenings should be entered into the record prior to the delivery of regular services. In the event that assessments were not indicated, the record would indicate the reason.
Response: This is in the current rule under 7.2.d, verbatim. The regulation should stand as written.

8.2.g.2. Assessment and Planning for Multiple Extensive Services:
Comment: 1) Not every consumer will require an individual support plan. Medicaid no longer requires this for those who are receiving 'low end services.' Health Facilities has issued a policy to providers regarding 'low end services.'
2) IS THIS THE INITIAL PLAN WHICH USED TO REQUIRE BEING DEVELOPED WITHIN 7 DAYS?
Response: Individual Support Plans are completed even for those with "low end services.' Only the content is abbreviated with the venue as a case note. This is covered under section 8.3 of the proposed regulations. The regulation should stand as written.

8.2.g.4.I. Assessment and Planning for Multiple Extensive Services:
Comment: IS THIS IN CONFLICT WITH APS?
Response: No. The regulation should stand as written.

8.2.g.4.K. Physician Notes as Part of the Treatment Plan:
Comment: Treatment Plans are not required for every consumer. In addition, treatment plans should not have to be re-done in their entirety each time a physician changes a dosage or makes similar changes in overall medication management for instance. Rather the physician's regular notes and the medication sheets maintained by the center should be sufficient.
Response: This is addressed in the proposed rule under 8.3. In some cases the Physician's Notes are the treatment plan. The regulation should stand as written.

8.2.h. Assessment and Planning for Multiple Extensive Services:
Comment: 1) Depending upon whether the consumer receives 24 hour services in a licensed residential setting or whether they receive 'low end services' only, some consumers would have a program plan review, while others would have only case notes. The requirement in this section is too prescriptive given the range of service options available.

2) WELL AMONG THE REASONS FOR THESE ARE TRANSFER/DISCHARGE, MOVING, CRISIS, CONDITION CHANGES. THESE ARE THE "MANDATED" ONES. MOVING FOR ALL CONSUMERS DOESN'T ALWAYS REQUIRE A TREATMENT PLAN REVISION, UNLIKE WAIVER CONSUMERS
Response: 1) and 2) This is addressed in the proposed rule under 8.3. The regulation should stand as written.

8.2.h.2. Assessment and Planning for Multiple Extensive Services:
Comment: 1) We do not know why the language here specifies 365 days, presumably to account for an annual review. However, it would be better to insert language which conforms to existing industry standards such as reviews at 'critical junctures', or else to be less prescriptive by allowing reviews to occur as consumer individual needs vary.
2) NOTE: SUPPORT PLAN = TREATMENT PLAN PER DEFINITIONS. THE PLAN REVIEW IS SPECIFIED FOR ANNUAL AND THE REQUIRED ONES ABOVE. INTERESTINGLY, NO 6 MONTH REVIEW REQUIRED.
Response: The support plan should be reviewed at least annually. The critical junctures issue is covered in 8.2.h.1.D (crisis points). This regulation should stand as written.

8.3. Assessment and Planning for Limited-Outpatient Clinic Services:
Comment: THESE APPEAR TO BE LOW-END SERVICES. ARE THEY?
Response: Yes.

8.3.a.2. Assessment and Planning for Limited-Outpatient Clinic Services:
Comment: WHERE DID THIS TIME FRAME COME FROM? "ENTERED INTO THE RECORD" MEANS COMPLETED AND FILED TO RECORDS, SO WE'D HAVE TO DOCUMENT WHEN THE ASSESSMENTS WERE FILED TO RECORDS. THIS ADDS AN EXTRA STEP FOR ONE DOCUMENT ONLY TO ASSURE WE'VE MET THE STANDARD. WHILE IT IS APPROPRIATE NOT TO DALLY, THIS IS THE ONLY DOCUMENT WITH THIS GUIDELINE; HOWEVER, GETTING THE DOCUMENT INTO THE CHART IS REALLY PRETTY MEANINGLESS WITH RESPECT TO THE CONSUMER'S SERVICES; WHAT IS IMPORTANT IS THE COMPLETION DATE OF THE ASSESSMENT AND WHEN THE SERVICES BEGIN. ALL THIS IS IRRESPECTIVE OF PROPER DOCUMENTATION FILING GUIDELINES.
Response: If the information is not in the chart, it cannot be available for review by physicians, other clinicians, employees working with the consumer, and of course surveyors. Therefore the timeliness is a health and safety issue. The regulation should stand as written.

8.3.a.4. Assessment and Planning for Limited-Outpatient Clinic Services:
Comment: TREATMENT JUNCTURES ARE NOT SPECIFIED FOR THIS POPULATION EXCEPT IF THEY NEED ADDITIONAL SERVICES

Response: They are specified in this regulation. The regulations should stand as written.

8.4. Residential Services:
Comment: Please clarify if 'residential services' refers only to 24 hour services licensed under the center's umbrella license such as an ICF/MR group home but not an individual's private home. Please clarify if "Crisis Residential Units" follow under residential services.
Response: Residential Services are provided in Residential Facilities as defined under 3.44. This includes Crisis Residential Facilities. Specific types of residential facilities and their corresponding requirements are listed under 8.4. In response to this comment, the following is added as a general statement under 8.4. "Specific Residential Services Provisions": These provisions are in addition to the general physical environment requirements found in Section 6.2.

8.4.a.1. Residential Services:
Comment: 'Assure' should be removed from this draft language. Centers cannot 'assure' availability as listed. They can make the same accommodation as would be available to any resident in any community, that emergency response or emergency vehicles would be accessed via local community response, dialing 911, or, or transport to hospital or other local medical facilities.
Response: The examples used by the commenter are ways that a center can 'assure'(sic) medical emergency services. The proposed regulation uses the term "ensure" not "assure". The regulation should stand as written.

8.4.a.4. Residential Services:
Comment: Centers should not be expected to develop a separate policy for threatened or actual assaults by consumers. Rather, the center's regular policy and procedure for emergencies most likely contains sufficient protective measures to assure protection and oversight.
Response: The purpose of this regulation is to ensure that centers have sufficient protective measures, not just are most likely to do so. The regulation should be modified to read: "The center's emergency events policy and procedure shall contain procedures for a consumer who attempts or threatens suicide or homicide, or attempts of threatens assault. It must include referral and follow-up of the consumer."

8.4.b.7. Residential Services:
Comment: REGARDING MR/DD CLIENTS: IF THEY DON'T HAVE `MENTAL HEATH SERVICES' NEEDS, WHAT THEN. WE KNOW WHAT THEY ARE SAYING, BUT THE LANGUAGE REQUIRES US TO SEND EVERY INDIVIDUAL WITH MR/DD FOR MENTAL HEALTH TREATMENT SERVICES, WHICH THEY MIGHT NOT NEED

Response: The point is well taken. The regulation was modified with the inclusion of 'if needed' to the regulation.

8.4.c.2.A. Public Inebriate Shelters:
Comment: IS THIS THE SAME AS THE ABOVE-REFERENCED SCREEN? IS IT AN UNNECESSARY REDUNDANCY FOR SA RESIDENTIAL PROGRAMS?
Response: This regulation doesn't deal with Substance Abuse Residential Programs but with PI shelters. Therefore the need to define assessments remains. The regulation should stand as written.

8.4.c.4. Public Inebriate Shelters:
Comment: API SHELTER IS NOT A COMMITMENT PLACEMENT AS WE UNDERSTAND THE TERM. SHOULD IT SAY "IF COMMITTED TO THE SHELTER, THE SHELTER SHALL NOT..." OR SHOULD THE LANGUAGE REMOVE THE TERM `COMMITTING'
Response: The regulation should stand as written.

8.4.e.3. Adult Residential Addictions Recovery Treatment Programs:
Comment: NOTE THE REQUIREMENT FOR MEDICAL HISTORY WHICH REQUIRES CONSUMERS TO INDICATE THEIR SELF-ADMINISTRATION STATUS. THIS ADDS COST AND BUREACRACY.
Response: This may be accurate, but is necessary to preserve health and safety. This particular regulation was written by a task force on Adult Addictions Recovery Programs, composed exclusively of providers. The regulation should stand as written.

8.4.e.5. Adult Residential Addictions Recovery Treatment Programs:
Comment: THIS IS MONITORED SELF-ADMINISTRATION, WHICH IS NOT THE SAME THING AS SELF-ADMINISTRATION. IT PLACES US IN RESPONSIBILTY TO ASSURE THAT THE MEDICATIONS TAKEN ARE PROPER. MORE EXPENSE AND GREATER RESPONSIBILITY HIDDEN UNDER THE GUISE OF "SELF-MEDICATION"
Response: This is necessary to preserve health and safety. This particular regulation was written by a task force on Adult Addictions Recovery Programs, composed exclusively of providers. The regulation should stand as written.

8.4.e.7. Adult Residential Addictions Recovery Treatment Programs:
Comment: WE WOULD, IN ACCORDANCE WITH PREVIOUS INTAKE REQUIREMENTS, HAVE THIS INFORMATION SO IT IS REDUNDANT WITH INTAKE PROCESSES. NOTE THAT IT REQUIRES A RECORD KEEPING REQUIREMENT FOR SUPERVISION OF SELF-ADMIN. SEE ABOVE
Response: This is necessary to preserve health and safety. This particular regulation was written by a task force on Adult Addictions Recovery Programs, composed exclusively of providers. The regulation should stand as written.

8.4.f.2. Adult Residential Addictions Recovery Treatment Programs:
Comment: WE WONDER WHAT MAKES A BED PERMANENT. ANY BED IS `TEMPORARY' BY DESIGN AND CAN BE TORN DOWN AND MOVED. THIS IS LIKELY JUST A LANGUAGE ISSUE. WE THINK THEY MUST MEAN `WE ARE GOING TO GIVE YOU A BED IN ROOM 1 AND NOT MOVE YOU'.
Response: This is necessary to preserve health and safety. This particular regulation was written by a task force on Adult Addictions Recovery Programs, composed exclusively of providers. The regulation should stand as written.

8.4.f.17. Adult Residential Addictions Recovery Treatment Programs:
Comment: THIS PROVIDES A REGULATORY REQUIREMENT TO DISASTER RESPONSE PLANNING
Response: This is necessary to preserve health and safety. This particular regulation was written by a task force on Adult Addictions Recovery Programs, composed exclusively of providers. The regulation should stand as written.

8.4.f.19.h. and 8.4.f.19.j. Adult Residential Addictions Recovery Treatment Programs:
Comment: MEDICAL HISTORY? WHY IS NECESSARY? IS IT TOO RESTRICTIVE FOR THIS POPULATION?
Response: This is necessary to preserve health and safety. This particular regulation was written by a task force on Adult Addictions Recovery Programs, composed exclusively of providers. The regulation should stand as written.

8.5 and 8.8. Medication /Medical Management ok
Comment: 1) These are two sections with the same title.
2) The rule continues to require that psychotropic drugs are to be ordered only as a part of the treatment plan. Most of our consumers receiving medication management services do not have an individualized service plan or treatment plan as identified in these regulations.
Response: 1) One is Medication Management and one is Medical Management.
2) This is covered in section 8.3. Assessment and Planning for Limited-Outpatient Clinic Services. There is no requirement for a treatment plan in this section.
The regulation should stand as written.

8.6.a. Medical Equipment:
Comment: ANOTHER ADDED EXPENSE
Response: Centers who have medical equipment have policies for their use. There should be no added expense. The regulation should stand as written.

8.7.b. Medication Services:

Comment: This is overly prescriptive. Our own physicians do not review our medications every 180 days, but rather when new symptoms develop, or the medication begins to lose its previous effectiveness.
Response: This is contained in the current rule under 7.10.b., except that the time frame was changed from 90 days to 180 days to correspond with Medicaid billing. The regulation should stand as written.

8.7.c. Medication Services:
Comment: This is overly prescriptive. Not all consumers have a treatment plan if receiving 'low end' services as allowed by existing Medicaid rules. In addition, physician's regular notes and medication sheets should satisfy any documentation requirements.
Response: This is exactly the same as the current regulation 7.10.b.2. The regulation should stand as written.

8.7.g Medication Services:
Comment: MERGES GUIDELINES AND GIVES THEM FORCE OF RULE. SEE ABOVE RE: ISSUES WITH THAT. ADDS THEM TO 64 CSR 60, THE AMAP RULES
Response: 64CSR60 is a state law, not a guideline. The regulation should stand as written.

