

TITLE 78
LEGISLATIVE RULE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 3
MINIMUM LICENSING REQUIREMENTS FOR RESIDENTIAL CHILD CARE AND TREATMENT FACILITIES
FOR CHILDREN AND TRANSITIONING ADULTS AND VULNERABLE AND TRANSITIONING YOUTH GROUP
HOMES AND PROGRAMS IN WEST VIRGINIA

§78-3-1. General.

1.1. Scope. -- This rule establishes standards and procedures for the licensure of residential child-care and treatment facilities and vulnerable and transitioning youth group homes and programs under the provisions of W. Va. Code §49-2-101 *et seq.*, §27-17-1 *et seq.*, and related federal and state codes except as set forth in subsection 2.3. of this rule (relating to exemptions). The West Virginia Code is available in public libraries and on the Legislature's web page, <http://wvlegislature.gov/>. This rule should be read in conjunction with the provisions of W. Va. Code §49-2-101 *et seq.*, §27-9-1, and §27-17-1 *et seq.*

1.2. Authority. -- W. Va. Code §49-2-121, §27-17-3, §27-1A-4(g), §27-1A-6(6) and §27-1A-7.

1.3. Filing Date. -- April 30, 2021

1.4. Effective Date. -- July 1, 2021.

1.5. Sunset Provision. -- This rule shall terminate and have no further force or effect on August 1, 2026.

1.6. Review and Revision -- This legislative rule will be reviewed at a minimum of every five years for content and applicability, with revisions and additions made as needed.

1.7. The organizations covered in this rule (excluding ICF-ID and PRTF) are exempt from the requirements of "Behavioral Health Centers Licensure," 64CSR11.

1.8. Purpose -- These standards are the basis for the licensing and approval of residential child-care and treatment facilities in West Virginia. Licenses or certificates of approval are issued if the standards and applicable rules and regulations are met. The purpose is to protect the health, safety and well-being of children receiving care in residential facilities and to regulate the provision of out of home behavioral health treatment for children with behavioral, emotional or developmental, or both, challenges, placed in congregate treatment settings, through the formulation, application and enforcement of minimum licensing requirements. Nothing in these standards are intended to interfere with any requirements relating to funding streams.

§78-3-2. Application and Enforcement.

2.1. The core requirements, section 1 through subsection 16.4., apply to all residential child care settings and congregate treatment settings, both public and private, that offer residential services to children and transitioning adults who have been separated from their family for the purpose of care or

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behavioral health treatment, or both, except where otherwise indicated within this rule. Organizations classified as providing foster family care by the Department of Health and Human Resources are exempt from this rule and are governed by the Department's rule "Child Placing Agencies Licensure," 78CSR2. Each organization included in this rule shall comply with core requirements in addition to specialized modules as applicable to program provision.

2.1.1. This rule contains the minimum requirements to obtain a license or certificate of approval to provide residential child-care and treatment for children in West Virginia.

2.1.2. This rule applies equally to for-profit, not-for-profit, publicly funded and privately funded facilities.

2.1.3. This rule applies to the following congregate living facilities serving children and transitioning adults:

2.1.3.a. Psychiatric residential treatment facilities for persons less than 21 years of age;

2.1.3.b. Residential crisis support or emergency shelter care for vulnerable children;

2.1.3.c. Residential maternity and parenting facilities;

2.1.3.d. High quality group residential child-care settings for vulnerable children;

2.1.3.e. Qualified residential treatment programs;

2.1.3.f. Outdoor therapeutic educational programs;

2.1.3.g. Intermediate care facilities for persons with mental retardation;

2.1.3.h. Therapeutic residential schools; and

2.1.3.j. Vulnerable and transitioning youth group homes and programs.

2.2. Enforcement

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

2.3. Exemptions

This rule does not apply to the following:

2.3.1. A program exempted by the state or federal statute;

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

2.3.3. Seasonal camps operated for children with a primary purpose of recreation, in which children are attending sessions for periods not exceeding 30 days;

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

2.3.5. Adoption and foster family care facilities recognized as such by the Department of Health and Human Resources; and

2.3.6. Hospitals or other medical facilities that are primarily used for temporary residential care of children for treatment, convalescence, or testing.

§78-3-3. Definitions.

3.1. Administrator -- The designated person responsible for carrying out the governing body's policies and overseeing the daily operations of the facility.

3.2. Aftercare -- Services to be provided subsequent to a child's discharge from placement as identified in the discharge plan.

