WEST VIRGINIA LEGISLATURE

2017 REGULAR SESSION

Introduced

House Bill 2778

BY DELEGATE WALTERS

[Introduced March 2, 2017; Referred

to the Committee on Health and Human Resources

then the Judiciary.]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated §64-5-2, relating to reauthorizing, with amendment, as one rule, the legislative rules contained in title sixty-four, series eleven and series seventy-four of the Code of State Rules relating to licensure of behavioral health centers (64 CSR 11) and behavioral health consumer rights (64 CSR 74).

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new section, designated §64-5-2, to read as follows:

ARTICLE 5. AUTHORIZATION FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES TO PROMULGATE LEGISLATIVE RULES.

§64-5-2. Department Of Health And Human Resources rules reauthorization.

The legislative rules contained in title sixty-four, series eleven and series seventy-four of the code of state rules relating to licensure of behavioral health centers (64 CSR 11) and behavioral health consumer rights, (64 CSR 74) and both filed in the State Register on April 13, 2000, are reauthorized as one rule to read as follows:

TITLE 64

LEGISLATIVE RULE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 11

MINIMUM LICENSING REQUIREMENTS FOR PROVIDERS OF BEHAVIORAL HEALTH SERVICES AND SUPPORTS IN WEST VIRGINIA

§64-11-1. General.

1.1 Scope. -- This rule establishes standards and procedures for the licensure of providers of behavioral health services and supports under the provisions of W.Va. Code §27-1A-7 and related federal and state codes. The W.Va. Code is available in public libraries and on the Legislature's web page http://www.legis.state.wv.us/.

1.2. Authority. -- W. Va. Code §§27-1A-7, 27-1A-6(6), 27-1A-4(g), 27-17 (et. seq.) and 27-9-1.

1.3 Filing Date:

1.4. Effective Date:

1.5. Repeal and Replacement of Former Rule: This legislative rule repeals and replaces "Licensure of Behavioral Health Centers", 64 CSR 11, effective July 1, 2000, and "Behavioral Health Consumer Rights", 64 CSR 74.

1.6. Purpose: -- These standards are the basis for the licensing and approval of behavioral health services and supports in West Virginia. Licenses are issued if the standards and applicable rules and regulations are met. The purpose is to protect the health, safety, and well-being of consumers receiving care from providers of behavioral health services and supports and to regulate the provision of such services through the formulation, application and enforcement of licensing requirements.

§64-11-2. Application and enforcement.

2.1. These apply to all providers of behavioral health services and supports, both public and private. Each provider included in this rule shall comply with these requirements.

2.2. This rule contains the requirements to obtain a license to provide behavioral health services and supports for consumers in West Virginia.

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

2.4. Enforcement: -- This rule is enforced by the Secretary of the Department of Health and Human Resources.

2.5. Exemptions:

2.5.a. The following programs or services are exempt from the requirements of this rule:

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

2.5.a.2 Adult emergency shelters and homeless outreach programs serving adults and

accompanying minors

2.5.a.3 Fellowship homes and halfway houses for support of individuals with addictions;

2.5.a.4 Hospitals operating within the scope of their license under Chapter 16 of the West Virginia Code;

2.5.a.5 Individuals or groups of behavioral health or health practitioners functioning within the scope of their license under Chapter 30 of West Virginia Code;

2.5.a.6. Specialized family care providers providing only services to individuals in specialized family care settings;

2.5.a.7. Legally unlicensed health care homes as defined in 64 CSR 50;

2.5.a.8. Case management services as defined in this rule.

2.5.b. The secretary shall deem the license of all facilities operating as intermediate care facilities for the intellectually disabled (ICF/ID) determined to be in compliance with federal certification standards and of residential children's programs functioning within the scope of their license as described in 78 CSR 3.

§64-11-3. Definitions.

3.1 Abuse: Any act on the part of a provider which directly results in death, significant physical or emotional harm, verbal, sexual and/or financial maltreatment or exploitation; an act committed by the provider which presents imminent serious harm.

3.2. Addiction: A disease characterized by the individual's pursuing reward and/or relief by substance use and/or other behaviors. Addiction is characterized by impairment in behavioral control, craving, inability to consistently abstain, and diminished recognition of significant problems with one's behaviors and interpersonal relationships; likely to involve cycles of relapse and remission.

3.3. Adult basic skills coaching: Unstructured coaching or prompting of individuals in their home or group home environment in areas including, but not limited to, money management, safety, housekeeping, personal care, nutrition, cooking, and medication education. This is

considered to be a supportive service.

3.4. Alteration: A change to a provider location that affects the usability of the building or facility or any part thereof. Alterations include, but are not limited to, remodeling, renovation, rehabilitation, reconstruction, historic restoration, changes or rearrangement in structural parts or elements, and changes or rearrangement in the plan configuration of walls and full-height partitions. Normal maintenance, reroofing, painting or wallpapering, asbestos removal, or changes to mechanical and electrical systems are not alterations unless they affect the usability of the building or facility.

3.5. Behavioral Health Service: A direct service provided to an individual with mental health, addictive, behavioral and/or adaptive challenges that is intended to improve or maintain functioning in the community. The service is designed to provide treatment, habilitation, and/or rehabilitation.

3.6. Behavioral Intervention: A behavior support approved by the service planning team. A behavioral intervention must be based on a functional assessment of the targeted behavior and must be specific and measureable.

3.7. Case management: A nonclinical service that helps the consumer arrange for appropriate services and supports. This service may involve, but is not limited to, assistance with completion of applications and forms, transportation, assistance in making appointments for medical or other care and telephone calls but is not a direct clinical service provided to a consumer. Case management is not considered to be a service unique to a health care setting and is therefore not a behavioral health or supportive service.

3.8. Chemical restraint: An anti-psychotic medication used to control behavior or to restrict the consumer's freedom of movement when the medication is not a standard treatment for the consumer's medical or psychological condition. Doses of any medication prescribed at levels beyond that recommended for normal clinical use shall also be evaluated for inclusion as a chemical restraint.

3.9. Chief executive officer: The individual designated by the governing body to be responsible for the provider's daily operations. The chief executive officer may also be referred to as the provider's president, executive director, or chief administrative officer.

3.10. Clinic behavioral health service: An episodic outpatient treatment service usually but not invariably provided in a clinic setting by mental health professionals who are licensed or under supervision to obtain licensure. Clinic behavioral health services may also be provided in alternative locations by a licensed provider through contract or memorandum of understanding or in a consumer's home to children, parents, adults and families. A consumer may receive more than one clinic behavioral health service.

3.11 Multiagency Comprehensive plans of services: A written description of the behavioral health services and supports provided to the consumer with measureable goals accompanied by a description of the supports the consumer is receiving. These services are usually provided by several agencies acting in coordination. The comprehensive plan is utilized for consumers receiving both behavioral health services and supports.

3.12. Comprehensive mental health center (CMHC): A provider designated by the secretary to provide mandatory specific mental health services to an identified target population in a designated region of the State of West Virginia.

3.13. Consumer: An individual who receives services and/or supports from a provider licensed under this rule.

3.14. Critical incident: An unusual and unexpected event that does not meet the definition of abuse or neglect however there is reasonable cause to believe that a consumer is of imminent risk of serious harm.

3.15. Critical treatment juncture: The occurrence of an unusual or significant event which may have an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the consumer and/or DLR and may cause a revision of the plan of services.

3.16. Crisis services: Twenty-four hour availability of certification screenings for commitment; telephone answering for behavioral health crises, with clinician follow up as necessary within thirty minutes; and personalized screening as necessary and appropriate by trained staff on 24-hour basis.

3.17. Designated legal representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a consumer and operating within the scope of his/her authority.

3.18. Disaster relief: Provision of community-based behavioral health services to individuals who are the victims of a natural or other disaster. Disaster relief may include emergency interventions with first responders experiencing distress due to their participation in recovery activities subsequent to a disaster.

3.19. Emergency: A situation or set of circumstances which presents a substantial and immediate risk of death or serious injury to a consumer.

3.20. Expanded plan of service: A description of the treatment, habilitation or rehabilitation goal(s) of the behavioral health services provided to the consumer stated in measureable terms, accompanied by a brief description of any supportive services to be provided. The expanded plan of service is developed at the conclusion of the assessment process and may be preceded by an initial plan of service.

3.21. Governing body: A clearly identified group of people (or person or partnership when applicable) which exercises authority over and has responsibility for the provider's operation, policies and practices. The provider will designate the governing body at the time of licensure. If an entity is a corporation with an out of state ownership or management structure, the provider will identify the governing body in conjunction with the secretary.

3.22. Habilitation: A direct service promoting the acquisition of skills or emotional or behavioral self-management abilities that the person did not develop at an appropriate

developmental phase.

3.23. Inappropriate behavior: A behavior which is hazardous to a consumer or individuals in his or her environment; a maladaptive behavior which interferes in the ability of the consumer to lead an integrated life in the community to an optimally independent degree.

3.24. Incapacitated adult: Any person who by reason of physical, mental, or other infirmity is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health;

3.25. Initial plan of service: The plan developed at the conclusion of the admissions process that describes the services and/or supports the consumer is to receive until the assessment process is complete and the expanded plan of service is developed.

3.26. Intensive community-based stabilization and maintenance programs: Multidisciplinary programs for in-home habilitation/rehabilitation, stabilization, and maintenance of individuals with behavioral health challenges.

3.27. Linkage and aftercare: Establishment of a relationship between a CMHC and a committed individual while the consumer is still in the hospital; subsequent case management and provision of services designed to prevent rehospitalization and promote stabilization and maintenance of function.

3.28. Locked behavioral health program: a program authorized by the secretary to be locked when consumers are present in order to protect consumers or other members of the general public.

3.29. Neglect: A lack of appropriate and reasonable action on the part of a provider that results in death, serious physical or emotional harm, sexual abuse or exploitation; Noncritical incident: Any unusual event occurring to a consumer that needs to be recorded and investigated for risk management or quality improvement purposes but does not meet the definition of abuse, neglect, or critical incident.

3.30. Nonmethadone medication-assisted programs for addictions and cooccurring

disorders: A program that provides medications other than methadone to assist consumers to deal with withdrawal symptoms and on-going cravings for substances of misuse, typically opioids; not to include programs utilizing medications for the purpose of short term detoxification.

3.31. Personal attendant: A supportive service that provides assistance in activities of daily living for the consumer that may include prompting. The service may assist the individual to maintain his or her skills and abilities but does not carry the expectation of habilitation or rehabilitation as the result of the receipt of the service.