8.7.h. Medication Services:
Comment: This is not realistic for outpatient services, but rather only for 24 hour residential sites.
Response: This not required for outpatient services, unless the medications are administered by the outpatient center. The regulation should be modified to read: "An individual medication administration record of all medications receive and refused by each consumer <u>that are provided by the center</u> shall be kept."

8.8.b. Medication Management:
Comment: 1) This is not realistic for an outpatient service, or with those who are not incapacitated. Assessments are expensive, and must be appropriate for the type of licensed setting under consideration.
2) ASSUMES ALL WILL BE ASSESSED FOR SELF MEDICATION. WHAT ABOUT OUT-PATIENT? SOME PROGRAMS REQUIRE MONITORING OF THIS, WHICH IS NOT SELF-MEDICATION BUT RATHER SUPERVISED SELF-MEDICATION (WHICH MAKES THE RESPONSIBILITY OURS, NOT THE CONSUMER'S). WE THINK THERE ISA BLURRING OF SELF-MEDICATION AND SUPERVISED SELF-MEDICATION SUCH THAT ACTUAL `SELF-MEDICATION' IS BEING SUBSUMED UNDER SUPERVISED SELF-MEDICATION, WHICH IT IS NOT. SEE ABOVE RE: BUREAUCRACY AND COST
Response: 1) and 2) The portion of the regulation requiring assessment only pertains to those with "Self Medication Management". This would not include

persons receiving outpatient services by definition. The regulation should stand as written.

8.8.c. Medication Management:
Comment: This is an antiquated requirement carried forward from the licensing of state hospital settings. Medical practitioners these days are adequately trained by their professions and their continuing educational requirements to safe guard the storage of medications appropriately.
Response: The regulation had been revised to read "The center shall provide double locked storage for all controlled substances and single locks for all others." Schedule Two and Three medications are required to be double locked by the Pharmacy Board and by the DEA. The regulation as it currently reads meets, but does not exceed these requirements. The regulation should stand as written.

8.8.d. Medication Management:
Comment:. The rule is too prescriptive and does not to allow agencies to develop their own procedures to safeguard medications which must be refrigerated.
Response: There is nothing in this regulation that prohibits a facility from developing its own procedures to address medication storage. This is actually a requirement under 8.7.a of the proposed regulation. The regulation should stand as written.

8.8.e. Medication Management:
Comment: THAT WOULD BE THE MEDICATIONS THE CENTER PRESCRIBES. WE WILL LIKELY HAVE NO SUCH INFORMATION FROM THE MEDICATIONS PRESCRIBED FROM FAMILY PHYSICIANS, DENTISTS, HOSPITALS ETC. THE RULE DOES NOT SPECIFY THE DIFFERENCE, WHICH COULD BE AN ISSUE
Response: The point is well taken. This section was modified to read "medications prescribed by the behavioral health provider."

8.9.a. Behavior Intervention:
Comment: CRISIS INTERVENTION TRAINING, NOT `BEHAVIOR MANAGEMENT, WHICH IS NOW CALLED BEHAVIOR SUPPORT. THIS ISA LANGUAGE ISSUE THAT SHOULD BE ADDRESSED.
Response: The language was kept general as not all centers may use Crisis Intervention training. There are multiple training programs for staff in this field. The regulation should stand as written.

8.9.b. Behavior Intervention:
Comments: 1) Please clarify what is meant by "predictable" problem behaviors. 2) THIS IS BEHAVIOR SUPPORT. `ALL INTERVENTIONS' CANNOT BE BASED ON A FUNCTIONAL ANALYSIS EXCEPT IN THE EVENT OF A PERSON IN NEED OF A

BEHAVIOR SUPPORT PLAN. WE CANNOT PREPARE PLANS FOR EVERY OUT-PATIENT PERSON WHO MIGHT `PREDICTABLY' ACT OUT. IT IS INAPPROPRIATE AND FRANKLY IMPOSSIBLE TO DO.
Response: 1) and 2) The regulation was modified to read "The Center shall ensure that all interventions for problem behaviors which are identified in the Individual Service Plan are based on a functional analysis of the behavior."

8.9.c. Behavior Intervention:
Comments: 1) The proposed Rule in this section is completely over stated and overly prescriptive, and does not allow behavioral intervention strategists or psychologists the necessary latitude to do the job for which they were hired, nor does it afford the client an individually customized intervention suited to his particular needs. In addition, there is reference to an interdisciplinary team which may or may not exist with every consumer entered into services.
2) THIS WHOLE SECTION IS NOT ABOUT CRISIS INTERVENTION, EVEN THOUGH IT MERGES SOME CRISIS INTERVENTION LANGUAGE IN THE FIRST SECTION. ALL OF ABOVE IS BEHAVIOR SUPPORT. WE WILL HAVE TO DETERMINE HOW THIS MERGES WITH REQUIREMENTS OF BEHAVIOR SUPPORT PLANNING AND WAIVER. THERE IS MH LANGUAGE INCLUDED ABOVE. WE THINK THIS SECTION SHOULD BE RESTRUCTURED TO ADDRESS BEHAVIOR ISSUES GENERALLY (CRISIS RESPONSE) AND MH/SA/OTHER BEHAVIOR PROBLEMS AND SEPARATELY DD BEHAVIOR PROBLEMS. THAT WOULD MAKE MORE STRUCTURAL SENSE. IS THIS A FORM OF `PRESCRIBING TREATMENT? IS THAT APPROPRIATE?
Response: 1) and 2) This regulation does not limit the types of interventions that may be used, nor does it limit individualized interventions or the population affected. It does limit how much time a center can spend on assessment prior to the development of a plan. It requires that a rationale must be fully explained through the functional analysis. The regulation should stand as written EXCEPT that the last sentence "However, the interdisciplinary team shall objectively monitor the symptoms in order to evaluate the effectiveness of the intervention employed" should be deleted.

8.9.d.3. Behavior Intervention:
Comment: SHOULD INCLUDE REFERENCE TO LANGUAGE THAT SECLUSION / RESTRAINT MUST FOLLOW POLICY
Response: This section deals with the items in a specific behavior plan. That document would not include a policy reference. The regulation should stand as written.

9.1. Consumer Rights:
Comment: 1) Consumer Rights under the Rule should be consistent with consumer rights in any health care setting as already established in statute and

in Code by the WV Legislature. This Rule should be no different. The language in this section exceeds that which is found in the West Virginia Code.
2) WHAT FOLLOWS HERE IS BEHAVIORAL HEALTH RIGHTS (SEE THE BEHAVIORAL HEALTH RIGHTS RULE)
Response: 1) and 2) This section is substantively identical to 64CSR74 and was included in this Rule in order to ensure enforcement of that law. 64CSR74 contains no enforcement provision. The regulation should stand as written.

9.1.a.2. Consumer Rights:
Comment: WE HAVE TO GIVE THEM A COPY OF THE RULE. SO, OUR CLIENT RIGHTS PAMPHLET ETC WILL BE HUGE, INCREASING COSTS AND INTAKE TIME. WILL THIS BE BILLABLE TO THE EXENT NECESSARY TO MEET THIS REGULATION?
Response: The rights are provided in writing upon request. The regulation should stand as written.

9.1.a.5. Consumer Rights:
Comment: WHILE APPROPRIATE, THERE IS ANOTHER REFERENCE TO THIS RIGHT EARLIER
Response: We are not sure where the commenter is referring. The regulation should stand as written.

9.1.b.3. Consumer Rights:
Comment: THIS SHOULD SAY "STATE AND FEDERAL LAW".HIPAA SOMETIMES OVER-RIDES STATE LAW
Response: The point is well taken. The regulation was revised to reflect this terminology.

9.2.b. Consumer Rights:
Comment: Consumers should be advised to seek qualified legal advice in preparing an advance directive. Centers should not be asked to provide legal advice.
Response: This rule reflects the Behavioral Health Consumer Rights rule §64CSR74. The regulation should stand as written.

9.3.a. Consumer Rights:
Comment: INTERESTINGLY, THIS IS UNDER THE SUBSECTION "INFORMED CONSENT" RIGHTS, BUT DOES NOT REQUIRE A SIGN OFF ON AN INFORMED CONSENT, BUT INSTEAD A GENERAL CONSENT
Response: That is correct.

9.3.b. Consumer Rights:
Comment: BUT, NOW `INFORMED' POPS UP HERE
Response: That is correct.

9.3.b.4. Consumer Rights:
Comment: STATES THAT IF I WITHDRAW MY CONSENT, IT MUST BE DOCUMENTED ON THE ORIGINAL INFORMED CONSENT FORM I DREW UP. THAT MAY MAKE SENSE FOR FACILITY BASED SERVICES, BUT DOESN'T FOR RESIDENTIAL ONES, WHERE THE ACTUAL ORIGINAL CONSENT IS IN MEDICAL RECORDS, AND NOT AT THE SITE. DO ACTIONS (NO-SHOWS ETC.) = A FORM OF WITHDRAWAL OF CONSENT FOR TREATMENT? SHOULDN'T THERE BE LANGUAGE THAT SAYS "MUST BE WITHDRAWN VERBALLY OR IN WRITING AND THE WITHDRAWAL SHOULD BE DOCUMENTED IN THE RECORD." THAT SHOULD BE SUFFICIENT
Response: The regulation should stand as written.

9.3.b.5. Consumer Rights:
Comment: THIS ISN'T THE GENERAL CONSENT. ITS THE CONSENT FOR MEDICAL TREATMENT
Response: This is correct.

9.4.a.9. Participation in Plan Development:
Comment: The mention of the words treatment plan and individual support plan in this section does not allow the recognition that Medicaid considers some individuals to be 'low end' and not to have requirements for written plans. It was actually Health Facilities which originally wrote the policy and distributed it to providers.
Response: This rule reflects the Behavioral Health Consumer Rights rule §64CSR74. The regulation should stand as written.

9.5.b. Consumer Rights:
Comment: NOW COMES THE GRIEVANCE PROCEDURE. NOTE THAT IT WAS NOT REFERENCED IN THE `DISSATISFACTION' SECTION OF INTAKE, WHERE IT SHOULD BE AND WAS INSTEAD, REPLACED WITH `IF YOU ARE NOT HAPPY, YOU MAY CONTACT OHFLAC'. SEE PREVIOUS AND BELOW
Response: This tag does not reference OHFLAC at all. It is unclear what the commenter means. The regulation should stand as written.

9.8.b. Consumer Rights:
Comment: THIS IS CORRECT IN PART... 42 CFR PART 2 ONLY APPLIES TO SA. HIPAA APPLIES TO ALL. ARRA 2009 MODIFIED HIPAA AND NEEDS TO BE INCLUDED. IT SHOULD SAY "ALL CONSUMERS ... IN ACCORDANCE WITH WV STATE LAW (CITATION), HIPAA 1996 AND ARRA 2009. IN ADDITION, A SUBSTANCE ABUSE CONSUMER SHALL, IN ACCORDANCE WITH 42 CFR PART 2." THIS WOULD ACTUALLY BE CORRECT
Response: The regulation is clear as it stands. It should stand as written.

9.9.a. Consumer Rights:
Comment: IN THIS CASE, RELEASE/AUTHORIZATION/CONSENT IS NOW CALLED JUST CONSENT. PERHAPS SOME CONSISTENCY IS IN ORDER?
Response: This regulation applies to consents. The regulation should stand as written.

9.12. Consumer Rights:
Comment: This language in 9.12 does not conform to that regarding juveniles already enacted and found elsewhere in West Virginia Code.
Response: This rule reflects the Behavioral Health Consumer Rights rule §64CSR74. The regulation should stand as written.

9.13.a. Consumer Rights:
Comment: WHICH IS DIFFERENT THAN PREVIOUSLY WHERE WE MUST TELL THEM THAT THEY CAN COMPLAIN TO OHFLAC. SEE BELOW AND ABOVE. REQUIRES A CHANGE TO THE CONSENT FORM.
Response: The regulation should stand as written.

9.13.e. Consumer Rights:
Comment: DO YOU COMPLAIN TO OHFLAC IF NOT HAPPY OR TO THE SECRETARY?
Response: OHFLAC acts for the Secretary. The regulation should stand as written.