3.3. Adult Protective Services/Child Protective Services (APS/CPS) Background Check -- an authorized disclosure of an individual's history with the Department as an identified adult or child abuse maltreater.

3.4. Aversive Conditioning -- The application of startling, painful, or noxious stimuli for the purpose of behavior management.

3.5. Aversive Procedures -- Restrictive procedures that impose undesirable consequences for inappropriate behaviors.

3.6. Behavior Support Plan. -- A written plan designed to teach adaptive behaviors and reduce or eliminate maladaptive behaviors.

3.7. Behavioral Health Services and Treatment -- Services designed to improve the adaptive functioning (including but not limited to emotional, behavioral, interpersonal, and age-appropriate independent functioning) of children with mental illness; developmental disabilities; behavioral challenges; traumatic brain injuries expressed as emotional or behavioral difficulties; or substance abuse.

3.8. Care Plan/Master Plan of Care -- A document describing the services to be provided to a child while in residential care and treatment. This plan may also be referred to as a treatment plan.

3.9. Case Record/Clinical Record -- A comprehensive collection of information about a child in the care of an organization providing residential treatment.

3.10. Case Record Review -- The review of case records for accuracy, consistency, quality, and compliance by an individual or group of individuals.

3.11. Child -- Any person less than 18 years of age or who is a transitioning adult as defined in subsection 3.85 of this rule.

3.12. Child Abuse -- Any act or omission that creates an abused child as the term is defined in W. Va. Code §49-1-201.

3.13. Child Neglect -- Any act or omission that creates a neglected child as the term is defined in W. Va. Code §49-1-201.

3.14. Child's Case Plan -- A comprehensive document prepared by the Department following an adjudication by the court that the child is an abused or neglected, or both, child, that directs the provision of services, including the services provided to the child and the provision of a permanent placement for the child.

3.15. Child-Specific Training -- Training provided to respond to the individualized needs of a child.

3.16. Civil Rights -- The rights of personal liberty guaranteed by the Constitutions of the United States and the State of West Virginia, by federal, and state laws.

3.17. Continuous Quality Improvement -- A well-defined process for assessing and improving the overall performance of the organization by identifying standards that will promote quality outcomes for persons served and modifying the organization's practices and services to meet those outcomes.

3.18. Corporal Punishment -- Punishment intended to cause physical pain to a child.

3.19. Corrective Action Plan -- A written agreement between the Department and an organization that outlines the steps an organization shall take to correct areas of non-compliances identified by the Department through an inspection or the investigation of a complaint.

3.20. Criminal History Background Check -- A review of information pursuant to the provisions of the West Virginia Clearance for Access: Registry and Employment Screening Act (WV CARES), W. Va. Code §16-49-1 *et seq.*, and 69CSR10, and an examination of protective service records to determine eligibility for employment or participation under this rule.

3.21. Crisis Intervention Skills and Techniques -- Methods used to de-escalate situations that could result in harm to persons or property.

3.22. Critical Incident -- An alleged, suspected, or actual occurrence that creates a significant risk of substantial or serious harm to the physical or mental health safety or well-being of a child in residential treatment, including but not limited to any of the following: abuse, neglect, death due to any cause, attempted suicide, behavior that will likely lead to serious injury or significant property damage, fire resulting in injury, relocation or an interruption of services, any major involvement with law enforcement authorities, injury that requires hospitalization or results in permanent physical damage, life-threatening reaction because of a drug or food, a serious consequence resulting from an apparent error in medication or dietary administration, extended and unauthorized absence of a child that exceeds his or her plan of care provision for community access, or the unplanned removal of a child, against his or her wishes, from either residential or program services.

3.23. Department -- The West Virginia Department of Health and Human Resources.

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

3.25. Direct Service Worker -- Any employee of an organization who works directly with children as a major function of his or her job.

3.26. Discharge -- The termination of a child's placement or services with an organization.

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

3.28. Discipline -- Corrective action to discourage rule violation or undesirable behavior.

3.29. Documentation -- A record in compliance with this rule.

3.30. Early Periodic Screening, Diagnosis and Treatment (EPSDT), also known as "HealthCheck" -- The child health component of the Medicaid program that establishes standards of medical care for children.

3.31. Family and Permanency Team -- A team required for children placed in qualified residential treatment programs designated to review and approve the child's placement and plan of care, as appropriate, that includes members of the family's choice.

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

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

3.34. Group Residential Child Care and Treatment -- A residential program that provides room, board, supervision and behavioral health treatment to children or transitioning adults with behavioral, developmental or psychiatric, or both, challenges that includes all sub-types of care addressed in this rule.