3.32. Physician extender: A medical professional including an advanced practice registered nurse or a physician's assistant functioning within their legal scope of practice.

3.33. Plan of service: A written description of the behavioral health services and/or supports that the consumer is to receive.

3.34. Programs requiring twenty-four hour medical monitoring: Any program providing around the clock supervision in a community-based location/site for the purpose of physical and/or psychiatric medical stabilization of mental, behavioral or addictions disorders.

3.35. Provider: An entity (including staff and individuals employed or contracted to provide consumer services on behalf of the entity) that provides behavioral health and/or supportive services under this regulation.

3.36. Psychosocial rehabilitation: A habilitation and/or rehabilitation service that seeks to effect changes in a person's environment and the ability of the person to deal with his/her environment so as to facilitate improvement in symptoms or personal distress. Psychosocial rehabilitation focuses on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the community environment.

3.37. Rehabilitation: A direct service that promotes reacquisition of skills or emotional or behavioral self-management abilities that the person has lost due to mental illness, traumatic brain injury, institutionalization or long-term addiction.

3.38. Residential treatment program for addictions and/or cooccurring disorders: A

program conducted twenty-four hours per day to stabilize, educate and treat individuals with addictions and cooccurring disorders. The program is usually time limited or the length of the program is dependent upon consumer progress toward the goal of stability and/or sobriety. The consumer does not consider the program to be a place of temporary or permanent residence.

3.39. Respite: A supportive service designed to provide temporary substitute care for an individual whose primary care is normally provided by the family of a consumer. The services are to be used on a short-term basis due to the absence of or need for relief of the primary caregiver. Respite consists of temporary care services and supervision for an individual who cannot provide for all of his/her own needs and may be provided in the consumer's home location, in the community, or in a location owned, rented or leased by the respite provider.

3.40. Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a consumer to move his or her arms, legs, body, or head freely. A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, lap belts on wheel chairs utilized for support, or other methods that involve the physical holding of a consumer for the purpose of conducting routine physical examinations or tests, or to protect the consumer from falling out of bed, or to permit the consumer to participate in activities without the risk of physical harm. Redirection through physical prompting and/or hand over hand instruction is not to be considered a restraint.

3.41. Screening: The act of evaluating an individual to determine if he or she meets the definitional requirements of the target population and is in need of a behavioral health service.

3.42. Seclusion: The involuntary confinement of a consumer alone in a room or area from which the consumer is physically prevented from leaving.

3.43. Secretary: The Secretary of the Department of Health and Human Resources or his or her designee.

3.44. Service coordination: A skilled service in which the professionally trained worker

assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex healthcare needs. This service typically involves the preparation of a detailed plan of services with specified objectives and time frames and when offered exclusively to a population of individuals with behavioral healthcare needs, is considered to be a behavioral health service.

3.45. Special program: A program with additional standards of operation beyond the general standards described in this rule.

3.46. Student: A student of a high school, community or technical college, college or university, health services intern, or medical resident.

3.47. Supportive service: This service is designed to assist the individual to live in the community in a manner that is socially inclusive, optimally independent and self-directed while preserving his/her health, safety and quality of life. These services are not designed to change behavior or emotional functioning but serve to support the individual in his or her community-based settings. Supportive services may include unstructured coaching or prompting of age appropriate living skills.

3.48. Treatment: A direct medical, behavioral, or psychotherapeutic service designed to ameliorate the effects of a mental illness, addiction or behavioral disorder and/or sustain the positive effects of interventions.

3.49. Twenty-four hour program accepting mothers with children: Any twenty-four hour program conducted for the purpose of behavioral health treatment or rehabilitation of mothers accompanied by children.

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

3.51. Volunteer: An individual who offers to provide assistance and support for consumers without pay. Natural support systems such as friends, neighbors and family members are not to

be considered volunteers.

3.52. Waiver: A declaration that a certain rule is inapplicable in a particular circumstance.

§64-11-4. State administrative processes.

4-1. General licensure provisions.

4.1.a. Before establishing, operating, maintaining or advertising as a provider of behavioral health services and supports as defined in this rule within the State of West Virginia, a provider shall first obtain from the secretary a license authorizing the operation.

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

4.1.c. The provider shall surrender an invalid license to the secretary on written demand.

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

4.1.e. The provider shall notify the secretary prior to the sale or merger of the entity if the ownership of a provider changes. The secretary shall require that a new license be obtained.

4.1.f. A provider shall demonstrate a need for the proposed service by obtaining a current certificate of need or a determination of nonreviewability from the Health Care Authority, unless otherwise exempted from review.

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

4.1.h. The secretary shall perform an on-site inspection prior to issuing initial, renewal or provisional licenses. Such inspection shall be performed within sixty days of receipt of a complete application.

4.2. License application.

4.2.a. The provider shall submit an application for license when establishing a new location for service provision, initiating or relocating a special program as defined by this rule, or renewing an expiring license. Providers shall submit an application at least sixty days in advance of the need for licensure.

4.2.b. Additionally, the provider shall notify the secretary sixty days in advance of the following:

4.2.b.1. A change in location of administrative offices;

4.2.b.2. A change in ownership;

4.2.b.3. A significant change in the population served or intensity of service provided; and/or

4.2.b.4. Termination of operation.

4.2.c. The secretary may require submission of a new or amended application for licensure at his/her discretion.

4.2.d. The provider shall submit all required information or the application is invalid.

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

4.2.f. A member of the governing body and/or the chief executive officer shall sign the application.

4.2.g. Prior to the issuance of a license, the chief executive officer and/or governing body shall ensure adequate resources to support the provider's services. If a new provider, the governing body and/or chief executive officer shall demonstrate sufficient operating funds for at least six months. Sufficient operating funds shall consist of cash or other liquid capital or an irrevocable letter of credit as required by a policy to be made available by the secretary.

4.3. Types of licenses.

4.3.a. Following application and review, the secretary shall issue a license in one of two categories.

4.3.a.1. Initial License: The secretary shall issue an initial license to providers establishing a new service found to be in compliance with regard to policy, procedure, provider, record keeping and service environment rules. It expires not more than six months from date of issuance and shall not be reissued. After a complete application for a regular license with required fee has been received, the existing initial license shall not expire until the regular license has been issued or

denied.

4.3.a.2. Regular license: The secretary shall issue a regular license to providers complying with this rule. It expires not more than three years from the date of issuance. The secretary may issue a regular license of shorter duration than three years to a provider with a level of service not in substantial compliance with this rule.

4.3.a.3. A regular license may be amended at any time during the cycle to reflect changes in the provider's service classification, programs, structure or population.

4.3.b. A valid initial or regular license shall be considered in effect until the secretary temporarily extends or denies in writing renewal of the license or until the secretary initiates formal action to terminate or otherwise modify the license and all due process actions have been resolved.

4.3.c. Provisional licensure status: The secretary may place a program, classification of service or agency on provisional status if the provider is not in substantial compliance with this rule, but does not pose a significant risk to the rights or health and safety of a consumer.

4.3.d. Such status shall expire not more than six months from date of issuance, and shall not be consecutively reissued unless the provisional recommendation is that of the State Fire Marshal.

4.3.e. A provisional status shall apply only to the particular program or service being reviewed unless a determination is made based on credible information that the same violations occur at other sites or within other programs of the same service classification.

4.3.f. If a program or service is issued provisional licensure status, notification of that provisional status shall be publicly posted in the location of the program or service receiving provisional status for the duration of the provisional status.

4.3.g. The secretary shall reevaluate a program or service operating under a provisional status before or near the end of the six month provisional period.

4.3.h. Once the program or service is deemed to be in substantial compliance with this

rule, the provisional status of the program or service shall be lifted.

4.3.i. If the program or service does not regain substantial compliance with this rule within six months, the license for the program or service will be terminated provided that if the review has not yet been completed by the secretary within the designated time frame, the program or service may continue to operate until such time as the review has been completed and due process alternatives, if any, pursued to completion.

4.4. Deemed status. The secretary shall accept an accreditation review from an accreditation commission for a provider instead of an inspection by the department for renewal of a license under 64 CSR 11, but only if:

4.4.a. The provider is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission, The Council on Accreditation (COA) or another national accreditation organization recognized by the department;

4.4.b. The accreditation commission maintains and updates an inspection or review program that, for each treatment facility, meets the department's applicable minimum standards;

4.4.c. The accreditation commission conducts a regular on-site inspection or review of provider according to the accreditation commission's guidelines; and

4.4.d. The provider submits to the department a copy of its most recent accreditation review from the accreditation commission in addition to the application, fee, and any report or other document required for renewal of a license.

§64-11-5. Construction and alteration.

5.1. Before new construction begins, a provider shall submit to the secretary for approval a copy of the site drawings and specifications for the architectural structure and mechanical work.

5.2. Before an alteration begins, the provider shall consult with the secretary regarding construction objectives. If the alteration does not affect consumer care and/or does not have an effect upon areas of the building(s) in which consumer care is provided, the alteration shall not be reviewable.

5.3. The secretary may require site drawings or other materials depending on the extent and type of alteration, provided that normal maintenance, reroofing, painting or wallpapering, asbestos removal, or changes to mechanical and electrical systems are not alterations unless they affect the usability of the building or facility to provide consumer care. Plans and blueprints may not be required in alterations with a construction budget of less than $100,000, adjusted upward annually according to the formula of the West Virginia Health Care Authority.

5.4. All altered and new structures owned or leased by the provider shall conform to the Americans with Disabilities Act (ADA) as amended.

5.5. The secretary shall provide consultation and technical assistance in obtaining compliance with this rule.

§64-11-6. Inspections and records.

6.1 The provider shall comply with any reasonable requests from the secretary to have access to the service, staff, consumers and relevant records of the agency. Consumers and/or their DLR may decline to be interviewed by the secretary at any time.

6.2 The provider may maintain files in an electronic medium.

6.3 The secretary shall review files in the location in which they are maintained, unless the provider agrees to a modified location.

6.4 The secretary may conduct announced and unannounced inspections of all aspects of the provider’s clinical operation and premises unless services or supports are provided in a location owned, rented or leased by a consumer. A consumer may deny access to his or her place of residence unless there is evidence of a clear and immediate danger to the health of a consumer.

6.5 A provider shall permit review of a provider’s medical records, employment records, and other relevant records as requested by the secretary. The secretary shall ensure the confidentiality of such information, including consumer or employee protected health information.

6.6 The secretary shall inspect a licensed provider thirty to ninety days prior to the

expiration of its license.