9.13.g. Consumer Rights:
Comment: OHFLAC, THE SECRETARY OR APPEAL TO OUR BOARD, OHFLAC, ADVOCATE OR ETC. THESE SECTIONS ARE ALL SIMILAR BUT SLIGHTLY DIFFERENT. ALL OF THESE SECTIONS NEED TO BE MERGED SO THERE IS NO CONFUSION. THE RULE SHOULD REALLY SAY "FOLLOW GRIEVANCE PROCEDURE; IF STILL NOT HAPPY, YOU CAN CONTACT ABOVE". AND THEY CAN SPECIFIY, IF THEY WANT, THAT WE WILL INCLUDE THE ADDRESS TO OHFLAC.
Response: Section 9, as noted earlier, is a reiteration of the 64CSR74. The regulation should stand as written.

10.11.b. Penalties:
Comments: Starlight does not feel that significant fees should be assessed for issues that are subjective and open widely to interpretation.
Response: None of the issues indicated under 10.11.b are subjective. All are empirically measureable. The regulation should stand as written.

Changes not based on Comments:

7.b.4. Change 'Section 10' to 'Section 9'

8.2.c.11. Delete the number 8.

9.3.b.7. Add (3) after "three months"

9.7.d. Change 'to' to 'of'

TITLE 64
LEGISLATIVE RULE
DIVISION OF HEALTH

SERIES 11
BEHAVIORAL HEALTH CENTERS LICENSURE

§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 -ehavioral Health Centers Licensure, §64CSR11, effective July 1, 2000.

1.6. Purpose. -- This rule is the basis for the licensing and approval of agencies, centers, and other entities providing behavioral health services for residents of West Virginia. Licenses are issued if the applicable rules are met. The purpose is to regulate the provision of behavioral health treatment for adults and children with behavioral, emotional, and/or developmental challenges caused by mental illness, developmental disabilities addiction/substance abuse and traumatic brain injuries through the formulation, application, and enforcement of minimum licensing requirements.

§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 disabilities, developmental disabilities or addiction, 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.

2.3. Applicability to Other Standards. When an individual receives care or treatment from a behavioral health center, state and federal requirements, accreditation standards applicable to the behavioral health center and the standards set forth in this rule apply. If there is a conflict between those requirements, accreditation standards and the standards specified in this rule, the more stringent standard applies, unless the federal standard must be met for the purposes of Medicare or Medicaid participation, then the federal standard prevails.

2.4. Exceptions.

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

2.4.a.1. Hospitals, Long Term Care Facilities, and Assisted Living Facilities regulated by the West Virginia Department of Health and Human Resources;

2.4.a.2. Entities other than hospitals operated by the state or federal government;

2.4.a.3. Specialized family care homes under the supervision of the West Virginia Department of Health and Human Resources;

2.4.a.4. Self-help groups;

2.4.a.5. Information and referral services;

2.4.a.6. A private practice as defined in this rule;

2.4.a.7. Non-supervised apartment living quarters occupied by consumers of a Center; and

2.4.a.8. Any person providing uncompensated services to a family member.

§64-11-3. Definitions.

3.1. Abuse.

3.1.a. Physical Abuse. -- Any act or failure to act by an employee or staff of a behavioral health service that was knowingly, recklessly, or intentionally performed, or that was failed to be performed, and that caused, or is likely to cause pain, psychological harm, injury, or death to a consumer, including, but not limited to:

3.1.a.1. The rape or sexual assault of the consumer;

3.1.a.2. The striking of a consumer with a part of the body or with an object;

3.1.a.3. Shoving, pushing, pulling, tugging, or twisting any part of the consumer's body with fingers or nails;

3.1.a.4. Burning or sticking the consumer with an object;

3.1.a.5. Acts of retaliation even in response to a physical attack;

3.1.a.6. The use of excessive force when placing an individual in bodily restraints;

3.1.a.7. The use of physical or chemical restraints that is not in compliance with federal or State law; or

3.1.a.8. The 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/Emotional Abuse. -- Humiliation, harassment, and threats of punishment or deprivation, sexual coercion or intimidation, whereby individuals suffer psychological harm or trauma.

3.1.c. Verbal Abuse. -- Any use of oral 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. Advance Psychiatric Directive. -- Any instruction written and signed by a consumer, describing preferences in health care written when the consumer is competent and psychiatrically stable and implemented when the consumer is not able to make informed decisions in the absence of an advance psychiatric directive.

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

3.4. 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.

3.5. Approved Medication Assistive Personnel. -- The unlicensed facility employee or staff, who meets eligibility requirements, has successfully completed the required training and competency testing, and is considered competent by the facility's registered nurse to administer medications to consumers of the facility in accordance with W. Va. Code §16-50-1.

3.6. 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.

3.7. Behavioral Health. -- Mental health, developmental disabilities, or substance abuse.

3.8. Behavioral Health Services. -- Inpatient, residential or outpatient services for the care, training, and treatment of individuals with mental illness, developmental disabilities or substance abuse.

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

3.10. Center. -- An entity or organization that provides behavioral health services.

3.11. 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 law.

3.12. Consumer. -- An individual receiving treatment or services in or from the Center.

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

3.14. 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.

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

3.15.a. Abuse;

3.15.b. Neglect;

3.15.c. Death due to any cause;

3.15.d. Attempted suicide;

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

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

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

3.15.h. An injury that requires hospitalization or results in permanent physical damage;

3.15.i. A life-threatening reaction because of a drug or food;

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

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

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

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

3.17. Discharge. -- The termination of a consumer's affiliation with the Center.

3.18. 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 if possible.

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

3.20. Employee – Any person who performs personal services for the Center in exchange for monetary compensation where monetary compensation is effected thorough the Center's payroll system, the personal service, including the results to be accomplished as well as the details and the means by which the results are accomplished, are controlled and directed by the Center in accordance with the provisions of this rule.

3.21. 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.

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

behavior.

3.23. 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.

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

3.25. Human Rights Committee. -- A committee 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.

3.26. Independent Health Contractor - A licensed, certified, and/or registered health care provider, or parents who provide services under the Title XIX Mental Retardation/Developmental Disability Program, who performs personal services for the Center in exchange for monetary compensation, where the Center has the right to specify the result to be accomplished by the work, but not the means and methods by which the result is accomplished.

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

3.28. Informed Consent. -- The written verification:

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

3.28.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

3.28.c. That a consumer or his or her legal representative ~~agrees~~ consents to the treatment.

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

3.30. Legal Representative. -- 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:

3.30.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;

3.30.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;

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

3.30.d. 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;

3.30.e. A surrogate decision-maker appointed pursuant to the West Virginia Health Care Decisions Act, W. Va. Code §16-30-8 et seq., or the West Virginia Do Not Resuscitate Act, §16-30C-1 et seq., within the limits set by the appointment;

3.30.f. 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;

3.30.g. 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;

3.30.h. A parent or guardian of a minor; or

3.30.i. 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.

3.31. Mechanical Supports. -- Devices used to support or align an individual's proper body position.

3.32. Medication Error. --

3.32.a. The failure to administer a drug ordered by a physician; or

3.32.b. The administration of a drug:

3.32.b.1. Without a physician's order;

3.32.b.2. In the wrong dosage;

3.32.b.3. In the incorrect form;

3.32.b.4. By the incorrect method; or

3.32.b.5. That is incorrect itself.

3.33. Neglect. -- The failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable consumer including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Neglect may be repeated conduct or a single incident. Neglect includes, but is not limited to:

3.33.a. The failure to establish or carry out a consumer's Individual Support Plan or treatment plan that placed or may have placed a consumer at risk of injury or death;

3.33.b. A failure to provide adequate nutrition, clothing, or health care;

3.33.c. A failure to provide a safe environment; or

3.33.d. A failure to follow written Center policies and procedures which jeopardizes consumer health or safety.

3.34. 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.

3.35. Policy. -- A statement of the principles that guide and govern the

activities, procedures and operations of a program.

3.36. 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.

3.37. Private Practice. -- The individual or group who practice a healing art or behavioral health profession and who holds a license issued by a state health regulatory board as a prerequisite for the practice.

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

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

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

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

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

3.43. 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.

3.44. Residential Facility. -- A structure in which is provided an interdisciplinary, therapeutic treatment program on a twenty-four (24) hour-a-day basis for behavioral health consumers

3.45. Restraint. -- A system or device to control a consumer, physically and/or behaviorally.

3.45.a. Chemical Restraint. -- The use of medication as a behavior control mechanism to substitute for seclusion or other restraint.

3.45.b. Physical Restraint. -- Any manual method or physical or mechanical device that the individual cannot remove easily, and that restricts the free movement of, normal functioning of, or normal access to a portion or portions of a consumer's body. Examples of manual methods include therapeutic or basket holds and prone or supine containment. Examples of mechanical devices include arm lap belts, side rails, splints, posey mittens, helmets, and straight jackets. Physical guidance and prompting techniques of brief duration and mechanical supports are not considered physical restraint.

3.46. Seclusion. -- The placement of a consumer alone in a room or enclosed space with closed doors that a consumer cannot open from inside. Persons with a mental retardation or development disability diagnosis may not be secluded.

3.47. Secretary. -- The Secretary of the West Virginia Department of Health and Human Resources or his or her designee.

3.48. Self-Administration of Medications. -- The act of a consumer who is independently capable of reading and understanding the labels of drugs ordered by

a physician in opening and accessing prepackaged drug containers, accurately identifying and taking the correct dosage of the drugs as ordered by the physician, at the correct time and under the correct circumstances.

3.49. Self-Help Group. -- A group with the following components:

3.49.a. All members who receive help also contribute help;

3.49.b. The group is member-owned and operated; and

3.49.c. The members are peers with the same problem or experience.

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

3.51. Staff. -- Any person or persons who perform personal services for the Center in exchange for monetary compensation where the personal services, including the results to be accomplished as well as the details and the means by which the results are accomplished, are controlled and directed by the Center, regardless of whether monetary compensation is accomplished through the Center's payroll system or the Center's accounts payable system.

3.52. Substance Abuse. -- A pattern of psychoactive substance misuse indicated by at least one of the following:

3.52.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

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

3.53. 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.

3.54. 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:

3.54.a. Placing a consumer in a quiet corner of the room; or

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

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

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

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

3.58. Volunteer. -- A person who provides direct services for no direct

financial remuneration, and who meets the Center's employment qualifications for health, safety, and training.

3.59. 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. The Center is responsible for compliance with this rule and other relevant federal and state laws.

4.1.b. The Center shall submit data to the Secretary as requested.

4.1.c. All licensed Centers shall have a business certificate or license from the Secretary of State.

4.1.d. 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.e. If the Secretary determines not to issue a license as applied for, the Secretary shall notify the applicant.

4.1.f. A license is valid for the Center named in the application and is not transferable.

4.1.g. The Center shall surrender an expired or otherwise invalid license to the Secretary upon written demand.

4.2. License Application.

4.2.a. The governing body shall ensure adequate resources to support the Center's services. If a new Center or an expansion of an existing Center is planned, the governing body must demonstrate sufficient operating funds for at least six (6) months. The demonstration may include reserves, a line of credit, or a history of adequate cash flow from an existing program to support a new program for six months.

4.2.b. An application shall identify all service locations and offices operated by the Center.

4.2.c. 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, along with a non refundable fee, and any additional information the Secretary may require.

4.2.d. Renewal applications shall be received by the Secretary not less than ninety (90) days prior to the expiration of the current license, along with a non refundable fee, and any additional information the Secretary may require.

4.2.e. Amended license applications are required by the Secretary under the following circumstances:

4.2.e.1. A change in the geographic location of a service or facility;

4.2.e.2. A change in bed capacity; or

4.2.e.3. Any extensive renovation or conversion of an existing facility costing in excess of $5000.

4.2.f. If the Center does not amend its license pursuant to this rule, the Center will be assessed a $500 penalty.

4.2.g. An application for an initial or renewal license shall identify the governing body, and administrator of the Center by name and home address.

4.2.h. An application shall be accompanied by the following:

4.2.h.1. Insurance coverage to include general, professional and vehicular liability and property damage;

4.2.h.2. Evidence that the Center will be audited at least annually by an independent certified public accountant;

4.2.h.3. The annual budget approved by the governing body; and

4.2.h.4. Any policies or procedures created or amended since the last survey.

4.2.i. After the Secretary receives a complete application with the required fee for a renewal license, according to Subdivision 4.4.b. of this rule, the existing license shall not expire until the Secretary issues or denies the new license.

4.3. Fees.

4.3.a. The license fee for an initial or amended behavioral health license is $100 and is nonrefundable.

4.3.b. The applicant is responsible for all direct costs of the initial licensure inspection and shall be received by the Secretary prior to the issuance of an initial license.