3.35. Health Screen -- A physical examination that is administered by a qualified health practitioner (i.e., medical or osteopathic physician; registered nurse; physician's assistant) that occurs within 72 hours of placement into a new milieu.

3.36. High-Quality Group Residential Child Care Treatment for Vulnerable Children -- Provision of supervision, room, board and psychosocial or habilitative treatment for vulnerable children and youth who are in need of out-of-home care and may be considered emotionally, developmentally and or behaviorally challenging. These programs will be operated with a trauma-informed structure throughout the organization.

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

3.38. Incident -- An act or series of acts or behaviors, that place a child or others at risk.

3.39. Independent Contractor -- Individuals who perform paid services for youth and are not employed by the residential facility. This individual performs services as specified in a contract or formal agreement as needed or required.

3.40. Informed Consent -- Written verification that a child and his or her parent or guardian have been informed of the nature of the treatment provided to the child and that they agree to the proposed treatment.

3.41. Institutional Investigative Unit -- A unit of the Department authorized by the Secretary to investigate complaints of child abuse or neglect.

3.42. Interdisciplinary Team -- A group including a child, representatives from the organization, parent or guardian, and guardian ad litem or attorney representing the child, whose responsibility is to design and review a child's plan of care.

3.43. Intermediate Care Facility for Persons with Intellectual Disability -- A facility that provides appropriate supervision, medical, and habilitation services for individuals with intellectual or developmental disabilities, or both, as defined in 42 C.F.R. §440.150.

3.44. Intervention -- Actions designed to assist the child in completing the objectives contained within his or her care plan.

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

3.46. Medication Error -- The failure to administer a drug in a manner as instructed or indicated in the Six Rights of Medication Administration as defined in subsection 3.81 of this rule.

3.47. Multidisciplinary Treatment Team -- A treatment team that includes the individuals listed in W. Va. Code §49-4-405(b) or 49-4-406(d)(2), as the case may be, who assess, plan, and implement a comprehensive, individualized service plan for the child.

3.48. Non-critical Incidents -- Events occurring to a child that need to be recorded and briefly investigated or reviewed by the organizations and tracked for risk management or quality improvement purposes. These incidents would not include behaviors for which there is a behavior support plan and data tracking mechanism in place.

3.49. Normalcy. -- A practice of allowing children and youth in out-of-home care to experience childhood and adolescence in ways similar to their peers who are not in child residential child care and treatment facilities.

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

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

3.52. Outdoor Therapeutic Educational Program -- Any entity that provides care, supervision and treatment for older children and transitioning youth and adults in an outdoor setting where routine and

specially planned activities are provided in an outdoor milieu and designed to improve the child's social, emotional, behavioral and educational functioning.

3.53. Parents or Guardian -- A person or persons with an ongoing, legally identified, and recognized responsibility for caring for a child.

3.54. Physical Escort -- Using a light grasp to escort a child to a desired location. If the child can easily remove or escape the grasp, it is not a physical restraint. If the child cannot easily remove or escape the grasp, it would be a physical restraint.

3.55. Placement -- any out of home living arrangement, or the ongoing care of a child in an adoptive or foster home, group facility, or other approved living setting.

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

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

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

3.59. Professional Employees -- Individuals who meet the criteria set forth by the licensing boards governing their specific scope of practice as found in Chapter 30 of the West Virginia Code.

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

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

3.62. Psychiatric Residential Treatment Facility for Persons under 21 -- A free-standing program or physically distinct part of a psychiatric inpatient facility that provides intensive, coordinated, and medically supervised behavioral health services in a residential setting to children and adolescents that do not need acute care as defined in 42 C.F.R. §483.350 and §441.151.

3.63. Psychotropic Medication -- Any drug that affects brain activities associated with mental processes and behaviors.

3.64. Qualified Individual -- A trained professional or licensed clinician who is not an employee of the organization, and who is not connected to, or affiliated with, any placement setting in which children are placed by the organization, who conducts a 30-day assessment of the appropriateness of the qualified residential treatment program for children entering those programs.

3.65. Qualified Residential Treatment Program -- Provision of supervision, room, board, high-level psychosocial or habilitative treatment operated with a trauma-informed treatment model for children with serious emotional or behavioral disorders, or both, and disturbances who have:

3.65.1. Been unable to be maintained in their families with preventative services; and

3.65.2. Demonstrated an inability to function in foster homes or less restrictive forms of group residential child care due to significant lack of behavioral control; and

3.65.3. Been diagnosed with a significant autism spectrum disorder, reactive attachment disorder, serious intellectual disabilities, sexual offense behavior, sexually reactive disorder, youth who are violent with serious behavioral disorders, and youth with serious self-injurious behaviors that make him or her at a higher risk of out-of-state placements; and

3.65.4. Been assessed to need the structure and mental health expertise provided by the services in a qualified residential treatment program.