6.7 An initial or regular license shall be considered valid until the secretary issues or denies in writing renewal of the license or until the secretary initiates formal action to terminate or otherwise modify the license.

6.8 The secretary shall issue a report within ten working days of completion of an inspection. The report may contain two types of findings, as appropriate:

6.8.a. Citations: The secretary shall describe the provider's noncompliance with the standard in detail and the provider shall be expected to supply the secretary with a plan of correction as described in the section "Corrective Action Plans".

6.8.b. Recommendations: If the provider's lack of compliance is with internal policy rather than with the rule itself, the secretary may elect to make note of this noncompliance and any minor infractions of the rule through a discussion with the provider and an informal note to the file.

§64-11-7. Complaint investigation.

7.1. Any person may file a complaint with the secretary alleging violation of applicable laws or rules by a provider. Incidents reported to the secretary may be considered complaints at the discretion of the secretary, but are not required to be considered complaints. A complaint shall state the nature of the complaint and the provider by name;

7.2. The secretary shall conduct unannounced inspections of providers involved in a complaint and any other investigations necessary to determine the validity of a complaint.

7.3. At the time of the investigation, the investigator shall notify the administrator and the person in charge of the location involved in the complaint as to the general reason for the complaint.

7.4. The secretary shall provide to the provider a written report of the results of the investigation along with specific findings, detailed analysis of licensure regulations implicated, a report of any violations, and a notice describing the provider's due process rights. The written report shall be issued by the secretary within ten working days of completing the investigation.

The complaint investigation may result in a citation and/or recommendation or neither outcome.

7.5. The secretary shall inform the complainant that an investigation was conducted and whether it was substantiated. The secretary shall keep the names of a complainant and of any consumer or DLR involved in the complaint or investigation and any information that could reasonably lead to the identification of the complainant confidential, but shall disclose the general nature of the complaint to the provider upon determining that a violation has occurred.

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

7.7. The provider shall not discharge or discriminate in any way against any individual or group of individuals who has been a complainant, on whose behalf a complaint has been submitted, or who has participated in an investigation process by reason of that complaint.

§64-11-8. Reports of investigations and inspections.

8.1. All investigations and inspections shall result in a written report by the secretary, even if no violation has been identified.

8.2. The report shall specify the areas of noncompliance with the rule it violates, if any, and describe the precise data, observation or interview to support the deficiency.

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

8.3.a. As specified in this section regarding complaint investigations;

8.3.b. Information of a protected nature from a consumer or staff's file; and

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

8.4. The secretary shall not make a report or complaint public until the provider has the opportunity to review the report and obtain an approved corrective action plan, if necessary. No report may be released until due process rights of appeal have been pursued to conclusion.

8.5. The provider shall make reasonable efforts to secure the necessary resources for the delivery of services. However, the secretary shall not cite the provider nor require services that

are not reimbursable.

§64-11-9. Corrective action plans.

9.1. Within ten working days after receipt of the licensing report, the provider shall submit to the secretary for approval a written plan to correct all areas of noncompliances that are in violation of this rule and described by citation, unless a variance or waiver is requested by the provider and granted by the secretary or the provider is appealing a citation through identified methods of due process. The plan shall specify:

9.1.a. Any action taken or procedures proposed to correct the areas of noncompliance and prevent their reoccurrence;

9.1.b. The date or projected date of completion of each action taken or to be taken; and

9.1.c. The signature of the chief executive officer or his or her designee.

9.2. The secretary shall approve, modify or reject the proposed corrective action plan in writing within 10 working days of receipt. The provider shall make modifications to the plan as requested by the secretary.

9.3. The secretary shall state the reasons for rejection or modification of any corrective action plan.

9.4. The provider shall submit a revised corrective action plan within ten working days whenever the secretary rejects a corrective action plan. If the secretary cannot approve the second submitted plan of correction, he or she may supply a directed plan of correction.

9.5. The secretary may release a report to the public within ten days of an approved plan of correction or a directed plan of correction unless the provider has elected to pursue due process appeals and has notified the secretary of intent to do so.

9.6. The provider shall immediately correct an area of noncompliance that clearly results in an immediate risk to the health or safety of a consumer or other persons unless the area of noncompliance relates to an environmental or other condition over which the provider has no control, such as a home owned or leased by the consumer or DLR.

§64-11-10. Waivers and variances.

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

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

10.3. The waiver shall contain provisions for a review of the waiver if necessary.

10.4. When a provider fails to comply with the waiver agreement, the agreement is subject to immediate cancellation, provided that such cancellation shall allow sufficient time to make alternative arrangements for consumers. The secretary shall immediately inform the provider in writing of cancellation of a waiver.

§64-11-11. Penalties.

11.1. The secretary may deny the provider's application for licensure or licensure renewal; modify or revoke a license; and/or prohibit admissions or reduce consumer census for one or more of the following reasons:

11.1.a. The provider fails to submit an adequate plan of correction without formally notifying the secretary that the agency intends to exercise due process rights of appeal;

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

11.1.c. The provider violates federal, state, or local law relating to building, health, fire protection, safety, sanitation or zoning, or payment of worker's compensation or employment security taxes, and fails to remedy such violation given sufficient notice;

11.1.d. The provider conducts practices that clearly and seriously jeopardize the health or safety of consumers;

11.1.e. The provider fails or refuses to make medical or employment records reasonably related to compliance with this rule available within a reasonable period of time as requested by the secretary; or

11.1.f. The provider refuses to provide access to its service locations within a reasonable period of time as requested by the secretary.

11.2. Where the operation of a behavioral health or supportive service clearly constitutes an immediate danger of serious harm to consumers served by the program, the secretary may issue an order of closure terminating operation of the specific segment of the provider's program array clearly giving rise to the immediate danger of serious harm. A provider appealing such a closure order may continue to operate the specified service(s) pending exhaustion of administrative and/or judicial appeals.

11.3. Where a violation of this rule shall clearly result in an immediate danger of serious harm to consumers receiving services, the secretary may seek injunctive relief against any person, corporation, provider or government official through proceedings instituted by the Attorney General, or the appropriate county prosecuting attorney, in the circuit court of Kanawha County, or in the circuit court of any county where the consumer is residing or shall be found.

11.4. The secretary will assist the provider, consumer and DLR to develop alternative service arrangements should closure of a program or service result.

§64-11-12. Administrative and judicial review.

12.1. Any provider aggrieved by a decision of the secretary made pursuant to this rule shall contest the decision upon making a request for an informal dispute resolution within ten working days of receipt of notice of the decision.

12.2. Administrative and judicial review may be made in accordance with the provisions of article five, chapter twenty-nine-a of the State Code of West Virginia. Any decision issued by the secretary shall be made effective from the date of issuance.

12.3. Immediate relief may be obtained by the provider upon a showing of good cause

made by a verified petition to the circuit court of Kanawha County or the circuit court of any county where the affected provider shall be located.

12.4. The pendency of administrative or judicial review shall not prevent the secretary or a provider from obtaining injunctive relief as provided for in this rule.

§64-11-13. Access and eligibility.

13.1. The provider shall define its service population and the eligibility criteria for each of its services.

13.2. Provider policy shall state that the provider does not discriminate by race, religion, color, age, national origin or disability.

§64-11-14. Confidentiality and privacy protections.

14.1. The provider shall conform to all federal and state requirements with regards to the confidentiality of consumers served.

14.2. The provider shall have clearly stated procedures regarding the disclosure of information about consumers served that are in compliance with state and federal code. The provider shall assure that a release of information is completed in full, prior to signature, for it to be valid. A copy of the signed form shall be placed in the case record.

14.3. The provider shall prohibit use of photographs, videotapes, audio-taped interviews, artwork or creative writing for public relations or fund raising purposes without the informed consent of the consumer and/or DLR.

§64-11-15. Access to case records and information management.

15.1. Consumers and/or their DLR shall have access to their case records to the extent permitted by state and federal law.

15.2. The provider may require that sensitive psychological, psychiatric or other information be reviewed with the support of clinical staffs. The provider shall document the reason for the requirement.

15.3. The provider shall have policy and procedures that protect electronically maintained

data in compliance with federal standards.

§64-11-16. Research protections.

16.1. The provider shall have written policies regarding the participation of consumers in research projects if the provider engages in research activities.

16.2. Provider policy shall clearly state whether or not the provider conducts, participates in, or permits research involving persons served.

16.3. If a provider does research, it shall have a human subjects committee or an internal review board that reports to the chief executive officer or a designated authority with policymaking functions; and

16.3.a. Reviews research proposals that involve persons served;

16.3.b. Makes recommendations regarding the ethics of proposed or existing research;

16.3.c. Makes recommendations as to whether or not to approve research proposals; and

16.3.d. Establishes a minimum frequency for monitoring of ongoing research activities.

16.4. Each research participant or when appropriate his or her parent or DLR shall sign a consent form that includes:

16.4.a. A statement that he or she voluntarily agrees to participate;

16.4.b. A statement that the provider will continue to provide services whether or not he or she agrees to participate;

16.4.c. An explanation of the nature and purpose of the research;

16.4.d. A clear description of possible risks or discomfort;

16.4.e. A guarantee of confidentiality; and,

16.4.f. The signature of the consumer, parent or DLR.

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

§64-11-17. Grievance procedures.

17.1. Written policy and procedures shall provide consumers and their parent or DLR, if

appropriate, with a formal mechanism for expressing and resolving complaints and grievances. The policy shall contain timelines for resolution not to exceed sixty days from the filing of the grievance.

17.2. These procedures shall be available to consumers and their parent or DLR via paper or electronic means (such as posted on the provider's website).

17.3. The procedures shall:

17.3.a. Be given to consumers, and their parent or DLR if appropriate, upon request;

17.3.b. Include an internal appeal procedure and options for external appeal as provided by the secretary, to include any appropriate and relevant state and federal agencies;

17.3.c. Provide for a timely resolution of the matter and require a written response to the aggrieved that includes documentation of the response in the case record and administrative file; and

17.3.d. Indicate that grievances shall be filed either orally or in writing and that all staff (with the exception of the target of the grievance) of the provider are responsible for assisting any person who wishes to file a grievance.

§64-11-18. Consumer rights and responsibilities.

18.1. The provider shall inform all consumers and/or DLRs of their rights and responsibilities as specified in Chapter 27 of the West Virginia Code.

18.2. Information on rights and responsibilities shall be appropriate to each of the provider's services.

18.3. Notification shall reflect the consequences of noncompliance with programmatic rules, as well as limitation on individual rights occasioned by involuntary placement or court orders.