4.3.c. The license fee for the renewal of a behavioral health license is $250 plus $25 per licensed bed, if any.

4.3.d. The Secretary may annually adjust the licensure fees for inflation based upon the consumer price index.

4.4. Issuance.

4.4.a. An inspection is required before an initial, renewal or provisional license is issued.

4.4.b. Following an application review, and onsite inspections and plans of correction, the Secretary shall, if there is substantial compliance with this rule, issue a license in one of three categories:

4.4.b.1. An initial six (6) month license to a Center establishing a new program or service which is found to be in substantial compliance upon initial inspection with regard to policy, procedure, organization, and recordkeeping;

4.4.b.2. A provisional license, when a Center seeks a renewal license and the 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 expires not more than six (6) months from the date of issuance, and may not be consecutively reissued, unless based on the provisional recommendation of the state fire marshal; or

4.4.b.3. A renewal license, when a Center is in substantial compliance with this rule. A renewal license shall not expire more than two (2) years from the date of issuance. A renewal license can be issued for any duration up to two (2) years at the discretion of the Secretary.

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

4.4.d. The Center shall notify the Secretary within thirty (30) days after the name of the Center is changed and apply for license renewal.

4.5. Construction and Renovation.

4.5.a. For new construction, renovations, and alterations, a Center shall submit to the secretary for review, complete construction drawings and specifications for the Center's construction project which alters a floor plan, impacts life safety, or requires approval under W. Va. Code §16-2D-1 et seq. prior to beginning work on the project. An architect or engineer registered to practice in West Virginia shall prepare and sign the drawings and specifications including architectural, life safety, structural, mechanical, and electrical drawings and specifications.

4.5.b. Prior to starting any renovations, a Center shall complete an infection control and safety risk assessment and shall develop a plan to control exposure of consumers, employees, staff, and the public. This plan shall be implemented prior to and during construction phases.

4.5.c. Site Selection.

4.5.c.1. There shall be adequate drainage, electricity, telephone, sanitation, water, transportation, and other necessary facilities available on or near the site.

4.5.c.2. Local building codes and zoning restrictions shall be observed. Where local codes or regulations permit lower standards than required by this rule, the standards contained in this rule take precedence.

4.5.c.3. Site conditions shall comply with the relevant sections of the "Guidelines for Design and Construction of Hospital and Healthcare Facilities" as recognized by the American Institute of Architects Academy of Architecture for Health.

4.5.c.4. Before beginning construction, a Center shall request in writing an inspection of a proposed site and obtain approval for construction from the Secretary.

4.5.c.5. The Secretary shall inspect new locations for all residential facilities and additions to existing residential facilities prior to the architect's beginning work on final drawings and specifications.

4.6. Inspections.

4.6.a. To carry out the intent of this rule, the Secretary shall require inspections by authorized representatives.

4.6.b. All inspections except for the initial license inspection shall be unannounced.

4.6.c. Inspections shall include, but are not limited to:

4.6.c.1. Observation of the service delivery milieu;

4.6.c.2. Review of life safety and environment;

4.6.c.3. Review of clinical and administrative records; and

4.6.c.4. Interviews with consumers, employees, staff and/or administrators.

4.6.d. At least once every two (2) years, each licensed Center shall be

inspected, except for residential facilities which shall be inspected yearly.

4.6.e. At a minimum, a Center shall be inspected ninety (90) days prior to the expiration of its license.

4.6.f. If a licensed Center is accredited by an accreditation body, it shall supply copies of all relevant accreditation reports to the licensing body within ten (10) days of receipt.

4.6.g. Inspections shall include every licensed location operated by the Center~~, if feasible~~.

4.6.h. The Center shall comply with any reasonable requests from the Secretary to have access to the Center, staff, employees, consumers (with their permission), and records.

4.6.i. Within fifteen (15) working days of completion of an inspection, the Secretary shall issue a report.

4.6.j. Based on a Center's previous substantial compliance with this rule, an onsite inspection is not always required for issuance of an amended license.

4.6.k. The Center may contest any deficiency issued by the Secretary or oversight body. This disagreement must be supported by documentation or other credible evidence. If necessary, an informal meeting may be held for the purposes of a dispute resolution. If the Center desires a meeting, appeals must be filed in writing with supporting documentation.

4.7. Complaint Investigation.

4.7.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.

4.7.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.

4.7.c. At the time of the investigation, the investigator shall notify the administrator or person in charge of the location involved in the complaint and the general reason for the complaint, without identifying the complainant.

4.7.d. Within fifteen (15) 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.

4.7.e. The Secretary shall provide to the complainant a determination of whether the complaint was substantiated. The Secretary may provide to the complainant a description of the corrective action the Center is required to take and of any disciplinary action the Secretary will take.

4.7.f. Written consent is required prior to disclosure of a complainant's name and of any consumer involved in the complaint or investigation. Any information that could reasonably lead to their identification shall be kept confidential and shall not be disclosed without their written consent. Before disclosure of investigative information to the public, the identifying information shall be deleted, unless the public interest requires disclosure in the particular instance.

4.7.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.

4.7.h. Centers shall not discriminate in any way against a consumer, staff, or employee who has been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process.

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

4.8. Reports and Records.

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

4.8.b. A report shall specify the deficiency and the provision of the rule it violates, and describe the precise data that supports the deficiency.

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

4.8.c.1. As specified in Subsection 4.7. of this rule;

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

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

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

4.9. Plans of Correction.

4.9.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, unless a variance is requested by the Center and granted by the Secretary. The plan shall specify:

4.9.a.1. Any action taken or procedures proposed to correct the deficiencies and prevent their reoccurrence;

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

4.9.a.3. The signature of the administrator or his or her designee.

4.9.b. The Secretary shall approve, modify or reject the proposed plan of correction in writing. In conjunction with the Secretary, modifications may be made by the Center.

4.9.c. The Secretary shall state the reasons for rejection or modification of any plan of correction.

4.9.d. Upon receipt of the rejection, the Center shall submit a revised plan of correction to the Secretary within ten (10) working days. The Secretary may issue a directed plan of correction if the revised plan submitted by the Center is not approved.

4.9.e. The Center shall immediately correct a violation that severely risks the health or safety of a consumer or other persons.

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

4.9.g. The Center shall make the

results of the Office of Health Facility Licensure and Certification's surveys, inspections, and investigations as well as plans of correction available for examination in a place readily accessible to consumers and shall post a notice of their availability.

4.10. Waivers.

4.10.a. The Secretary may grant a waiver or variance to a provision of this rule if its application clearly would be impractical and if any alternate arrangements are not detrimental to the health, well-being, or safety of the affected consumer.

4.10.b. All waivers shall be in writing.

4.10.c. No waiver shall be granted for an issue involving the health or safety of consumers or that violates any state or federal statute.

4.10.d. A waiver shall be granted with each licensure renewal.

§64-11-5. Management and Administration.

5.1. Operating Authority.

5.1.a. The Center shall have documentation of the source of its operating authority, e.g., certificate of incorporation and partnership agreement, prominently displayed.

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

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 shall evaluate and ensure implementation of its policies.

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

5.2.d. At least annually, the governing body shall evaluate the administrator's performance in writing.

5.2.e. The governing body members shall:

5.2.e.1. Receive an orientation to the governing body, to the responsibilities of membership, and to the Center's organization, mission, and history;

5.2.e.2. Receive a current manual that specifies the member's fiduciary and other responsibilities to the organization;

5.2.e.3. Be instructed as to federal and state rules of confidentiality;

5.2.e.4. Receive annual reports from management;

5.2.e.5. Maintain minutes and records generated from all meetings, if the governing body is more than one person;

5.2.e.6. Hold quarterly meetings at a minimum;

5.2.e.7. Maintain comprehensive policies and procedures that include governing body-approved policy statements each of which shall include effective dates and the most recent dates of revision;

5.2.e.8. Ensure that the comprehensive policies and procedures shall be available to all staff in all programs; and

5.2.e.9. Ensure that the Center complies with all laws related to fiscal accountability and governance.

5.3. Administration.

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

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

5.4. Conflicts of Interest.

5.4.a The Center shall have a policy which defines and prohibits conflicts of interest.

5.5. Fiscal Protections.

5.5.a. The Center shall purchase insurance including, but not limited to: general liability, workers' compensation, professional liability, automotive liability for Center-owned or leased vehicles, and malpractice.

5.5.b. The Center shall ensure that all employees who sign checks, handle cash or contributions, or manage consumer funds, are bonded or that the Center maintains insurance coverage to cover potential losses at no cost to the consumer.

5.5.c. A Center that provides transportation for consumers served as part of a service shall maintain adequate vehicular insurance coverage.

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

5.6. Consumer Funds.

5.6.a. The governing body shall establish policies and operational procedures that comply with legally applicable requirements regarding the protection of consumer's assets under the control of the Center.

5.6.b. 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 for each consumer's funds. The Center shall provide to a consumer at least monthly and upon request, a statement of his or her account.

5.6.c. All money earned by a consumer shall be used for the sole benefit of that consumer.

5.6.d. Centers shall allow a consumer or his or her legal representative to use his or her personal funds.

5.6.e. Centers shall not commingle a consumer's funds with the Center's funds or with the funds of any person other than another consumer.

5.6.f. If a Center handles consumer funds in excess of $25 per consumer and in excess of $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 $2500. When the amount of any bond is insufficient to adequately protect the funds of consumers, the Center shall obtain an additional bond in an amount necessary to adequately protect the funds of consumers.

5.7. Center Responsibility.

5.7.a. Centers shall clearly define 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.

5.7.b. Centers shall develop and implement a code of ethics that includes, but is not limited to those provisions covered in Section 9 of this rule.

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

5.7.d. The Center may release consumer information only according to its written policies and legal requirements.

5.7.e. Centers shall not discriminate in any matter of employment on the basis of race, color, national origin, ancestry, religion, disability or gender, or any other category protected by applicable law.

5.7.f. If the Center uses volunteers, it shall implement written policies and procedures for the use of volunteers.

5.7.g. The Center shall ensure that all allegations of neglect or abuse, as well as injuries of unknown sources, are reported immediately to the administrator or to other officials in accordance with state law.

5.7.h. Except as permitted 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:

5.7.h.1. The specific information to be released;

5.7.h.2. The time-period in which the consent is in effect;

5.7.h.3. The recipients;

5.7.h.4. The purpose of the release;

5.7.h.5. The date on which the release is signed;

5.7.h.6. The event or condition upon which the authorization expires; and

5.7.h.7. Information as to how and when the authorization can be revoked.

5.7.i. The Center shall protect the confidentiality of a consumer by prohibiting:

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

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

5.7.j. 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.

5.7.k. 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 of these policies available to all new employees.

5.7.l. The Center shall implement a policy pertaining to communicable diseases affecting consumers, employees, and staff.

5.8. Relationships with Other Providers.

5.8.a. If the Center arranges externally or contractually for the provision of services, the Center shall have a written agreement or contract, which specifies:

5.8.a.1. The roles and responsibilities of the Center and the external entity;

5.8.a.2. The documentation required of the external entity, with timelines for provision of the documentation;

5.8.a.3. Services to be provided and timelines for the service delivery;

5.8.a.4. The provision of liability or malpractice insurance either by the Center or the external entity;

5.8.a.5. Procedures for the exchange of information;

5.8.a.6. The consumers to be served;

5.8.a.7. The terms of payment; and

5.8.a.8. Assurances that the external entity adheres to state and federal requirements governing the provision of the contracted services.

5.8.b. The Center shall maintain a record on each Independent Health Contractor who provides direct services to Center consumers, including:

5.8.b.1. A job description for the services provided;

5.8.b.2. Identifying information and emergency contacts;

5.8.b.3. Verification of the contractor's education;

5.8.b.4. Verification that the independent health contractor meets all criteria for the position as stated in the job description;

5.8.b.5. Records of orientation and current training as required for full time independent contractors or the documented lack of need for the training;

5.8.b.6. Performance evaluations;

5.8.b.7. References;

5.8.b.8. Criminal background checks;

5.8.b.9. Verification of a nurse aide abuse registry and national sex abuse registry check, if applicable; and

5.8.b.10. An Adult Protective

Services and Child Protective Services background check.

5.8.c. Multiple Service Providers.

5.8.c.1. If a Center serves consumers who are also served by another Center or Centers, there shall be a written agreement or memorandum of understanding between the Centers delineating the responsibilities and functions of each.

5.8.c.2. The agreement or memorandum of understanding shall be signed by representatives of both Centers.