3.66. Reasonable and prudent parent standard. – The practical decision making of caregivers to allow children and youth in residential child care and treatment facilities to participate in health and developmentally appropriate activities.

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

3.68. Requirement -- The specific minimal condition or standard that shall be met by an organization as a condition of licensure or approval, or both, to operate.

3.69. Residential Child Care and Treatment Facility -- A residential program that provides room, board, supervision, and may provide behavioral health treatment to children or transitioning adults with behavioral, developmental, or psychiatric, or both, challenges.

3.70. Residential Crisis Support/Shelter Care -- A form of short-term residential care for children that temporarily provides food, shelter, clothing and other necessary crisis intervention and stabilization services for children experiencing emotional, familial, or behavioral crises.

3.71. Residential Living Unit -- Living quarters used by a particular group of children in care, consisting of separate units in a residential building, including a common room, dining or snack area, facilities for bathing, toileting and personal hygiene and bedrooms.

3.72. Residential Maternity and Parenting Facilities. -- Provision of supervision, room, board and psychosocial or habilitative treatment services to young women who are either pregnant or parenting, young men who are parenting, and their children.

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

3.74. Restraints -- (1) Any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or any other method that involves the physical holding of a child for the purpose of conducting routine physical examinations or tests or to protect the child from falling out of bed or to permit the child to participate in activities without the risk of physical harm to the child. This term does not include a physical escort; and (2) a drug or medication that is used as a restraint to control behavior or restrict the child's freedom of movement that is not a standard treatment for the child's medical or psychiatric condition.

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

3.76. Safety Committee/Officer -- An individual or group of individuals whose responsibility is to review service modalities or other organizational practices that limit freedom of choice or involve risk. The committee/officer shall review the organization's facilities and buildings on a quarterly basis for safety, cleanliness, and proper maintenance.

3.77. Seclusion -- The involuntary confinement of a child alone in a room or area from which the child is physically prevented from leaving. The term does not include a time-out.

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

3.79. Self-disclosure Application and Consent Form -- A signed declaration of criminal convictions, indictments, and authorization to allow a criminal history background check.

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

3.81. Six Rights of Medication Administration -- A best-practice criteria for medication administration recognized by the West Virginia Board of Examiners for Registered Professional Nurses. These criteria are used to assure that each resident receives the specific medication prescribed for the person, in the ordered amount, at the scheduled time, by the designated route- both as prescribed and prepared, that is accurately recorded in the resident's record: (1) the right resident; (2) the right drug; (3) the right dosage; (4) the right time; (5) the right route; and (6) the right record or documentation.

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

3.83. Therapeutic Residential School -- A long-term residential, educational facility providing post-secondary education preparation, room, board, and supervision while providing a structured environment and therapeutic support to older children and transitioning adults who may need emotional, behavioral, familial, social, intellectual, or academic development.

3.84. Time-Out -- A behavior management technique that is part of an approved treatment program and may involve the separation of the child from the group, in a non-locked setting, for the purpose of a short time away from other people or attention. Time-out is not seclusion and is not physically enforced or coerced in any way.

3.85. Transitioning Adult -- An individual with a transfer plan to move to an adult setting who meets one of the following conditions:

3.85.1. Is 18 years of age but under 21 years of age, was in departmental custody upon reaching 18 years of age, remains under the jurisdiction of the juvenile court, or requires supervision and care to complete an education and or treatment program;

3.85.2. Is 18 years of age but under 21 years of age, was adjudicated abused, neglected, or in departmental custody upon reaching 18 years of age and enters into a contract with the Department to continue in an educational, training, or treatment program.

3.86. Transitioning Youth – A youth, aged 16 or 17, in the Department’s custody and engaged in a program to enhance skills to assist the transition into adulthood.

3.87. Trauma-Informed Organizational Structure -- Understanding, recognizing, and responding to the effects of all types of trauma as evidenced by:

3.87.1. Sufficient workforce development in understanding trauma and staff support in sustaining trauma-informed treatment;

3.87.2. Residents and their families are part of care planning and decision-making;

3.87.3. Use of data as a driving force with quality improvement; and

3.87.4. Systemic reviews are conducted within the organization.

3.88. Treatment -- A broad range of planned habilitative or rehabilitative services, including diagnostic evaluation, counseling, medical, psychiatric, psychological, training, and social service care, that are provided to enable a child to meet identified goals and objectives. This definition does not supersede definitions related to funding streams.