18.4. Providers shall inform all consumers of their rights and their responsibilities as consumers of services in a format that can be utilized and understood by the person and, as appropriate, his or her Designated Legal Representative (DLR).

18.5. All consumers and/or their DLRs, upon request, shall receive information about their rights and responsibilities that is:

18.5.a. Posted in a public area (as appropriate);

18.5.b. Provided in writing; and

18.5.c. Distributed during their initial contact with the provider during admission.

18.6. Each consumer's record shall contain documentation that the individual received an explanation of his or her rights and responsibilities as described in this rule, initialed by the consumer and/or DLR.

§64-11-19. Continuous quality improvement.

19-1. Each provider shall have a Continuous Quality Improvement process which shall be coordinated by a designated staff person.

§64-11-20. Safety review process.

20.1. Each provider shall implement a process to be utilized by the provider to oversee maintenance, repair and safety of all properties owned or leased by the provider. The entity responsible for safety shall evaluate the physical condition of the provider properties, identify any maintenance needs. Each provider location shall be reviewed at least annually.

§64-11-21. Case review process.

21.1. Each provider shall develop a process for reviewing the quality and adequacy of documentation of services in the consumer record. The provider shall apply a sampling method that does not regard funding source, and shall record the results of each review.

§64-11-22. Governing body.

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

22.2. The governing body shall be one of the following:

22-2-a. A Board of Directors in the case of a nonprofit or for-profit corporation;

22-2-b. A proprietor in case of a sole proprietorship;

22-2-c. Partners, in case of a partnership; or,

22-2-d. Any other entity as agreed by the secretary at time of licensure.

22.3. If the governing body is a board, all members of the board shall be provided:

22.3.a. A formal orientation to the provider and responsibilities of membership of the governing body, which shall be documented;

22.3.b. Annual reports of the programmatic and fiscal activities of the provider; and

22.3.c. Results of accreditation and/or licensure surveys.

22.4. If the Governing Body is a Board, it shall:

22.4.a. Identify in writing the mission of the provider and ensure the operation of programs and services to further the mission;

22.4.b. Review and approve the provider's annual budget;

22.4.c. Designate a chief executive officer and/or leadership staff and delegate authority to that entity to manage day-to-day operation of the provider;

22.4.d. Develop a policy regarding retention of minutes and records generated from all meetings, including members who were present or absent; and

22.4.e. Meet at least four times annually.

§64-11-23. Chief executive officer.

23.1. The chief executive officer shall:

23.1.a. Coordinate the development and implementation of policies governing the provider's program of services;

23.1.b. Coordinate the development and implementation of programs and services which further the mission of the provider;

23.1.c. Ensure that a written report is provided to the governing body at least annually regarding the provider's operations as they relate to the mission of the entity; and

23.1.d. Ensure a written report on the provider's financial condition and the results of case

review, safety and CQI processes is submitted to the governing body at least annually.

§64-11-24. Administrative file for the provider.

24.1. A provider shall make available upon request of the appropriate governmental reviewer. The following information and documents:

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

24.1.b. A mission statement;

24.1.c. The most recent audit or financial statement;

24.1.d. The provider's current organizational chart;

24.1.e. The name and position of persons authorized to sign agreements for the provider;

24.1.f. The governing body structure and its composition with names and addresses and terms of membership;

24.1.g. Existing purchase of consumer service agreements, if any;

24.1.h. Insurance coverage (all types) including bonding documents if appropriate; and

24.1.i. A copy of any Memoranda of Understanding with other service-related agencies or entities.

§64-11-25. Risk management.

25.1. The provider shall purchase or self-fund appropriate types of insurance including as appropriate, but not limited to: General liability, fire and theft, professional liability, officer's or director's liability, and automobile liability for provider owned or leased vehicles.

25.2. The provider shall ensure that all staff who handle or manage consumer funds, are bonded at the provider's expense or that the provider maintains appropriate insurance coverage to cover potential losses, unless the aggregate amount of consumer funds is less than $2500.

25.3. Parents acting in their legal capacity as conservators for their children or protected adults, even if employed by the provider, are not included in the requirement for bonding.

25.4. The provider may elect to self-insure but must guarantee replacement of losses of

consumer funds.

25.5. All bonding policies shall be adequate to replace the aggregate of consumer funds managed by the provider or if the provider elects to self-insure, there must be evidence of sufficient financial capacity to replace consumer funds.

§64-11-26. Transportation.

26.1. A provider that provides transportation in vehicles owned or leased by the provider for use with consumers as part of a service shall have procedures for ensuring:

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

26.1.b. Adequate passenger supervision relative to the ages, sexes, behavioral challenges and disabilities of the consumers being transported;

26.1.c. Proper and timely licensure and inspection of the vehicles;

26.1.d. First aid kits in each provider vehicle;

26.1.e. Proper and timely maintenance of vehicles;

26.1.f. That the number of persons in any vehicle used to transport consumers shall not exceed the number of available safety restraint systems;

26.1.g. Sufficient liability insurance;

26.1.h. Secure anchoring for wheelchairs except in automobiles; and

26.1.i. Annual validation of driver licenses of individuals driving vehicles that transport consumers.

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

§64-11-27. Legal compliance.

27.1. The provider shall comply with all applicable federal, state, and local laws, rules and regulations associated with all aspects of service delivery and operations and shall possess all necessary licenses.

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

§64-11-28. Security of information and consumer records.

28.1. The provider shall have policies and procedures regulating access to records of staff and consumers that are in compliance with all federal and state requirements. Regulatory agencies shall be allowed access to relevant service and employment information as necessary to fulfill their statutory duties.

28.2. The provider shall ensure that service and employment records, whether paper or electronic, are made available for inspection within normal business hours except in unusual or emergency circumstances.

28.3. The provider shall have procedures to protect service and employment records, whether in electronic or paper form, from destruction by fire, water, loss or other damage and from unauthorized access.

28.4. Written procedures shall govern the retention, maintenance and destruction of consumer records.

28.5. At a minimum, the provider shall retain consumer records for a minimum of five years from date of last service and for five years following a child's eighteenth birthday if service ends prior to that time. Conversion of paper records to an electronic copy and destruction of paper is acceptable.

28.6. The provider shall have a policy regarding disposal of records which respects confidentiality and security of consumer information.

28.7. The format of electronically transmitted data shall comply with legal standards and requirements.

§64-11-29. Contractual relationships.

29.1. If the provider arranges externally or contractually for the provision of consumer services, the provider shall have a written agreement which specifies:

29.1.a. Roles and responsibilities of the provider and the subordinate service provider;

29.1.b. A guarantee that the subcontracting provider shall obtain and provide copies of information regarding employees to demonstrate that the employee is in compliance with the regulatory and/or risk management needs of the provider.

29.1.c. Clinical documentation required of the subordinate service provider(s) with time lines for provision of the documentation;

29.1.d. Services to be provided;

29.1.e. Provision of appropriate liability or malpractice insurance either by the contractor or subordinate provider;

29.1.f. A general definition of the consumers to be served; and

29.1.g. That the subordinate provider shall adhere to state and federal requirements of confidentiality.

29.2. The provider shall maintain a file on each contracted subordinate provider, including:

29.2.a. Evidence of appropriate training, licensure or certification; and

29.2.b. Evidence of malpractice or liability insurance as specified in the contract.

§64-11-30. Financial management system.

30.1. The provider shall have a written budget, approved by the governing body if there is one, that shall serve as a plan for managing its financial resources for the fiscal year.

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

§64-11-31. Financial accountability for consumer funds.

31.1. A provider that assumes fiduciary responsibility for client funds shall have written operational procedures that ensure:

31.1.a. Separate individual accounting of funds with quarterly statements to the consumer and his or her DLR, if any. Funds managed on behalf of clients shall not be commingled with provider funds;

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

§64-11-32. Management of human resources.

32.1. Deployment and supervision of staff.

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

31.1.b. The provider shall identify an individual responsible for overall administration of the program for each site.

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

32.2. Personnel practices.

32.2.a. Upon employment, the provider shall train employees with regard to written policies and procedures pertaining to their employment and job responsibilities.

32.2.b. The provider shall have policies which shall comply with federal and state statutes, rules and regulations regarding employment practices.

32.2.c. The provider shall review with the applicant a written job description at the time of the interview and provide a copy of a written job description upon employment and upon significant changes in job assignment or responsibilities, provide a modified job description.

32.2.d. The provider shall submit a request for a Criminal Identification Bureau (CIB) records check and a Protective Services records check in the manner required by the secretary on each potential employee prior to working with consumers.

32.2.e. The provider may use applicants for employment prior to receiving the result of the records check under the following conditions:

32.2.e.1. The applicant's information has been submitted for clearance; and

32.2.e.2. The employee is informed in writing that final approval for employment is contingent upon the receipt of an acceptable CIB and/or other check as mandated by the secretary.

32.2.f. Provider policy shall prohibit employment of staff or utilization of volunteers or contractors with responsibility for care and supervision of consumers who have a history of convictions for or substantiation through the Protective Service or Office of the Inspector General systems of;

32.2.f.1. Abduction;

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

32.2.f.3. Child or protected adult abuse or neglect;

32.2.f.4. Crimes which involve the financial or other exploitation of a child or an incapacitated adult;

32.2.f.5. Felony arson;

32.2.f.6. Felony drug related offenses within the last ten years;

32.2.f.7. Felony DUI within the last ten years;

32.2.f.8. Hate crimes;

32.2.f.9. Neglect or abuse by a caregiver;

32.2.f.10. Pornography related crimes involving children or incapacitated adults;

32.2.f.11. Purchase or sale of a child; or

32.2.f.12. Sexual offenses including, but not limited to, incest, sexual abuse, or indecent exposure.

32.2.g. The provider may apply to the secretary for a written waiver of employment restrictions on a case by case basis depending on the particulars of the conviction or substantiation.

32.2.h. The provider shall have a policy and required training process for all employees

with regard to mandatory reporting of allegations of consumer abuse or neglect.

32.2.i. The provider shall have a written job description and selection criteria for each position or group of similar positions that includes the position's qualifications, and responsibilities and the title of the position's supervisor.

32.2.j. The provider shall designate a supervisor for each separate service or program. A supervisor may be responsible for more than one program.

32.2.k. The provider shall employ persons who are qualified according to the job description and selection criteria for the positions they occupy. A provider employing any person who does not possess the qualifications noted in the position's job description shall have a written statement justifying the individual's employment.