5.8.c.3. A Center shall not refuse to provide services to a consumer on the basis that the consumer is being served by another agency.

5.9. Personnel.

5.9.a. The Center shall have policies that address unemployment and workers' compensation.

5.9.b. 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 provision of quality care.

5.9.c. Criminal background checks covering all fifty (50) states shall be completed for all staff, employees, and independent health contractors, within thirty (30) days of hiring. Organizational policy shall prohibit employment of staff, employees, or independent health contractors who have a history of conviction for:

5.9.c.1. Abduction;

5.9.c.2. Any violent felony crime including, but not limited to, rape, sexual assault, homicide, felonious physical assault, or felonious battery;

5.9.c.3. Child or adult abuse or neglect;

5.9.c.4. Crimes which involve the exploitation of a child or an incapacitated adult;

5.9.c.5. Domestic battery or domestic assault;

5.9.c.6. Felony arson;

5.9.c.7. Felony or misdemeanor crime against a child or incapacitated adult which causes harm;

5.9.c.8. Felony drug related offenses within the last the ten (10) years;

5.9.c.9. Felony DUI within the last the ten (10) years;

5.9.c.10. Hate crimes;

5.9.c.11. Kidnapping;

5.9.c.12. Murder/Homicide;

5.9.c.13. Neglect or abuse by a caregiver;

5.9.c.14. Pornography crimes involving children or incapacitated adults;

5.9.c.15. The purchase or sale of a child; and

5.9.c.16. Sexual offenses including, but not limited to, incest, sexual abuse, or indecent exposure.

5.9.d. The Center shall have evidence that staff and employees directly serving consumers are not listed on the National Sex ~~Abuse~~ Offender Registry and the Nurse Aide Abuse Registry for West Virginia and the state in which the staff or employee resides, if available.

5.9.e. For all employees, the Center shall maintain a personnel record that includes:

5.9.e.1. The job description and application;

5.9.e.2. Identifying information and emergency contacts;

5.9.e.3. References;

5.9.e.4. Verification of education for employees;

5.9.e.5. Verification that the employee meets all criteria for his or her position as stated in the job description;

5.9.e.6. Orientation and training records; and

5.9.e.7. The employee's performance evaluations.

5.9.f. The Center shall provide to an employee, or to his or her designee, access to his or her personnel record.

5.10. Personnel Training.

5.10.a. Beginning on the first day of employment, professional and direct care employees shall begin orientation and training on treatment policies and procedures, consumer rights and the use of emergency procedures, such as crisis intervention and restraints. Training shall be kept current.

5.10.b. As part of employee orientation, all direct care employees and staff shall be trained in first aid, infectious disease control, cardiopulmonary resuscitation and ~~the Heimlich maneuver~~ abdominal thrusts. This training shall be kept current.

5.10.c. Employees and staff 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 available until newly hired staff are fully trained.

5.10.d. Staff and employees 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.

5.10.e. All professional employees, professional independent health contractors, and consultants of the Center shall be in compliance with applicable State professional licensure requirements.

5.10.f. Specialized Personnel Requirements.

5.10.f.1. Employees and staff providing direct care to consumers shall be eighteen (18) years of age or older and capable of performing the duties assigned.

5.10.f.2. Employees who are hired as mental health or substance abuse professionals shall be either fully credentialed to practice mental health or substance abuse treatment or actively working on becoming fully credentialed to

practice mental health or substance abuse treatment.

5.10.f.3. Staff and employees who are hired to provide mentally retarded/developmentally disabled waiver services shall be fully credentialed in compliance with state mentally retarded/developmentally disabled waiver standards.

5.10.f.4. Approved medication assistive personnel shall meet all the criteria specified in the Division of Health rule, "Medication Administration by Unlicensed Personnel," §64CSR60.

5.11. Records Management.

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

5.11.b. Consumer records shall contain information essential to the services or treatment and include, but not be limited to:

5.11.b.1. Identification data;

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

5.11.b.3. A summary of the assessments ~~process~~;

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

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

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

5.11.b.7. Legal representative documents;

5.11.b.8. Court orders; and

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

5.11.c. Consumer records shall be retained for a minimum of ~~six (6)~~ seven (7) years following discharge. In the case of minors, records shall be retained until ~~six (6)~~ seven (7) years after the consumer's eighteenth birthday.

5.11.d. The Center shall release consumer records without written consent as follows:

5.11.d.1. In a proceeding to disclose the results of an involuntary civil commitment;

5.11.d.2. In a proceeding to disclose the results of an involuntary examination;

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

5.11.d.4. To protect against a clear and substantial danger of imminent injury by a consumer to himself or herself or to another person;

5.11.d.5. For treatment or internal review purposes, to employees of the Center where the consumer is being cared for or to other health professionals involved in treatment of the consumer;

5.11.d.6. To the medical examiner's office and child and adult protective services during an open investigation;

5.11.d.7. As provided under the Privacy Rule of the Federal Health Insurance Portability and Accountability Act of 1996, 45 CFR §164.506 for thirty (30) days from the date of admission to a mental health facility if: (i) the Center makes a good faith effort to obtain consent from the consumer or legal representative prior to disclosure; (ii) the minimum information necessary is released for a specifically stated purpose; and (iii) prompt notice of the disclosure, the recipient of the information, and the purpose of the disclosure is given to the consumer or his or her legal representative; and

5.11.d.8. To the state's federally mandated protection and advocacy system, pursuant to access authority provided under the PAIMI (Protection and Advocacy for Individuals with Mental Illness) Act at 42 USCA 10805-10806 and the PADD (Protection and Advocacy for Individuals with Developmental Disabilities) Act at 42 USC 10542.

5.11.e. 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.

5.11.f. No consent or authorization for the transmission or disclosure of confidential information is effective unless it is in writing and signed by the consumer or by his or her legal representative.

5.11.g. Every person signing ~~an~~ a consent/release and/or authorization shall be given a copy.

5.11.h. The Secretary shall have full access to a consumer's records as needed in administering state and federal requirements.

5.11.i. The Center shall ensure the reasonable safety and protection of records, including service and organizational records, from destruction by fire, water, loss, or other damage, and from unauthorized access.

5.12. Quality Assurance.

5.12.a. The Center shall have and implement a systems review of the appropriateness and effectiveness of consumer services, which includes peer review, documentation review, health and safety review of all facilities, and a review of the outcomes, including an analysis of the results, the critical incident tracking system and of reports by the human rights committee.

5.12.b. The Center shall maintain a system for critical incident reporting and tracking and demonstrate that it uses the system to protect the rights, health, and safety of consumers.

5.12.b.1. The Center shall classify each incident as:

5.12. b.1.A. An allegation of abuse and/or neglect;

5.12.b.1.B. A critical incident; or

5.12.b.1.C. An incident requiring monitoring and follow-up.

5.12.b.2 The Center shall investigate all critical incidents and allegations of abuse or neglect. When

multiple Centers or agencies are involved in an investigation, the investigation may be cooperative. A cooperative investigation does not negate the timelines for an investigation.

5.12.c. Abuse or neglect allegations shall be reported immediately to the following entities:

5.12.c.1. Adult Protective Services, Institutional Investigative Unit, or Child Protective Services, as applicable;

5.12.c.2. The Office of Health Facility Licensure and Certification;

5.12.e.3. The guardian or health care surrogate, if any;

5.12.c.4. Any advocate identified in the consumer record and/or the State's federally mandated protection and advocacy system; and

5.12.c.5. The administrator or his or her designee.

5.12.d. The Center shall have and implement investigative policies and procedures that comply with the Office of Health Facility Licensure and Certification Guidelines for Incidents.

5.12.e If the findings and actions of a Center following an investigation are unfavorable, insufficient, or not forthcoming, the affected consumer or his or her legal representative may appeal to the grievance process of the Center, the State licensure body, an advocate, or other appropriate resource, including an attorney. Consumers are to be informed of the appeal process in writing.

5.12.f. The final order by the Secretary after a hearing before the State licensure body is binding upon the parties, unless appealed in accordance with W. Va. Code §29A-6-1.

5.12.g. The Center shall maintain a human rights committee to:

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

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

5.12.g.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;

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

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

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

5.12.g.7. 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.

5.12.g.8. At least one-third of the committee members shall be consumers or consumer legal representatives and no more than one-third shall be employees of the Center.

5.12.g.9. Ensure that the members have training in confidentiality in order to review consumer records.

§64-11-6. Health and Safety.

6.1. Transportation Services.

6.1.a. When transportation is provided for consumers, the Center shall maintain adequate insurance coverage.

6.1.b. Employees and staff transporting consumers in their own vehicles as a part of their duties shall provide the Center with evidence that they are insured in case of an automobile accident.

6.1.c. The Center shall have and follow written policies and procedures for:

6.1.c.1. The proper maintenance of vehicles;

6.1.c.2. Adequate passenger supervision;

6.1.c.3. Appropriate passenger restraining systems;

6.1.c.4. The licensure of drivers; and

6.1.c.5. Provision of first-aid kits in each vehicle.

6.2. Physical Environment.

6.2.a. General.

6.2.a.1. The provisions of this section apply to all behavioral health facilities. A behavioral health site licensed prior to the effective date of this rule shall be maintained in accordance with applicable standard of practice as referenced in the "Guidelines for Design and Construction of Hospital and Healthcare Facilities" as recognized by the American Institute of Architects Academy for Health.

6.2.a.2. The Center shall implement programs in an environment that is safe, accessible, sanitary, and appropriate for the needs of the consumers.

6.2.a.3. The documents in this paragraph are adopted as construction, equipment, physical facility, and related procedural standards for all new construction and any additions, alterations, renovations, or conversions of existing buildings.

6.2.a.3.A. The Center shall meet regulatory requirements for Psychiatric Facilities in the "Guidelines for Design and Construction of Hospital and Healthcare Facilities" as recognized by the American Institute of Architects Academy for Health, where applicable.

6.2.a.3.B. The Center shall comply with the West Virginia Building Code as the 2003 edition of the International Building Code.

6.2.a.3.C. The Center shall comply with the guidelines set forth in the Americans with Disabilities Act (§28 CFR Part 36) 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 modifications that are readily achievable within the resources of the Center.

6.2.a.3.D. All Centers shall comply with the Fire Commission rule, "Fire Code," §87CSR1.

6.2.a.4. The Center shall provide adequate housekeeping, laundry, maintenance, storage, and other administrative support functions required to carry out its services.

6.2.a.5. The Center shall have procedures for infection control and emergency preparedness to identify, monitor, reduce and eliminate health and safety risks.

6.2.a.6. The Center shall evaluate the likelihood of exposure to blood borne pathogens for all persons likely to come in contact with blood.

6.2.a.7. The Center shall have written procedures to deal with fire, medical emergencies, natural disasters and other life-threatening situations.

6.2.a.8. 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 employees, and capable consumers shall be instructed on how to use them.

6.2.a.9. A standard first-aid kit shall be readily accessible at all times at each location.

6.2.b. Fire Code.

6.2.b.1. The Center shall have evidence that facilities rented, owned or used for services are in full compliance with applicable rules of the West Virginia State Fire Commission.

6.2.b.2. 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.

6.2.b.3. The Center shall have fire extinguishers reviewed by a qualified professional annually.

§64-11-7. Consumer Services Standards - General.

7.1. Applicability.

7.1.a. General Consumer Services Standards apply to all licensed Centers.

7.2. Program Description.

7.2.a. Each program shall have a written description that shall include:

7.2.a.1. A description of the population to be served;

7.2.a.2. A description of the types of services offered; and

7.2.a.3. Exclusion criteria.

7.2.b. The Center shall admit only those consumers whose service needs are consistent with its service description, to whom services are available, and for which staffing levels and types meet the needs of the consumers to be served.

7.2.c. The Center shall assure that all services provided shall be based on each

consumer's identified needs.

7.3. Consumer Screening.

7.3.a. The Center shall maintain written documentation of each screening performed, including:

7.3.a.1. The date of initial contact;

7.3.a.2. The name, age, and gender of the individual;

7.3.a.3. The individual's address and phone number, if applicable;

7.3.a.4. Presenting needs or situation;

7.3.a.5. The name of the screening employee or independent health contractor;

7.3.a.6. The method of screening;

7.3.a.7. The screening recommendation; and

7.3.a.8. Disposition of individual referral.

7.3.b. If the individual is admitted, the screening documentation shall be included in the consumer's record. For individuals not admitted, the screening documentation shall be retained for one hundred eighty days.

7.4. Consumer Admission.

7.4.a. A consumer or his or her legal representative shall sign a written consent for the Center's services prior to treatment.

7.4.b. Upon admission, the consumer or his or her legal representative shall sign verification that he or she was informed in writing of his or her rights as contained in Section ~~10~~ 9 of this rule.

7.4.c. Upon admission, the consumer or his or her legal representative shall sign verification that he or she was informed in writing that he or she may contact the Office of Health Facility Licensure and Certification if the consumer or his or her legal representative is unsatisfied with any aspect of the consumer's treatment. This information shall include the address, phone number, and fax number for the contact.

7.4.d. The Center shall have a formal intake process that assesses a consumer using its criteria for admission and only admits a consumer who meets those criteria.

7.4.e. Intake documentation shall include all relevant preliminary screening and diagnostic, social, medical and legal information, and shall be signed and dated by the person completing the intake.

7.5. Consumer Discharge.

7.5.a. Discharge planning shall be based on consumer needs.

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

7.5.b.1. The reasons for discharge;

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

7.5.b.3. A final evaluation

summary of the consumer's progress toward the consumer's needs and the goals set in the treatment plan, if a treatment plan is required;

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. Medical Information.

7.6.a. Health History.

7. 6.a.1. The health history shall be completed as a part of the screening process.

7. 6.a.2. The medical information shall include:

7. 6.a.2.A. The current name, address, and phone number of the consumer's primary care physician, and any recently seen specialists;

7. 6.a.2.B. The current name, address, and phone number of any relative, legally authorized representative, or other person to be notified in case of an emergency;

7. 6.a.2.C. Current Medical insurance information, if any;

7.6.a.2.D. Currently prescribed medications and over the counter medications used by the consumer and the diagnostic rationale for their use;

7 6.a.2.E. Medication and food allergies and reactions;

7.6.a.2.F. Any history of substance abuse;

7. 6.a.2.G. Any significant medical problems;

7.6.a.2.H. Any significant communication problems and any communicative devices used; ~~and~~

7.6.a.2.I. Advance directives, if any; and

7.6.a.2.J. Self medication status.

7.6.b. Current emergency medical information shall be readily available to employees or contractors wherever services are provided.

7.7. Medical and Psychiatric Emergency Management.

7.7.a. The Center shall have policies and procedures for handling medical and psychiatric emergencies that ensure:

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

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

§64-11-8. Consumer Services Standards - Specific.

8.1. Applicability.

8.1.a. Specific Consumer Services Standards apply to a licensed Center only if the specific service is provided by the Center.

8.2. Assessment and Planning for Multiple Extensive Services.

8.2.a. The Center shall document and implement an assessment policy. The policy shall define how assessments will be documented.

8.2.b. An ~~preliminary~~ initial assessment shall be done at the time of admission.

8.2.c. The Center shall conduct a final assessment to identify an individual's strengths, preferences and needs, in these areas, as applicable: physical, medical, behavioral, functional, and social abilities. The finalized assessment shall address:

8.2.c.1. The onset and duration of problems;

8.2.c.2. Social, behavioral, developmental and family history;

8.2.c.3. Employment, vocation and educational background;

8.2.c.4. Previous interventions and outcomes;

8.2.c.5. Financial resources and benefits;

8.2.c.6. A health history and current medical care needs;

8.2.c.7. Legal status, including guardianship, commitment and representative payee status, and relevant criminal charges or convictions, probation or parole status;

8.2.c.8. Daily living skills;

8.2.c.9. Social and family supports;

8.2.c.10. Housing arrangements; and

8.2.c.11. Ability to access services.

~~8.~~

8.2.d. Frequency of assessments.

8.2.d.1. The preliminary assessment shall be updated and finalized during the first thirty (30) days of service and prior to completing the individualized support plan.

8.2.d.2. Longer term assessments may be included as part of the individualized services plan. The Center shall document the reason for assessments requiring more than thirty (30) days.

8.2.d.3. Reassessments shall be completed when there is a need based on the medical, psychiatric or behavioral status of the individual.

8.2.e. The Center shall make and document reasonable attempts to obtain previous assessments.

8.2.f. Assessment documentation.

8.2.f.1. Initial assessments shall be entered in a consumer's record within five working days of the intake interview.

8.2.f.2. Diagnoses shall be:

8.2.f.2.A. 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

8.2.f.2.B. Based upon accepted professional standards of examinations and factual description of a consumer's symptoms and problems.

8.2.f. 3. When additional evaluations and assessments are completed, recommendations for treatment and training shall be entered in a consumer's record.

8.2.g. Individual Support Plan.

8.2.g.1. The Center shall develop a preliminary individual support plan for the first thirty (30) days.

8.2.g.2. A preliminary individual support plan shall be developed and implemented within twenty-four (24) hours of admission and shall continue in effect until the individual support plan is developed or the individual is discharged, whichever comes first.

8.2.g.3. Centers providing short-term services shall develop and implement a policy for the development of individual support plans within a time frame consistent with the expected length of stay of consumers.

8.2.g.4. The individual support plan shall include:

8.2.g.4.A. The consumer's needs and preferences;

8.2.g.4.B. Relevant psychological, behavioral, medical, rehabilitation and nursing needs, as indicated by the assessments;

8.2.g.4.C. Individualized strategies and methods, including the frequency of services needed and staffing levels required;

8.2.g.4.D. The behavior intervention plan, if applicable;

8.2.g.4.E. Identification of the treatment plan participants and documentation of their participation;

8.2.g.4.F. Descriptions and dates of the assessments on which the individual support plan goals and objectives are based;

8.2.g.4.G. Specific goals to improve or maintain the mental health and optimal adaptive functioning of the individual;

8.2.g.4.H. Measurable objectives related to the goals and expected achievement dates;

8.2.g.4.I. At least one (1) objective per goal shall specify the expected outcome of the goal for the consumer;

8.2.g.4.J. A description of all services, including services provided by other Centers, provided to a consumer and directed primarily toward achievement of the expected outcomes; and

8.2.g.4.K. The physician notes, as part of the treatment plan, including the consumer's current medications, dosages, and diagnoses related to the use of these medications, and the rationale for changes or continuation of psychotropic drug regimens.

8.2.g.5. The individual support plan shall be developed by an

interdisciplinary team consisting of:

8.2.g.5.A. Representatives of the Centers serving the consumer;

8.2.g.5.B. The consumer;

8.2.g.5.C. The consumer's legal representative, if any;

8.2.g.5.D. Other persons as determined by the consumer; and

8.2.g.5.E. Other service agencies such as schools, as applicable.

8.2.h. Support Plan Review.

8.2.h.1. A review or revision shall occur at significant times including, but not limited to:

8.2.h.1.A. Admission, transfer, and discharge from a Center's services;

8.2.h.1.B. Changes in the living arrangements of a consumer;

8.2.h.1.C. Major changes in a consumer's condition; and

8.2.h.1.D. Crisis points including, but not limited to hospitalization.

8.2.h.2. There will be a support plan review at least every three hundred sixty-five (365) days.

8.2.h.3 Each review shall summarize the amount of treatment or training provided, document progress towards the objectives, identify problems that impeded progress, and provide a decision to continue the same plan or to modify it.

8.3. Assessment and Planning for Limited-Outpatient Clinic Services.

8.3.a. When a consumer receives only medication management or individual therapy from the Center, the assessment and planning process is simplified, as follows:

8.3.a.1. An assessment, following screening, shall be limited to the service of medication management and/or therapy as needed;

8.3.a.2. Initial assessments shall be entered into a consumer's record within five (5) working days of the intake interview;

8.3.a.3. Diagnoses shall be:

8.3.a.3.A. 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

8.3.a.3.B. Based upon accepted professional standards of examinations and factual description of a consumer's symptoms and problems.; and

8.3.a.4. Consumer progress shall be reviewed at each treatment juncture and shall be documented in the case note.; and

8.3.a.5. The case note shall include the presenting problem, the results of the treatment juncture, and a plan for future treatment.

8.3.b. In the event that the consumer's needs require additional services, the assessment and planning process shall follow Subsection 8.2 of this rule.

8.4. Residential Services.

Specific Residential Service Provisions: These provisions are in addition to the general physical environment requirements found in Subsection 6.2.

8.4.a. Emergency Medical and Psychiatric Services in Residential Facilities.

8.4.a.1. The Center shall ensure the availability of a physician for medical consultation twenty-four (24) hours per day, seven (7) days per week.

8.4.a.2. 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 himself or herself or other persons.

8.4.a.3. The Center shall assure that the onsite employees have immediate access to treatment and medical information in a consumer's records in the case of an emergency.

8.4.a.4. The Center's emergency events policy and procedure shall contain procedures ~~F~~ for a consumer who attempts or threatens suicide or homicide, or ~~commits~~ attempts or threatens assault~~, a written policy shall be developed and implemented for the treatment~~,. It must include referral and follow-up of the consumer.

8.4.b. MR/DD and Mental Health Residential Facilities.

8.4.b.1. Centers providing residential services shall either provide or arrange for the provision of appropriate medical care. The Center shall define instances when it shall provide or arrange for appropriate medical and dental care and instances when it shall refer the consumer to appropriate medical care.

8.4.b.2. A physical examination by a qualified practitioner shall be administered or obtained within thirty (30) days of admission to a licensed residential site. This physical may be completed prior to admission, but cannot be more than (60) sixty days old. For Title XIX MR/DD Waiver, if the consumer has a valid (within the current year) ~~Waiver~~ annual physical evaluation, a nursing assessment conducted within thirty (30) days of admission shall be accepted in lieu of a repeat physical examination.

8.4.b.3. The Center shall have rules of conduct for consumers to follow while in residence.

8.4.b.4. The consumers shall be provided foods that promote healthful living.

8.4.b.5. Onsite employees shall ensure that each consumer receives training and practices good habits in personal care, hygiene, and grooming.

8.4.b.6. Consumers who require twenty-four (24) hour staffing shall not be left unattended during normal sleeping hours.

8.4.b.7. Consumers shall be referred for ongoing mental health services, if need, and shall be assisted in keeping appointments and participating in treatment

programs. Documentation of referrals shall be kept in the consumer's record.

8.4.c. Public Inebriate Shelters.

8.4.c.1. Trained employees or staff shall screen a consumer to determine his or her need for medically monitored detoxification or for referral to acute medical care.

8.4.c.2. 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:

8.4.c.2.A. A documented evaluation of the consumer;

8.4.c.2.B. Documentation of vital signs including a blood alcohol count, taken every four (4) hours; and

8.4.c.2.C. Documentation of any changes in withdrawal symptoms.

8.4.c.3. 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.

8.4.c.4. 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.

8.4.c.5. If a consumer leaves the shelter prior to being discharged, the referring court and the sheriff's office shall be notified.

8.4.c.6. The shelter shall inform a consumer of alternative services and, upon a consumer's request, assist in arranging follow-up appointments.

8.4.c.7. The shelter shall submit recommendations to the court as required for the disposition of publicly inebriated individuals.

8.4.c.8. If the shelter is located in a building housing another agency or program, the shelter shall have:

8.4.c.8.A. A separate entrance; and

8.4.c.8.B. A separate bathroom and shower facilities for the sole use of shelter consumers.

8.4.d. Detoxification Services.

8.4.d.1. The Center shall perform a physical examination and screening at a consumer's intake to determine the need for medical services.

8.4.d.2. A physician shall be available for medical consultation twenty-four (24) hours per day, seven (7) days per week.

8.4.d 3. During the withdrawal process, qualified employees shall maintain contact with a consumer regarding the consumer's detoxification protocol.

8.4.d.4. The Center shall refer a consumer to a more intensive level of medical care if screening and a medical examination indicate that more intensive medical monitoring or management is required.

8.4.e. Adult Residential Addictions Recovery Treatment Programs

8.4.e.1. The center shall ensure the availability of nursing staff sufficient to address the assessed medical needs of a consumer.

8.4.e.2. The center shall maintain policies and procedures to handle contraband substances brought into the group residential facility.

8.4.e.3. Adults in residential addictions recovery treatment programs shall be evaluated or assessed by a medical professional to ensure their ability to self-administer their own medications.

8.4.e.4. All medications shall be maintained under lock and key or in a secured and locked cabinet, including all over-the-counter medications. Medications should be separated for each consumer and accessible only to designated staff.

8.4.e.5. Medications shall be self-administered under the supervision of staff.