32.2.l. The provider shall verify the credentials of all employees and contractors providing client care, including:

32.2.l.1. Education and training;

32.2.l.2. Applicants without a high school diploma or GED must demonstrate competencies required of the job. The provider will have and follow a policy for these employees;

32.2.l.3. Relevant experience; and

32.2.l. 4. State licensing or certification for their respective disciplines, if any.

32.2.m. If the job description requires professional licensure or certification, but an employee under supervision for licensure or certification is employed in the position, the provider shall demonstrate that:

32.2.m.1. A person with requisite credentials provides supervision to the staff; and

32.2.m.2. The staff is actively working toward licensure and/or certification.

32.2.n. This requirement shall not be construed to apply to individuals performing job duties that would not normally require licensure or certification.

32.3. Volunteers.

32.3.a. The provider shall have a policy which specifies the roles and responsibilities that

volunteers shall assume.

32.3.b. The provider shall ensure that volunteers receive regular supervision to provide assistance, directions for activity and support.

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

32.3.d. The provider shall train volunteers concerning the responsibilities of the position and the time commitments required prior to formal assignment.

32.3.e. The provider shall formally train volunteers in confidentiality prior to beginning their duties and shall maintain documentation of the training.

32.3.f. The provider shall have a policy requiring volunteer screening, which shall include criminal and protective services background checks on all volunteers with responsibility for care and supervision of consumers, as required by department policy. Department policy shall address the background clearance of volunteers, including a clarification of those volunteers who should receive clearance and the process for doing so.

32.4. Students.

32.4.a. Students serving less than thirty hours per quarter shall be continually supervised by staff and shall not work alone with consumers.

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

32.4.c. Students serving an academic placement of more than thirty hours on site per three month quarter may work with consumers independently as defined by provider policy however the provider shall ensure that students receive regular documented supervision in order to provide assistance, directions for activity and support.

32.4.d. Students of this type shall receive training in abuse, neglect and mandatory reporting.

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

32.4.f. The provider shall formally train all students in confidentiality prior to beginning their duties and shall maintain documentation of the training.

32.5. Employee, volunteer, and student records.

32.5.a. The provider shall maintain current records for all employees and for students and volunteers working directly with consumers and spending regularly scheduled time in the provider's or consumer's locations. These records shall contain, as appropriate:

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

32.5.a.2. An application for employment or resume (for employees only);

32.5.a.3. A job description or contract;

32.5.a.4. Reference verification (for employees);

32.5.a.5. Documentation of education and/or licensure or certification (for employees);

32.5.a.6. Documentation of relevant education or experience as appropriate;

32.5.a.7. Documentation of orientation and required trainings;

32.5.a.8. Documentation of criminal and protective services background checks for employees and volunteers and students as required by the secretary; and

32.5.a.9. Documentation relating to performance, including disciplinary actions and termination summaries.

32.5.b. Each employee shall have a record, stored separately, containing the employee's results of random drug screens if required by provider policy.

32.5.c. The files shall be secured in a confidential manner with limited access.

32.5.d. Students touring, observing or on site less than thirty hours per three month quarter are not included in the requirements of this section.

32.6. Disciplinary reviews and termination. The provider shall have a policy which

delineates procedures governing disciplinary actions and nonvoluntary termination of staff.

32.7. Orientation of new staff.

32.7.a. The provider shall ensure that all new clinical staff receive an orientation within the first ten days of employment and shall document that orientation in the individual's personnel record. The orientation shall include an introduction to the staff person's primary job responsibilities and requirements.

32.7.b. Within the first thirty days of employment or initiation, the provider shall also train all new staff in:

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

32.7.b.2. Its services, policies and procedures pertaining to the employee, contract clinician, student, or volunteer's job responsibilities;

32.7.b.3. An organizational chart that delineates lines of accountability and authority pertaining to the employee, contract clinician, student, or volunteer's job responsibilities;

32.7.b.4. The provider's policies and procedures on consumer confidentiality and disclosure of information, including penalties for violation of these policies and procedures and an orientation to federal confidentiality requirements as they apply to the provider;

32.7.b.5. Consumer rights;

32.7.b.6. Universal precautions;

32.7.b.7. Training on identification of abuse and neglect and mandatory reporting procedures;

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

32.7.b.9. Sensitivity to differences in cultural norms and values;

32.7.b.10. Proper documentation procedures;

32.7.b.11. CPR, the abdominal thrust and first aid; updated as required;

32.7.b.12. Fire drills and evacuation procedures (if applicable); and

32.7.b.13. Procedures regarding medical or other emergencies (if applicable).

32.7.c. Additionally, except for outpatient clinical staff providing only clinic behavioral health services, program staff with direct care responsibilities in-home or site-based programs shall be trained within thirty days upon:

32.7.c.1. Psychiatric emergency procedures and management including systematic de-escalation;

32.7.c.2. Blood borne pathogens; and

32.7.c.3. Infection control.

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

32.9. The provider shall document all training provided to staff.

§64-11-33. Service environment.

33-1. Safety and Environmental Quality.

33-1.a. The provider shall provide services in an environment (buildings, grounds and equipment) that meets all applicable federal, state and local health, building, safety and fire codes unless the location for provision of service is the consumer's home or another community based location not owned or leased by the provider.

33-1.b. All structures and equipment owned or leased by the provider shall be maintained free from danger to health and safety.

33-1.c. Facilities and buildings owned, leased or rented by the provider for use with consumers shall be clean, safe, accessible, and appropriate for the needs of the consumer.

33-1.d. The provider shall post by the telephone in all provider owned or leased direct care and residential service locations emergency telephone numbers for the fire department, poison control hotline, and local police.

33-1.e. Buildings owned or leased by the provider shall be in compliance with Title III of the Americans with Disabilities Act unless otherwise exempted.

33-1.f. All buildings owned, leased, or rented by the provider for consumer use shall

conform to the current Life Safety Code of the National Fire Protection Association, unless exempted by the State Fire Marshal.

33-1.g. The provider shall have documentation that the facilities owned or leased by the provider and used for services are in substantial compliance with the State Fire Code. That evidence shall be renewed as required by the State Fire Marshal.

33-1.h. The provider shall have fire extinguishers reviewed by a qualified professional annually.

33-1.i. All power driven equipment used by a facility shall be kept in safe and good repair. The equipment shall be used by consumers only under the supervision of a staff member.

33.2. Food services

33.2.a. If food services are provided or if food is managed by the provider in a consumer residence owned or leased by the provider, food shall be stored, prepared and served in a sanitary manner.

33.2.b. Where applicable, The provider shall conform to the requirements for food service as specified by the Department's rule, "Food Establishments", 64CSR17.

§64-11-34. Compliance with legal, health and regulatory requirements.

34.1. Emergency planning and response.

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

34.1.a.1. Address the needs of any special population served by the provider;

34.1.a.2. Specify evacuation procedures including an evacuation site, parties to notify, and emergency items to take when evacuating;

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

34.1.a.4. Specify appropriate responses to medical emergencies.

34.1.b. The provider shall have procedures in place for dealing with consumers or other individuals who threaten violence or harm to themselves or others including staff and other consumers.

34.2. Medication control and administration.

34.2.a. Prescription Medication shall be prescribed and monitored by a licensed physician, dentist or physician's assistant or nurse practitioner. Contracted medical staff functioning on the provider's premises is responsible for complying with provider policies and procedures. The physicians and other staff shall have files containing the materials or information specified in this rule.

34.2.b. Providers that administer medication using approved medication assistive personnel shall comply with the department's rule, "Medication Administration by Unlicensed Personnel", 64 CSR 60.

34.2.c. When medication is administered by the provider, the organization shall ensure that there is an individual record for those consumers who receive medications to include:

34.2.c.1. Medications administered;

34.2.c.2. The date medications were administered;

34.2.c.3. The time of administration (medications are to be administered within one hour of the prescribed time unless otherwise allowed by physician's order); and

34.2.c.4. The individual administering the medication; and

34.2.d. A record of missed medications and the reason. Prescription medications administered by the provider shall be properly labeled and packaged and include:

34.2.d.1. The name of the person served;

34.2.d.2. The route of administration;

34.2.d.3. The dosage and the name of the medication;

34.2.d.4. The name of the prescribing physician; and

34.2.d.5. An expiration date.

34.2.e. The provider shall have written procedures that govern:

34.2.e.1. The safe disposal of discontinued, out-of-date or unused medications, syringes, medical waste or medication; and

34.2.e.2. Provision for locked, supervised storage of medications with access limited to authorized staff.

34.2.f. Medication samples are considered to be the property of the provider. Samples shall be stored in a systematic fashion in a locked area with limited access to unauthorized staff or consumers. The provider shall document distribution of sample medications in the consumer medical record.

34.2.g. If a provider both prescribes and administers medications, only licensed nursing staff shall accept verbal orders for changes in medication regimens. These shall be signed by the prescribing physician within one week.

34.2.h. A registered or practical nurse shall be responsible for:

34.2.h.1. Generating and reviewing monthly Medication Administration Records;

34.2.h.2. Matching physician's orders or prescriptions to the medication administration records;

34.2.h.3. Assisting interdisciplinary teams to develop educational goals for consumers taking regularly prescribed medications and participating in a supervised self-administration protocol as identified in the consumer's plan for services;

34.2.h.4. Instructing staff in dietary or medication administration issues as necessary; and

34.2.h.5. Responding to emergency calls from staff on medical issues.

34.2.i. Medications shall be self-administered under supervision of staff under the following conditions:

34.2.i.1. As part of the consumer's plan of care, he or she is taught to identify his or her medications, recognize possible side effects, describe the purpose for the medication and indicate the time of day and frequency of which he or she is to take the medications;

34.2.i.2. The consumer is assessed by either a registered nurse, physician or licensed psychologist as being cognitively capable of learning these skills;

34.2.i.3. Medication is kept in a secure location with access limited to staff only except at dosage times;

34.2.i.4. Staff is fully trained as to the purpose, most common side effects and dangers of each medication prescribed for consumers in the facility or home, and can identify each medication on sight or have access to mechanism for which to identify; and

34.2.i.5. Staff is trained in emergency procedures for overdose or adverse reactions.

34.2.j. Delivering and monitoring medications in a consumer's place of residence:

If a provider delivers medications to a consumer on a regular basis, the provider must:

34.2.i.1. Document delivery date, time, person receiving and name of medication delivered including amount delivered;

34.2.i.2. Ensure that if there are children or other incapacitated adults in the home, medications are at least initially stored properly in secured containers;

34.2.i.3. Provide medications in properly packaged format as required by Chapter 30, Article 5 of the West Virginia Code; and

34.2.i.4. Develop a system of monitoring the consumer's compliance with consumption of medications that is created with the permission and participation of the consumer. This system may consist of the consumer logging consumption of his or her own medications. The consumer has the right to refuse participation in a monitoring system however the provider may then refuse to deliver medications to the consumer's residence and/or make alternative arrangements for the provision of medications.