8.4.e.6. Any habit-forming or addictive medication is prohibited on the premises while the consumer is in residence as it poses a risk to all recovering consumers. Individuals who require habit-forming or addictive medication can be granted a short-term medical leave of absence from the program or may be transitioned to other services including other residential programs where nursing staff are more available or intensive outpatient programs.

8.4.e.7. Each consumer shall complete medication records that will be maintained on-site for each dose of medication that the client self-administers. Records will include both prescription and non-prescription or over-the-counter medications. Medication records will include at a minimum the name of the medication, the strength of the medication or dosage, the route, the date taken, time taken, the initials of the individual consumer. A separate record will contain the documentation of the staff person supervising the self-administering consumer. Once the medication record is completed, it will be stored in the medical record of the individual consumer.

8.4.f. Physical Requirements for 24 Hour Residential Treatment Services.

8.4.f.1. For construction occurring after the enactment of this rule, bedrooms shall provide a minimum of one hundred (100) square feet of floor space per person for one (1) person occupancy and a minimum of eighty (80) square feet of floor space per person for two (2) person occupancy. There shall be a maximum of two (2) persons per bedroom.

8.4.f.2. Each consumer 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.

8.4.f.3. Each room shall be arranged in consideration of the consumer's clinical needs.

8.4.f.4. Each room shall be arranged and equipped to preserve the dignity, comfort, and privacy of consumers.

8.4.f.5. Each bedroom shall be directly accessible from a corridor or common use activity room and have an exterior window. Each bedroom shall have the windows covered for privacy.

8.4.f.6. Furnishings shall be

homelike and personalized and maintained in good condition.

8.4.f.7. There shall be separate storage areas for items including: foodstuffs, utensils, work materials and cleaning supplies, clothing, linens, and medicines.

8.4.f.8. 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.

8.4.f.9. There shall be a sufficient number of accessible, 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. The minimum number of bathrooms is calculated at a minimum of one per ten consumers.

8.4.f.10. Solid waste storage shall be sufficient to contain all solid waste in a safe and sanitary manner.

8.4.f.11. Solid waste, including garbage and refuse, shall be removed from the premises weekly, or more often, if necessary.

8.4.f.12. Grounds and structures shall be maintained free of insects and rodents of public health significance.

8.4.f.13. Food shall be stored, prepared and served in a sanitary manner.

8.4.f.14. Food services, when provided, shall:

8.4.f.14.A. Meet or exceed national nutritional standards; and

8.4.f.~~13~~14.B. Provide three well-balanced meals and snacks daily. Exceptions may be approved by the Secretary.

8.4.f.15. The use of paper or throw-away plates, beverage containers and utensils shall be limited and not used in day-to-day meal service.

8.4.f.16. A minimum of an emergency three (3) day supply of food sufficient for all consumers provided food services shall be maintained.

8.4.f.17. Each site shall have an emergency operations plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would interrupt normal operations or affect the Center's ability to provide care.

8.4.f.18. The Center shall maintain a health history and emergency medical information for all residential consumers.

8.4.f.19. The health history shall include:

8.4.f.19.A. Allergies and symptomatologies;

8.4.f.19.B. Recent medical complaints and conditions;

8.4.f.19.C. Chronic conditions and their duration;

8.4.f.19.D. Communicable diseases and their treatment;

8.4.f.19.E. Disabilities or restrictions on physical activities, if any, and any adaptive equipment needed;

8.4.f.19.F Past serious illnesses, serious injuries, and hospitalizations;

8.4.f.19.G. Current or past drug usage including alcohol, prescription and nonprescription medications, illicit drugs, and current treatment, if any;

8.4.f.19.H. A sexual health and reproductive history;

8.4.f.19.I. Routine laboratory reports and communicable disease screening as recommended by the Centers for Disease Control and Prevention; and

8.4.f.19.J. An immunization history and records.

8.5. Medical Management.

8.5.a. The Center shall develop and implement a written policy for the provision of adequate medical care.

8.5.b. Centers providing residential or inpatient services shall either provide or arrange for the provision of appropriate medical and dental care for residential consumers. A Center providing other services shall define instances when it shall provide or arrange for appropriate medical care and instances when it shall refer the consumer to appropriate medical and dental care.

8.6. Medical Equipment.

8.6.a. The Center shall develop and implement a policy on the maintenance and use of medical equipment, including personal medical equipment and devices. There shall be timeframes for preventative maintenance and cleaning.

8.7. Medication Services.

8.7.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.

8.7.b. All orders for medications shall be reviewed at least every one hundred eighty (180) days by a physician.

8.7.c. Psychotropic drugs shall be 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.

8.7.d. All medications shall be administered in compliance with a physician's order.

8.7.e. All medications shall be administered only by persons authorized by state law.

8.7.f. Medication errors, as defined by this rule, and adverse drug reactions shall be reported immediately to the physician.

8.7.g. Medication errors shall be monitored and tracked in accordance with the Office of Health Facility Licensure and Certification Behavioral Health Program Guidelines for Incidents and the Division of Health rule, "Medication Administration by Unlicensed Personnel," 64CSR60.

8.7.h. An individual medication administration record of all medications received and refused by each consumer that are provided by the Center shall be kept.

8.7.i. This record shall include:

8.7.i.1. The signature and job title of all employees or staff administering medications;

8.7.i.2. Any errors in the administration process; and

8.7.i.3. A notation of any missed medications and the reason for the omission, including refusals.

8.7.j. For consumers who are capable of self medication, the record will include a legible signature and initials of the consumer.

8.8. Medication Management.

8.8.a. The Center shall note in the consumer's record any changes in a consumer's condition, including adverse reactions, as a result of receiving a medication.

8.8.b. A consumer, to the extent capable, shall administer his or her own medication. All consumers receiving self medication management shall be assessed to determine the extent of their self medication capability. At least annually, a reassessment shall be completed, or when there is significant change in the consumer's self administration skills.

8.8.c. The Center shall provide double-locked storage for all controlled substances and single-locked storage for all other medications.

8.8.d. Medication and food items shall not be stored in the same container or area.

8.8.e. The Center shall have evidence of written informed consent from a consumer, or his or her legal representative, about the medications prescribed by the behavioral health provider: the dosage, purpose, possible side affects, affects of not taking the medication; and about alternate treatments and their affects.

8.8.f. The Center shall promptly dispose of discontinued drugs, outdated drugs, and drug containers with worn, illegible, or missing labels.

8.9. Behavior Intervention.

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

8.9.b. The Center shall ensure that all interventions for ~~"predictable"~~ problem behaviors which are identified in the Individual Support Plan are based on a functional analysis of the behavior.

8.9.c. Once a problem behavior has been identified, the functional analysis shall be completed within twenty (20) calendar days. The development of formal interventions, based on the functional analysis, shall occur within fifteen (15) days of the completion of the functional analysis and its rationale and shall be clearly identified in the behavioral intervention plan. If the functional analysis determines that the behaviors are a symptom of psychosis (hallucinations, delusion, etc.), then a Behavior Intervention Plan is not required. ~~However, the interdisciplinary team shall objectively monitor the symptoms in order to evaluate the effectiveness of the intervention employed.~~

8.9.d. The behavior intervention

plan shall:

8.9.d.1. Include positive programming to teach the consumer adaptive, more effective behavior;

8.9.d.2. Ensure that a consumer does not discipline another;

8.9.d.3. Ensure that seclusion and physical restraints are used only as a last resort and used only as long as necessary to mange behavior; and

8.9.d.4. Include a mechanism of data collection and measurement that allows an objective measurement of progress toward the behavioral outcome.

§64-11.9. Consumer Rights.

9.1. General Consumer Rights.

9.1.a. A consumer shall have rights protected and promoted including, but not limited to, the following general rights:

9.1.a.1. The right to be informed orally and in writing in appropriate language and terms, of the rights described in this section. The Center shall have the consumer or his or her legal representative sign and date an acknowledgement of receipt of rights information as part of the intake process. The acknowledgement shall become a part of the consumer's record;

9.1.a.2. The right to be informed of this rule. Upon request, the Center shall provide a consumer or his or her legal representative a copy of this rule;

9.1.a.3. The right not to be discriminated against because of the receipt of behavioral health services;

9.1.a.4. The right to exercise his or her civil rights, except as abrogated by court order or for the reasons provided in this rule; and

9.1.a.5. The right to all available services without discrimination because of race, religion, color, sex, sexual orientation, disability, age, national origin or marital status.

9.1.b. A consumer shall have the following additional rights:

9.1.b.1. The right to a legal representative when unable to act on is or her own behalf;

9.1.b.2. The right to access an advocate in order to understand, exercise and protect his or her rights;

9.1.b.3. The right to access his or her own consumer records in accordance with state and federal law;

9.1.b.4. The right to be informed in advance of any charges for services;

9.1.b.5. The right to be free from physical, verbal, sexual or psychological abuse or punishment, and neglect;

9.1.b.6. The right to appropriate referrals to other licensed Centers;

9.1.b.7. The right to be free from retaliation;

9.1.b.8. The right to be free from humiliation; and

9.1.b.9. The right to be free from financial or other exploitation.

9.1.c. A residential or day services consumer shall have the following rights:

9.1.c.1. The right to be served with other consumers of similar age and need, unless otherwise specified in the consumer's Individual Support Plan or treatment plan;

9.1.c.2. The right to privacy and the right to move about freely, unless his or her safety or the safety of others is threatened;

9.1.c.3. The right to unimpeded access to his or her attorney, advocate or religious advisor;

9.1.c.4. The right to constant access to his or her personal possessions, unless contraindicated by treatment needs. The reason for any restriction shall be clearly documented in the consumer's record and approved by the treatment team and human rights committee prior to implementation. The treatment team shall periodically reevaluate the need for continuation of the restriction;

9.1.c.5. The right to unimpeded private communication by any means with whomever a consumer chooses, except as specified in Subsection 10.10 of this rule;

9.1.c.6. The right not to be deprived of any right for punishment or clinical reasons. When an incident occurs related to the exercise of a right, the right may be deprived for clinical reasons, but only for as long as is necessary to permit correction of a situation. The restriction and the clinical reasons for it shall be clearly documented in the consumer's record and shall be approved by the human rights committee prior to implementation; and

9.1.c.7. The right of a consumer receiving care and treatment to receive it in accordance with accepted behavioral health and medical practice standards.

9.2. Advance Psychiatric Directive Rights.

9.2.a. A consumer with psychiatric or mental health needs has a right to an advance psychiatric directive prepared at a time when the individual has not been adjudged to be incompetent. Any advance psychiatric directive written and signed by a consumer may be withdrawn at any time verbally or in writing.

9.2.b. A consumer has the right to be informed by the Center of the availability and applicability of an advance psychiatric directive and to receive education and assistance from the Center in preparing the directive.

9.2.c. A consumer has the right to refuse to create an advance psychiatric directive.

9.2.d. A consumer with an advance psychiatric directive has the right to have it entered into his or her clinical record at the Center at which he or she is receiving or may receive care or treatment.

9.2.e. An advance psychiatric directive shall be honored, unless:

9.2.e.1. It is withdrawn verbally or in writing by a consumer;

9.2.e.2. The Center lacks sufficient resources; or

9.2.e.3. A professional employee member of the Center believes that the directive would endanger the consumer's life

or be dangerous to other persons.

9.2.f. A consumer has the right to be informed of the Center's reason for not honoring his or her advance psychiatric directive.

9.2.g. Nothing in this section should be interpreted to prevent any individual with behavioral health needs from entering into an advance directive related to preferences in health care or conduct of business.

9.3. Informed Consent Rights.

9.3.a. The Center shall have the consumer or his or her legal representative sign a general consent to receive treatment.

9.3.b. In order for a consumer to give informed consent for care or treatment, the Center shall inform him or her of the following:

9.3.b.1. The rights provided under this rule;

9.3.b.2. The nature of his or her condition and the treatment proposed;

9.3.b.3. Any reasonable alternative treatments available;

9.3.b.4. That consent for any part of treatment may be withdrawn at any time in writing or verbally to a member of the treatment staff. Revocation of consent shall be documented on the consent form, and further treatment shall not be provided except as authorized in an emergency;

9.3.b.5. The reason for taking a proposed medication, including the likelihood of the consumer's condition improving or not improving without the proposed medication;

9.3.b.6. The type, dosage, including the use of PRN (as needed) orders, the method of administration (oral or injection), and the duration of taking the proposed medication; and

9.3.b.7. The common side effects, any side effects probable with the particular consumer, and additional side effects that may occur when taking the proposed medication longer than three (3) months.

9.3.c. In the absence of written consent, if treatment is provided to a consumer, he or she or his or her legal representative has the right to documentation of the precipitating causes for providing the treatment.

9.3.d. The procedures outlined in this section shall not apply to those individuals who:

9.3.d.1. Need life-saving medication for chronic medical conditions, such as diabetes or heart disease; or

9.3.d.2. Have been taking medications prior to admission and have not refused to continue the medication, even though they may not be able to give informed consent.

9.3.e. A consumer has the right to be free from unnecessary or excessive medication.

9.4. Right to Treatment.

9.4.a. A consumer has the right to:

9.4.a.1. Treatment in the least restrictive, most appropriate and potentially most effective setting possible that supports

a consumer's personal liberty and results in positive outcomes to the maximum extent possible;

9.4.a.2. Treatment that is provided humanely in an environment that affords him or her full protection of his or her rights and promotes personal dignity and self-esteem;

9.4.a.3. Treatment by sufficiently trained and competent employees and staff capable of implementing the consumer's individual support plan or treatment plan;

9.4.a.4. Employee and staff to consumer ratios sufficient for adequate protection and supervision;

9.4.a.5. Periodic evaluations related to his or her needs while an active consumer of the Center;

9.4.a.6. Treatment based on diagnosis and assessment of their needs;

9.4.a.7. Treatment based on a treatment plan that identifies immediate needs and interventions and responsibility for implementing the plan;

9.4.a.8. Have the treatment plan updated as his or her needs change;

9.4.a.9. Participate in the development of his or her individual support plan or treatment plan and any revisions to the plan. The consumer or his or her legal representative shall sign and date to give consent for the individual support plan or treatment plan and any revisions to the plan;

9.4.a.10. Have a copy of his or her individual support plan or treatment plan;

9.4.a.11. Have present at any treatment planning or discharge planning meeting representatives of all disciplines providing treatment to the consumer and any other individual, including this consumer's case manager, advocate and family members; and

9.4.a.12. Have all treatments administered recorded in his or her record.

9.4.b. A consumer who resides in an inpatient behavioral health facility has the right to outdoor exercise and activity programming conforming with the Division of Health rule, "Behavioral Health Client Rights, §64CSR59.

9.5. Right to Refuse Treatment.

9.5.a. As a participant in the program planning process, a consumer has the right to object to or refuse any aspect of the individual support plan or treatment plan.

9.5.b. If informal discussion and negotiation do not resolve differences, a consumer's right to object to or refuse treatment shall be recognized as legitimate, and shall be responded to in accordance with the provisions of the Center's consumer grievance procedure.

9.5.c. A consumer who has refused psychotropic medications or other recommended therapy or treatment has the right to have an agreed-upon effective alternative treatment offered, and it shall be provided if the consumer consents and if it is within the scope of the Center's practice.

9.5.d. A consumer has the right to orally refuse medication or other treatment that overrides prior written consent, except

in emergency situations in which it is documented that the absence of medication or other treatment would be harmful to the consumer or other persons.

9.6. Right to Refuse Research and Experimental Treatment.

9.6.a. A consumer or his or her legal representative has the right to refuse to participate in or be subjected to research or experimental treatment. Participation by a consumer requires voluntary, informed and written consent, and an opportunity for consultation with independent specialists.

9.7. Rights Regarding Seclusion and Restraints.

9.7.a. A consumer has the right to freedom from seclusion and restraints, unless the restraints are documented as clinically necessary and all other less restrictive measures have been exhausted. Seclusion or restraint shall cease as soon as clinically possible.

9.7.b. A consumer with a diagnosis of mental retardation or another developmental disability has the right not to be secluded or restrained, but time-out procedures may be used when they have been developed specifically for the consumer as part of an authorized behavioral support or management plan and described in the consumer's treatment plan.

9.7.c. A consumer has the right to not have seclusion or restraint used as punishment. Seclusion or restraint may be used only as a last resort as an emergency measure to control imminent destructive behavior that is a threat to a consumer or to others or to prevent injury to a consumer or other persons.

9.7.d. A consumer has the right to not have physical restraints used as punishment or as a convenience ~~to~~ of employees.

9.7.e. A consumer has the right for drugs or medications to not be used as punishment, as a convenience to employees, as a substitute for adequate staffing, or as a substitute for an individualized programming or treatment.

9.8. Right of Confidentiality.

9.8.a. A consumer has the right to have all information about his or her diagnosis and treatment kept confidential.

9.8.b. A consumer shall have the right to confidentiality in accordance with federal regulations (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996;

9.8.c. Confidential information includes, but is not limited to:

9.8.c.1. Information obtained during diagnosis or treatment, including the fact that an individual is or has been a consumer;

9.8.c.2. Information provided by a consumer or his or her family for purposes related to diagnosis or treatment;

9.8.c.3. Information provided by the treatment staff;

9.8.c.4. Diagnoses, opinions or remarks made by treatment staff that relate to a consumer's treatment;

9.8.c.5. Advice, instructions, or prescriptions issued in the course of diagnosis or treatment; and

9.8.c.6. Any record of a consumer's treatment.

9.8.d. Confidential information does not include:

9.8.d.1. Information which does not identify a consumer;

9.8.d.2. Information from which a person acquainted with a consumer would not recognize the consumer; and

9.8.d.3. Encoded information from which there is no possible means to identify a consumer.

9.8.e. A consumer has the right to have information relating to his or her treatment disclosed only:

9.8.e.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 or §27-5-3;

9.8.e.2. In a proceeding under W. Va. Code §27-6A-1 et seq. to disclose the results of an involuntary examination made pursuant to those provisions;

9.8.e.3. Pursuant to an order of any court based upon a finding that the information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining the confidentiality established by this section;

9.8.e.4. To the attorney of the consumer, whether or not in connection with pending judicial proceeding;

9.8.e.5. To agencies requiring information necessary to make payments to or on behalf of the consumer pursuant to contract or in accordance with law, provided that only information shall be released to third-party payers that is required to certify that covered services have been provided;

9.8.e.6. To protect against a clear and substantial danger of imminent injury by a consumer to himself or herself or another person;

9.8.e.7. For treatment or internal review purposes, to staff of the Center where the consumer is being cared for or other health professionals involved in treatment of the consumer; and

9.8.e.8. Without the consumer's consent as provided for under the Privacy Rule of the federal Health Insurance Portability and Accountability Act of 1996, 45 CSR §164.506 for thirty days from the date of admission to a Center if: (i) the provider makes a good faith effort to obtain consent from the patient or legal representative prior to disclosure; (ii) the minimum information necessary is released for a specifically stated purpose; and (iii) prompt notice of the disclosure, the recipient of the information and the purpose of the disclosure is given to the consumer or legal representative.

9.8.f. A consumer has the right to be informed about the limits of confidentiality in this rule.

9.9. Consent for Disclosure of Confidential Information.

9.9.a. A consent for the disclosure of confidential information shall be in writing and signed by the consumer or by his or her legal representative. A consumer who signs a consent has the right to a copy of the consent.

9.9.b. A consumer shall not be denied treatment on the basis of refusing to provide consent to disclose confidential information, except when and to the extent disclosure is necessary for treatment, or for the substantiation of a claim for payment for treatment from a source other than the consumer.

9.10. Right to Unrestricted Communication.

9.10.a. A consumer has the right to unimpeded and private communication by any means with whomever a consumer chooses, except as specified in this rule.

9.10.b. A consumer's right to communication, except for that with his or her legal representative, attorney or religious adviser, may be restricted or denied if authorized by the treatment team for a specified time not to exceed thirty (30) days, after which time the restriction may be reviewed and reinstated.

9.11. Rights Regarding Labor, Earnings and Funds.

9.11.a. A consumer has the right not to be required to perform uncompensated labor that involves the operation and maintenance of the Center, but may voluntarily perform it with compensation in accordance with the requirements of relevant State and federal requirements.

9.11.b. A consumer shall not suffer consequences for refusing to perform uncompensated labor for the Center.

9.11.c. A consumer may perform vocational training tasks that do not involve the operation and maintenance of the Center when the assignment:

9.11.c.1. Is an integrated part of a consumer's individual support plan or treatment plan;

9.11.c.2. Has been approved as a program activity by the treatment staff; and

9.11.c.3. Is supervised by an employee or staff person.

9.11.d. A consumer shall have unlimited access to his or her funds except as provided by state law, or by regulations promulgated by the Social Security Administration.

9.12. Additional Rights of Juveniles.

9.12.a. A consumer under the age of eighteen (18) has the right to be housed separately from emancipated consumers over the age of eighteen (18), except in the case of unusual circumstances where a juvenile over the age of sixteen (16) is developmentally similar to the adults with whom the juvenile will reside and the treatment team and legal representative approve of the arrangement.

9.12.b. A consumer under the age of eighteen (18) has the right to an education.

9.12.c. A consumer under the age of eighteen (18) has the right to appropriate contact and communication with his or her family members, unless restricted by the West Virginia Department of Health and Human Resources for good reason when the juvenile is in the legal custody of the West Virginia Department of Health and Human Resources.

9.12.d. A consumer under the age of eighteen (18) has the right to be informed about behavior expectations for the

protection of others.

9.12.e. All other rights under this rule apply to consumers under the age of eighteen (18).

9.13. Right of Advocacy and Grievance Procedure.

9.13.a. A consumer has the right to be informed of and receive a written copy of the Center's grievance procedure.

9.13.b. A consumer or another person acting on a consumer's behalf has the right to file a grievance, orally or in writing, with the Center concerning any alleged violation of the rights afforded by this rule.

9.13.c. A consumer has the right to receive a reasonable and timely written decision from the Center.

9.13.d. A consumer or his or her legal representative has the right to a response to his or her grievance within fifteen (15) working days of its filing with the Center.

9.13.e. A consumer may, after receipt of the decision or lack of a timely decision on his or her grievance, request a hearing by the Secretary or bring action in circuit court against the Center.

9.13.f. A consumer has the right to withdraw his or her grievance at any time.

9.13.g. If the 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 has the right to appeal to the governing body of the Center, the State licensure body, an advocate or other appropriate resource, including an attorney.

9.13.h. A consumer has the right to pursue other relief even if he or she does not file a grievance.

9.13.i. A consumer has the right to report any reasonable suspicion of abuse or neglect to civil and criminal authorities in accordance with the applicable Adult Protective Services Act, W. Va. Code §9-6-1 et seq. or Child Protective Services act, W. Va. Code §49-6A-1 et seq., in addition to using the grievance procedure of the Center.

9.13.j. 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 is or her legal rights granted under state or federal law.

§64-11-10. Penalties.

10.11.a. The Secretary may deny the Center's application for licensure or licensure renewal; revoke or suspend a license; and/or order an admissions ban or a reduction in consumer census for one or more of the following reasons:

10.11.a.1. The Secretary makes a determination that there has been a conviction for fraud or other illegal action by the Center;

10.11.a.2. The Center has violated federal, state, or local law relating to its building, health, fire protection, safety,

sanitation, or zoning;

101.11.a.3. The Center conducts practices that jeopardize the health, safety, well-being, or clinical treatment of a consumer;

10.11.a.4. The Center has refused to provide access to its location or records as requested by the Secretary; or

10.11.a.5. The Center has failed or refuses to submit reports or documents as requested by the Secretary.

10.11.b. The Secretary may assess civil monetary penalties for one or more of the following reasons:

10.11.b.1. Failure to submit a plan of correction in accordance with Subsection 4.9 of this rule, for which the civil monetary penalty shall be $50 per each day the Center is delinquent; or

10.11.b.2. Failure to correct deficiencies based on the following provisions of this rule, if also cited in the previous licensure inspection, for which the civil monetary penalty shall be $1000:

10.11.b.2.A. Subdivision 5.9.a, 5.9.b, 5.9.c and 5.9.d. regarding personnel;

10.11.b.2.B. Subsection 5.12 regarding quality assurance;

10.11.b.2.C. Subsection 6.2 regarding physical environment; or

10.11.c. If a license has been revoked, the Secretary may stay the effective date of the revocation by no more than ninety (90) days, if the Center can show that the stay is necessary to ensure appropriate referral and placement of consumers.

§64-11-12. Administrative Due Process.

12.1. 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 "Rules of Procedure for Contested Case Hearings and Declaratory Rulings,§64CSR1, a copy of which may be obtained from the Secretary of State.