§64-11-35. Services.

35.1. Admission.

35.1.a. The program must be appropriate for the needs of the consumer.

35.1.b. If after the consumer is admitted, the program is unable to meet his/her needs,

the provider shall discharge the consumer and is responsible for referral of the consumer to an alternative level of care and/or provider.

35.2. Assessments/intake procedures.

35.2.a. Each consumer entering or reentering a provider program shall have an assessment by an appropriately qualified staff person (as identified by the provider credentialing committee or officer) prior to or within forty-eight hours of admission.

35.2.b. Assessments from other provider entities are acceptable if comprehensive and performed within the past sixty days.

35.2.c. A consumer reentering a program within a twelve month period may receive an abbreviated assessment. A consumer entering a program based on an assessment performed by another agency within the past sixty days may receive an abbreviated assessment. These assessments and updates must be available in the consumer record.

35.2.d. The initial assessment shall review the consumer's psychiatric and psychosocial history, history of medical and psychiatric treatment, current mental status, current medical and psychiatric status with regard to health and medications prescribed, evaluation of suicidal or homicidal ideation, presenting problems as identified objectively and subjectively, and summarize the consumer's needs and preferences.

35.2.e. An abbreviated assessment shall review the current mental status, presenting problems identified objectively and subjectively, current medical and psychiatric status with regard to health and medications prescribed, and a summary of consumer needs and preferences.

35.2.f. The consumer's plan of services shall be based on the most recent assessment.

35.2.g. The consumer's assessment must record any reported life-threatening medical conditions, allergies, or dietary restrictions. The plan for services must define the provider's responsibility in management of such conditions, if any, while the consumer is on the provider's site or under the provider's supervision. The notification must be posted in the record in a way that is accessible to all staff working with the consumer or there must be documentation that staff

has been advised of such conditions.

35.3. Planning for services.

35.3.a. The provider shall ensure each consumer has a plan of service in a format consistent with the type of service the consumer receives. The plan of service shall be reviewed at intervals specified by provider policy and updated or modified as necessary.

35.3.b. The consumer shall have the right and the responsibility to participate in the development of the plan of services to the extent that the consumer is willing and medically and behaviorally able.

35.3.c. If the consumer has an advanced psychiatric directive, the provider shall honor the directions provided in the advanced directive to the best of the provider's ability.

35.4. Participation of the DLR in planning for services.

35.4.a. The provider must obtain permission from the DLR prior to initiating treatment except in emergent conditions.

35.4.b. If the consumer has a DLR whose scope of responsibility appropriately includes assisting in and/or directing planning for services for the consumer, the provider is responsible for documenting that the DLR has been informed of all meetings and activities regarding planning. The provider must document a good faith effort to involve the DLR in the planning and review processes. The DLR is entitled to participate in the manner he or she chooses, including by telephone or video conference.

35.4.c. If the provider has documented attempts to involve the DLR in the planning process without success, the provider may continue the current plan for service for up to thirty days past its expiration date while alternative plans are made to meet the needs of the consumer or to obtain DLR permission.

35.5. Clinic behavioral health services.

35.5.a. If the consumer is receiving only clinic behavioral health services from the provider, the provider shall ensure the health care professional responsible for the service has a

treatment strategy that is reasonable and appropriate given the consumer's initial and on-going assessments.

35.5.b. The strategy must be described in documentation of each consumer contact.

35.5.c. Documentation of clinic behavioral health services shall include:

35.c.1. A subjective and objective assessment of the consumer, including a description of any recent unusual events that may have an impact on the consumer's treatment;

35.c.2. An assessment of the effectiveness of the treatment approach; and

35.c.3. A plan to continue or modify the treatment approach as necessary.

35.d. Each consumer receiving a service shall have a plan of services, except as described above.

35.6. Initial plan of service.

35.6.a. When the consumer is admitted to a provider agency, he or she shall have an initial plan of service at the conclusion of the admission process.

35.6.b. This plan shall consist of the following at a minimum:

35.6.b.1. Description of any further assessments or referrals that may need to be performed;

35.6.b.2. A listing of immediate interventions to be provided along with some basic objectives for the interventions;

35.6.b.3. A date for development of an expanded plan of services. The designated date must be appropriate for the planned length of service but at no time will that exceed thirty days from the date of the signing of the initial plan; and

35.6.b.4. The signature of the consumer and/or DLR, intake worker, and other persons participating in the development of the initial plan. If a party is participating by phone, video or other means a notation on the plan is acceptable.

35.7. Expanded plan of services.

35.7.a. The expanded plan of services is developed when a consumer is receiving a

variety of services from a single provider provided that if all services are clinic behavioral health services, no expanded plan is required.

35.7.b. The expanded plan shall relate directly to the consumer's initial and/or any subsequent assessments or information regarding the consumer, shall include all services provided to the consumer by the provider developing the plan, and shall consist of the following:

35.7.b.1. Date of development of the plan;

35.7.b.2. Participants in the development of the plan;

35.7.b.3. A statement or statements of the goal(s) of services in general terms;

35.7.b.4. A listing of specific objectives relating to each goal unless the services are supportive in nature;

35.7.b.5. The measures to be used in tracking progress toward achievement of an objective, unless the services to be provided are supportive services;

35.7.b.6. The technique(s) and/or services to be used in achieving the objective unless the services are supportive;

35.7.b.7. Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives; and

35.7.b.8. A date for review of the plan.

35.7.c. The date for review shall be reasonable given the projected duration of treatment but at no time shall exceed one hundred eighty days days.

35.7.d. Selected objectives may be reviewed earlier than the scheduled plan review as desired by the consumer or provider.

35.7.e. Plans for supportive services are incorporated into the expanded plan of service and shall include:

35.7.e.1. Services to be provided;

35.7.e.2. How often;

35.7.e.3. By whom; and

35.7.e.4. The objectives of the support.

35.7.f. Objectives of supportive services may be stated in simple terms and outcomes need not be stated in measureable terms. Maintenance of health, daily living skills or functionality may be an objective for a supportive service.

35.7.g. If the consumer is receiving only supportive services, the plan shall be reviewed at a minimum of each one hundred days. Date of the planned review shall be recorded on the plan for services.

35.8. Multiprovider comprehensive plans of service.

35.8.a. If a consumer is receiving a combination of behavioral health and/or supports services from a team of provider agencies, the consumer shall have a comprehensive plan of services.

35.8.b. All providers participating in the provision of service to the consumer shall be represented in the development of the comprehensive plan, as shall the consumer and/or DLR as appropriate. Representation shall be documented by signature of the parties involved in the development of the comprehensive plan.

35.8.c. The team must be made aware of any advanced directives made by the consumer or any instructions for care imposed by the DLR. These directives must be included as an addendum to the plan.

35.8.d. Unless the team decides otherwise, comprehensive plans are completed by a service coordination provider who is responsible for tracking the implementation of the plan and organizing the reviews of the plan and subsequent modifications. The service coordination provider must be identified in the plan.

35.8.e. The comprehensive plan must clarify which provider agency is responsible for each aspect of the plan. Objectives for behavioral health treatment, habilitation and rehabilitation services must be specific and measured, as described in section.

35.8.f. It is the responsibility of the service coordination provider to ensure that each

member of the provider team including the consumer and/or DLR has a copy of the plan within seven working days of its completion.

35.8.g. The comprehensive planning process shall culminate in an agreed date for review of progress in reaching the objectives described in the plan.

35.9. Reviews of plans of service.

35.9.a. The review shall be documented and shall consist of examination by the team or provider of progress toward achievement of an objective using the measurements described in the plan or in the case of supportive services, an evaluation of achievement of maintenance objectives.

35.9.b. The consumer and DLR is expected to be present at the scheduled review. If the consumer and/or DLR are not present, the reason for holding the review in their absence shall be documented and for good cause.

35.9.c. The provider shall modify objectives and/or goals if the planned interventions have not produced evidence of improvement or maintenance, if such is the stated goal, within an amount of time to be identified in advance by the clinical team.

35.9.d. The goals or objectives on a plan may be modified if desired by the consumer or DLR.

35.9.e. At the conclusion of the review, a date shall be set for the next review. Revisions to the behavioral health service plan shall be made if necessary or a new plan may be developed.

35.10. Critical treatment junctures.

35.10.a. The provider and consumer shall meet to review and modify the consumer's treatment or supports services at a critical treatment juncture.

35.10.b. The team may decide to review all of the plan of services, or only a segment of the plan of services. Regardless of the extent of the review, it must be documented and a date identified for the subsequent review of the plan in its entirety, not to exceed one hundred eighty days from the last review of the entirety of the plan.

35.10.c. The consumer and/or the DLR should be provided with a copy of the plan for services and any review documents.

35.10.d. If a critical treatment juncture occurs for a consumer who has a comprehensive plan for services, the members of the team must be informed of the situation and participate in a decision regarding the need for the team to meet. Participation in this decision may be by telephone or other electronic or digital method.

35.11. Discharge planning.

35.11.a. Each provider shall have a policy and procedure regarding discharge of the consumer from services.

35.11.b. Such policies shall promote an organized transition to another provider, level or type of care or to full independence from treatment/support.

35.11.c. With consumer and/or DLR permission, the provider is responsible for ensuring that sufficient information is provided to an alternative provider to enable a smooth transition of care.

35.11.d. The provider is responsible for offering transitional services within the financial and staff resources available. If the consumer is an incapacitated adult, the transitional services should be individualized and delivered in a manner that facilitates the individual's movement from one health care setting to another.

35.12. Special services and populations. If a provider provides specialized services to a unique population the provider shall ensure that:

35.12.a. The service and clinical model reflects knowledge and use of research based and theory guided practices;

35.12.b. Clinical and professional staff are appropriately trained, certified and/or licensed in the area of service provided;

35.12.c. Direct care staff are trained to understand issues in clinical treatment of the population and able to use suitable intervention techniques when necessary and appropriate;

35.12.d. The environment and milieu of the treatment location is clinically, structurally and developmentally appropriate for the population served; and

35.12.e. The facility is consistent with the consumer's treatment plan. In cases in which a staff ratio is not specified in the consumer's plan of care, the provider shall assure that sufficient staff is present to enable consumer safety.

§64-11-36. Abuse, neglect and critical incidents.

36.1. The provider shall report, investigate monitor and remediate consumer-related incidents in a manner consistent with minimum current guidelines, "Reporting and Investigation Guidelines for Incidents involving a Licensed Behavioral Health Services and Supports Provider", set forth by the secretary and made available by the secretary to providers and the public.

36.2. These guidelines shall be amended as necessary through a participative process including consultation with providers and consumers and other stakeholders.

36.3. The provider's policy regarding abuse and neglect may allow the provider a range of remediation alternatives with the employee depending upon the severity of the incident and the possibility of successful remediation.

36.4. These guidelines represent a minimum standard of investigation and correction. Third party payers or providers may voluntarily require a more stringent level of correction.

36.5. Incidents shall be evaluated by the provider's designated representative and classified as one of the following:

36.5.a. An allegation of abuse and/or neglect;

36.5.b. A critical incident; or

36.5.c. An incident requiring provider monitoring and correction.

§64-11-37. Abuse and neglect.

37.1. WV Code 9-6-11(a) and WV Code 49-1-201 require that upon notification that an incident has occurred, the provider immediately report the neglect, abuse, and/or suspected neglect or abuse of an incapacitated adult or a child, or an emergency situation representing

hazard to such an adult or a child to the secretary's local protective services agency.

37.2. Additionally, a provider shall immediately report the neglect, abuse, and/or suspected neglect or abuse of any consumer who receives services from a provider licensed under the conditions of this rule. This requirement mandates self-reporting of neglect, abuse, and/or suspected neglect or abuse by the servicing provider.

37.3. The initial report shall be made by telephone followed by a written report by the complainant or the receiving agency within forty-eight hours.

37.4. All employees of a provider are considered to be mandatory reporters as defined in section 9-6-11.

37.5. A consumer has the right to report any suspicion of abuse or neglect to civil and criminal authorities in accordance with the adult protective services act, in addition to using the grievance procedure of the provider.

§64-11-38. Critical incident.

38.1. The provider must keep a central file of critical incidents for review by the secretary upon request.

38.2. The file shall contain a description of the incident, actions taken by the provider to mitigate the incident and, at minimum, a description of systemic corrective action taken by the provider, if any, as a result of the provider investigation, utilizing unique but confidential consumer identifiers.

38.3. In the case of a critical incident involving an incapacitated adult, the provider shall follow department policy with regard to reporting such events to the secretary.

§64-11-39. Noncritical incidents.

Noncritical incidents must be documented, reviewed by a supervisory staff person, investigated if necessary and filed in the central investigation file.

§64-11-40. Quality assurance.

The provider shall ensure that the central file of reports of abuse, neglect, critical and

noncritical incidents is reviewed, collated by the Continuous Quality Improvement Committee or staff person and reported to the governing body on an annual basis. The file should be representative of efforts by the provider to utilize information to improve provider policy, procedure, or performance.

§64-11-41. Injuries of unknown source.

41.1. An injury should be considered an “injury of unknown source” when:

41.1.a. The source of the injury was not witnessed by any person and the source of the injury could not be explained by the consumer; and

41.1.b. The injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

41.2. Minor occurrences which are not of serious consequence to the individual and do not present as a suspicious or repetitive injury (as discussed above) should be recorded by the facility staff once they are aware of them and follow-up should be conducted as indicated.

41.3. If, however, the injury meets both criteria listed above, the injury or injuries must be reported and investigated as required by the secretary.

41.4. For injuries that do not rise to the level of reportable “injuries of unknown source”, the facility should follow its policies and procedures for monitoring and trending such occurrences.

§64-11-42. Management of continued inappropriate behavior.

42.1. The provider shall have a policy for management of regularly occurring inappropriate behavior on the part of incapacitated or minor consumers.

42.2. The functional assessment may result in informal environmental alterations and/or in the development of a written plan for intervention.

42.3. Only trained staff may be responsible for performing functional assessments of behavior and developing and monitoring plans for intervention.

42.4. Implementing staff shall be oriented to and fully trained on all behavior management plans for consumers with whom they are working. Training shall include demonstration of the procedures to be utilized.

42.5. Behavioral interventions shall:

42.5.a. Be planned and approved by the service planning team;

42.5.b. Be individualized, consumer-centered, capable of implementation within the resources available and applied consistently in all environments managed by the service team;

42.5.c. Be based on a functional assessment of the inappropriate behavior;

42.5.d. Utilize positive behavior techniques that focus on replacing inappropriate behaviors with more productive prosocial behaviors;

42.5.e. Be based on fundamental principles of behavior;

42.5.f. Be data-based and monitored on an on-going basis; and

42.5.g. Be amended in a timely fashion if necessary.

42.6. The following aversive consequences are not to be utilized by providers:

42.6.a. Corporal punishment;

42.6.b. Deprivation of basic human rights;

42.6.c. Treatment of a demeaning nature;

42.6.d. Noxious or painful stimuli; and

42.6.e. Deprivation of nutrition or hydration, excluding dietary or fluid restrictions ordered by a physician.

42.7. Restraint techniques shall only be incorporated into a behavioral intervention if it is used as an intervention of last resort and only when the targeted behavior is immediately dangerous to the consumer or others in the environment.

§64-11-43. Emergency management of potentially dangerous behavior.

43.1. The provider shall have in place policies and procedures regarding emergency management of potentially dangerous consumer behavior.

43.2. Seclusion is not an intervention permitted in any licensed community-based program, with the exception of a psychiatric residential treatment facility for children and/or youth.

43.3. Staff shall be trained and able to demonstrate competency in systematic de-escalation procedures as part of orientation. Training shall be renewed at intervals determined by provider policy.

43.4. Staff must have education, training and demonstrated knowledge based upon the specific needs of consumers being served. Training will consist at a minimum of:

43.4.a. Techniques to identify staff and consumer behaviors, events and environmental factors that may trigger potentially dangerous behavior;

43.4.b. Use of nonphysical intervention skills;

43.4.c. Selection of least restrictive/least intrusive intervention based on individualized assessment, and

43.4. Safe application of restraint as a last resort if provider policy allows restraint as an intervention.

43.5. Physical, mechanical or chemical restraints may be used only as a last resort for the management of dangerous, violent or self-destructive behavior that is an immediate threat to the consumer's physical safety or the safety of others in the immediate environment.

43.6. A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, lap belts on wheel chairs utilized for support, or other methods that involve the physical holding of a consumer for the purpose of conducting routine physical examinations or tests, or to protect the consumer from falling out of bed, or to permit the consumer to participate in activities without the risk of physical harm.

43.7. All supportive or protective devices should be assessed by the team for safety and appropriateness at annual intervals or more frequently as determined by provider policy.

43.8. Redirection through physical prompting and/or hand over hand instruction is not to be considered a restraint.

43.9. Restraint may only be used when less intrusive interventions have been exercised and determined to be ineffective to protect the consumer or others from harm. No restraint may be utilized for more than a half hour without review of the consumer's condition by an agency designated staff.

43.10. The use of restraint must be implemented in accordance with safe and appropriate techniques.

43.11. The restraint must be discontinued at the earliest possible time.

43.12. Documentation in the consumer's record must include the following:

43.12.a. A description of the consumer's behavior and the danger it posed to self or others;

43.12.b. A description of the alternatives or other less intrusive interventions that were attempted prior to the restraint;

43.12.c. A description of the intervention used, including the duration of the restraint if physical or mechanical or dosage if chemical; and

43.12.d. The consumer's response to all the intervention(s) used.

43.13. Debriefing of the restraint is a required aspect of provider policy with regard to restraints.

43.14. If a consumer receiving extended services exhibits a behavior which is immediately dangerous to him or herself and/or others at a rate of three or more times in a six month period, the provider shall consider convening the clinical team to develop a written plan for behavioral intervention.

§64-11-44. Medical/dental procedures for incapacitated adults and children with developmental disabilities.

44.1. Whenever possible, a desensitization procedure should be developed in advance to prepare incapacitated adults and children with developmental disabilities for a medical or dental procedure.;

44.2. If the desensitization procedure is not successful in easing the consumer's agitation, anxiety or fear, medicinal interventions are to be used in preference to mechanical restraints unless otherwise agreed by the clinical team;

44.3. All efforts to prepare and manage a consumer during a medical or dental procedure should be documented in the consumer's medical record.

§64-11-45. Special programs.

Special programs shall have additional standards of implementation as follows:

§64-11-46. Standards for respite and personal attendant services.

46.1. Staff providing respite and personal attendant services must receive the following training or orientation prior to assuming care of a consumer:

46.1.a. Specific information pertaining to the needs, preferences and medical issues of the consumer for whom the staff is assuming care;

46.1.b. List of tasks for which the personal attendant or respite provider is responsible, including any unusual circumstances that could reasonably be predicted in advance;

46.1.c. List of emergency contacts including emergency contact number for primary caregiver and for staff supervisor;

46.1.d. Training in any specific protocols contained within the consumer's plan for services as appropriate;

46.1.e. Review of mandatory reporting obligations;

46.1.f. Any emergency procedures unique to the consumer and his/her medical or behavioral needs;

46.1.g. Orientation to the consumer's home or other service location; and

46.1.h. Boundary definition with regards to the relationship of staff to primary caregiver, other family members, chain of supervisory responsibility, appropriate use of consumer resources such as food or equipment, other issues as necessary and appropriate.

46.2. Supervision of the respite or personal attendant employee shall be the responsibility

of the employing agency with regular input and consultation by the primary caregiver and/or consumer. The agency shall provide on-site supervision of staff on a regular schedule as described by agency policy with the permission of the consumer and/or primary caregiver. Supervision activities shall be documented by the agency.

46.3. If the respite or personal attendant service is provided at a location away from the consumer's primary residence, the location must be safe and free from immediate threat of harm to the consumer. The location must consider the needs and preferences of the consumer and his/her primary caregiver.

46.4. The respite and/or personal attendant provider is responsible for complying with applicable services or conditions outlined in the consumer's plan for services during the time in which the staff person is providing services for the consumer.

46.5. Documentation must include:

46.5.a. Any unusual incidents or events occurring during the period;

46.5.b. A summary of the activities of the consumer during the period;

46.5.c. Any health or behavioral issues which were of significance during the period; and

46.5.d. Any medications that were taken by the consumer during the period.

§64-11-47. Standards for residential services.

47.1. The provider must ensure that in home staff has access to twenty-four hour emergency telephone contacts for supervisory staff and for parents/guardian.

47.2. The provider shall ensure that in home staff has knowledge of mandatory reporting procedures and the reporting number must be easily available in the home.

47.3. Staff must be trained in emergency evacuation procedures.

47.4. The provider shall ensure availability in the home of commonly needed company policies and procedures for staff reference. The provider shall have a policy which identifies those sections of the provider staff manual that will be available in the homes.

47.5. The provider is responsible for training staff to be supportive of consumer:

47.5.a. Needs and preferences;

47.5.b. Behavioral and health management issues; and

47.5.c. Privacy.

47.6. The provider shall have a process in place to address consideration of appropriate blending of consumer populations with regard to sex, developmental age, activity level and consumer preferences in congregate living situations.

47.7. The service environment shall be appropriate to the physical and health needs of consumers and shall be safe from threat of immediate harm for consumers and staff.

47.8. The provider will use reasonable efforts to monitor and facilitate the consumer's health within the resources available to the consumer.

47.9. The provider is responsible for linkage and referral to address the consumer's acute medical and psychiatric health concerns.

47.10. A referral must be made for basic primary care at least once per year.

47.11. Health considerations should be incorporated into a residential consumer's plan of services and providers shall be responsible for advocating that unmet needs be addressed if possible. The service coordination agency shall be responsible for advocacy if the consumer has a service coordinator.

47.12. If appropriate, the provider shall assist the consumers in the service environment to develop a homelike atmosphere that addresses the preferences of the individuals residing in the environment, taking into consideration the financial resources of the residents.

47.13. The provider shall have a process in place for facilitating choices of activity and home management that respects the needs and preferences of the residents. The provider shall promote consumer choices and control within the household to the degree possible and clinically appropriate.

47.14. The provider shall develop and maintain a process for communication from one shift of staff to the next that conveys information necessary to conduct business in the home.

Additionally the provider shall supply a method of communicating information regarding consumers from one shift to the next in a confidential manner. Such communication shall include:

47.14.a. Any unusual incidents or events occurring during the shift;

47.14.b. Any health or behavioral issues which were of significance during the shift; and

47.14.c. Any medications that were taken by the consumer(s) during the shift.

47.15. If the home is owned or leased by a provider, it must have:

47.15.a. Adequate bedroom and living space for the number of consumers living within the home;

47.15.b. Private space for storing personal items for each consumer;

47.15.c. Adequate heating and cooling;

47.15.d. External windows in consumer bedrooms;

47.15.e. Hinged doors in bedroom doorways; and

47.15.f. Appropriate access for physically handicapped or challenged consumers.

47.16. If the home is owned or leased by the consumer or DLR, the provider will respect the consumer's choice of living environment and resources while advocating for adequate housing and living conditions, provided that nothing obligates the provider to supply services in an unsafe environment. If the provider suspects that an incapacitated consumer is living in unsafe conditions, the provider is obligated to conform to statutes regarding mandatory reporting.

§64-11-48. Standards for clinic behavioral health service.

48.1. Staff providing clinic behavioral health services shall be credentialed by the provider's credentialing committee or officer.

48.2. Each provider of clinic behavioral health services must develop and maintain a working credentialing committee composed of experienced licensed and/or certified staff representative of the disciplines or practitioners within the agency. A provider agency with few clinical staff may designate a credentialing officer. This committee or officer is responsible for overseeing and assuring the following activities:

48.1.a. Written criteria shall be developed for each type of service provided.

48.1.b. These criteria must identify the required education, licensure, certification, training and experience necessary for each staff person to perform each type of service. These criteria must be age and disability specific to populations served as well as ensuring that staff has demonstrated competency to provide the services rendered.

48.1.c. All documented evidence of credentials such as educational transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. shall be reviewed by the committee or officer. Based on this review, the committee or officer shall determine which services staff are qualified to provide. Documentation of the credentials review must be filed in each staff person's personnel file.

48.1.d. All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) shall be maintained in staff personnel records.

48.1.e. Staff must be assigned job responsibilities that are within the scope of practice delineated by the credentials committee or officer.

48.1.f. Providers shall develop standards for staff training and continuing education, supervision and compliance monitoring.

48.1.g. All episodes of provision of clinic behavioral health services shall be documented. Documentation shall be sufficient to demonstrate:

48.1.a.1. That treatment, habilitation or rehabilitation is based on the needs identified in the initial or on-going assessments;

48.1.a.2. The response of the consumer to treatment, habilitation or rehabilitation activities (preferably provided in both subjective and objective terms and in the case of habilitation or rehabilitation activities, data); and

48.1.a.3. Adjustments are being made to the treatment, habilitation or rehabilitation approach as necessary and appropriate.

§64-11-49. Standards for twenty-four hour programs requiring medical monitoring.

49.1. The provider must supply adequate staff monitoring of individuals in the program either through “eyes on” or technological methods. The initial plan of services will detail the necessary monitoring which may be modified on an on-going basis as treatment moves forward and the plan of services is revised.

49.2. A medical staff person such as a physician extender, registered nurse or licensed practical nurse functioning within his or her scope of practice must evaluate each patient in the program each shift unless the physician documents no further need for medical monitoring, provided that no such order can occur until the consumer has been in the program for twenty-four hours.

49.3. The provider must have a policy regarding the face to face or telemedicine availability of medical staff to directly observe the patient after hours within thirty minutes as necessary and appropriate unless an arrangement is made for alternative medical care.

49.4. Programs providing medical stabilization must provide or arrange to obtain prescribed psychotropic and general medical medications after initial review by admitting medical staff with prescriptive authority.

49.5. Programs providing medical stabilization must assist consumers in obtaining needed medications as part of discharge planning. The provider shall have a policy with associated procedures regarding the ability of consumers to retain personal medications if discharged against medical advice.

§64-11-50. Standards for nonmethadone medication assisted programs for addictions and cooccurring disorders.

50.1. The provider must ensure that the program format includes initial and random urine or saliva drug screening as part of the plan of service. Frequency of screening will be defined by provider policy and in the plan of service, however screens must be comprehensive (eight to twelve substances) and include the substance being prescribed by the program.

50.2. Individual and group therapy must be an integral aspect of the program plan of service. The ratio of individual and group must be individually determined by the needs of the consumer.

50.3. Prescription of benzodiazepine medications for individuals in medication assisted programs is strongly discouraged. Cooccurring use of benzodiazepines must be justified in the clinical record by a physician.

50.4. Standards for Intensive community-based stabilization and maintenance programs:

50.4.a. The multidisciplinary team providing the services must include medical participation or regular consultation.

50.4.b. Consumers must be provided the majority of their services in their own homes by appropriately trained and qualified staff in order to promote and sustain generalization of learning and independence.

50.4.c. Consumers must be clearly informed of methods of contacting the team for emergency assistance.

50.4.d. The program content must assist the consumer towards greater independence through prompting and training of adult living skills, promotion of medication compliance as appropriate and necessary, and offer development of advance directives.

50.4.e. If medication delivery is a part of the service provided, the provider must comply with the rules detailed under the section entitled “Delivering and monitoring medications in a consumer’s place of residence”.

§64-11-51. Standards for residential treatment programs for addictions and/or cooccurring disorders.

51.1. The intake assessment for the program must include a review by a physician or physician extender of the physical health status of the consumer and the appropriateness of his or her prescribed medications. This review may have been conducted by a referring entity or other medical party.

51.2. The provider shall have a policy regarding screening for common chronic diseases association with particular addictions. The policy must address infection control and universal precautions for staff and other consumers as necessary and appropriate.

51.3. The provider is responsible for arranging the provision of medications deemed necessary by the intake medical staff.

51.4. The provider must ensure that medications brought to the program by consumers are correctly identified and stored.

51.5. The provider shall have a policy with associated procedures regarding the ability of consumers to retain personal medications if discharged against medical advice.

51.6. Consumers participating in such programs may be required to contribute to program maintenance through performance of daily assigned chores. As such, they may have unrestricted access to cleaning and other supplies unless the team decides otherwise, provided potentially intoxicating substances are held in a secure location and utilized only under staff supervision.

51.7. Coeducational programs must have sleeping areas clearly separated and monitored by staff. Consumers involved in coeducational activities must be monitored by staff during both structured and unstructured time.

51.8. Programs need not be medically monitored however the provider must have a policy which ensures that medication taken by consumers is:

51.8.a. Kept in a secure location;

51.8.b. Taken only under supervision of staff; and

51.8.c. Documented by the consumer with documentation to be initialed by staff observing.

51.9. Aftercare arrangements must be detailed, supportive, and an integral aspect of the discharge planning process.

51.10. Standards for twenty-four hour programs accepting mothers with children:

51.10.a. Program content must include or arrange for the provision of the following, as

necessary and appropriate:

51.10.a.1. Parenting training;

51.10.a.2. Trauma recovery;

51.10.a.3. Assertiveness training;

51.10.a.4. Basic household maintenance; and

51.10.a.5. Budgeting and money management.

51.10. b. The provider must have a policy ensuring and monitoring the health, safety and welfare of children in the program.

51.10. c. School age children must be involved in an appropriate educational program that ensures educational credit towards graduation.

51.10. d. Children must be properly supervised by parent or staff at all times.

§64-11-52. Standards for locked behavioral health programs.

52.1. The secretary may authorize locking the facility housing a behavioral health provider program under certain circumstances.

52.2. The facility must meet the appropriate life safety standards of construction required by the secretary and State Fire Marshal.

52.3. The facility must be locked for the safety of consumers or other members of the public and may not be locked solely for staff convenience.

52.4. The clinical needs of the consumers must require specialized security measures for their safety.

52.5. Staff must be readily able to unlock doors at all times.

52.6. Unannounced fire drills must be conducted at least once per quarter.

52.7. Evacuation plans must be available for review by the secretary and staff on every shift must be knowledgeable in their implementation.

52.8. Staffing must be sufficient to provide for the safety of consumers twenty-four hours per day.

52.9. The need for placement of a consumer in a locked facility must be reevaluated by the clinical team at regularly specified intervals, never less than each ninety days. Review must be documented.

52.10. Placement in a locked facility because of inappropriate behavior must result in a plan to mitigate or modify such behavior as described in "Management of continued inappropriate behavior".

§64-11-53. Administrative due process.

Any person aggrieved by an order or other action by the secretary based on this rule 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.

NOTE: The purpose of this bill is to reauthorize, with amendment, as one rule, the legislative rules contained in title sixty-four, series eleven and series seventy-four of the code of state rules relating to licensure of behavioral health centers (64 CSR 11) and behavioral health consumer rights, (64 CSR 74).

Strike-throughs indicate language that would be stricken from a heading or the present law, and underscoring indicates new language that would be added.