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

3.90. Variance -- A written declaration by the Secretary that a certain requirement of this rule may be satisfied in a manner different from the manner set forth in the rule.

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

3.92. Vulnerable and transitioning youth group homes and programs -- Residential child-care facilities providing vulnerable and transitioning youth group homes and programs without behavioral health treatment.

3.93. Vulnerable Child -- A vulnerable child is a young person under the age of 21 who has been, or is at risk of becoming, a victim of sex trafficking, as indicated by one or more of the following risk factors:

3.93.1. Runaway behaviors;

3.93.2. History of abuse or neglect;

3.93.3. History of homelessness;

3.93.4. Identify as lesbian, gay, bi-sexual, trans-sexual, or question their sexuality (LGBTQ);

3.93.5. No meaningful connections to family or community;

3.93.6. Experienced significant trauma;

3.93.7. Indiscriminate or unsafe sexual activities; or

3.93.8. History of involvement with the juvenile justice or child welfare systems.

3.94. Waiver -- A written declaration by the Secretary that a certain requirement may be treated as inapplicable in a particular circumstance.

§78-3-4. State Administrative Procedures.

4.1. General Licensure Provisions.

4.1.1. Before establishing, operating, maintaining, or advertising a residential child care and treatment program within the State of West Virginia, an organization shall first obtain from the Secretary a license authorizing the operation.

4.1.2. A license is valid for the organization named in the application and is not transferable.

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

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

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

4.1.6. An organization shall demonstrate a need for the proposed service by obtaining a current certificate of need from the Health Care Authority.

4.1.7. The Secretary shall make a decision on each application within 60 days of its receipt and shall provide to unsuccessful applicants written reasons for the decision.

4.1.8. The Secretary shall perform an on-site inspection prior to issuing initial, renewal or provisional licenses.

4.2. License Application.

4.2.1. The organization shall submit an application for a license or certificate of approval for:

4.2.1.a. Establishment of a new facility;

4.2.1.b. A change in location;

4.2.1.c. A change in ownership;

4.2.1.d. A change in the population served, including but not limited to gender, age, and capacity;

4.2.1.e. Upon expiration of existing license; or

4.2.1.f. A significant change in services provided.

4.2.2. The organization shall submit the completed application at least 60 days in advance of the planned opening date, change of location, change of ownership, change in program or expiration of existing license.

4.2.3. The organization shall provide all required information, or the application is invalid.

4.2.4. The application shall be accompanied by supporting documentation.

4.2.5. A member of the governing body and the administrator shall sign the application. In appropriate instances, this may be the same person.

4.2.6. The application shall be accompanied by a current fire inspection report by the State Fire Marshal's Office and a current food service and environmental inspection by the local health department.

4.2.7. The governing body or its designated authority shall ensure adequate resources to support the organization's services. If a new organization or an expansion of an existing organization, the governing body shall demonstrate sufficient operating funds for at least six months. The demonstration may include reserves, lines of credit or history of adequate cash flow from an existing program to support a new program for six months.

4.2.8. Existing organizations shall demonstrate financial stability. The organization shall submit a statement from an independent certified public accountant that proper accounting procedures, including an annual audit from a CPA, are in place for the organization.

4.3. Types of Licenses.

4.3.1. Following application review, on-site inspection and approved corrective action, if necessary, and if there is compliance with the requirements of this rule, the Secretary shall issue a license in one of three categories. A license may be amended at any time during the cycle to reflect changes in the program, structure, or population.

4.3.2. The Secretary shall issue an initial license to organizations establishing a new service found to be in compliance with regard to policy, procedure, organization, record keeping and service environment rules. The initial license shall expire not more than 6 months from date of issuance and may not be re-issued pursuant to W. Va. Code §49-2-115.

4.3.3. The Secretary shall issue a provisional license to an organization seeking to renew a previously issued license that is not in substantial compliance with this rule. The non-compliant organization must not, however, pose a significant risk to the rights, well-being, health, and safety of a child.

4.3.4. The Secretary shall issue a regular license to organizations complying with this rule. A regular license may be issued of any duration up to two years at the discretion of the Secretary pursuant to W. Va. Code §49-2-115.

4.4. Construction and Renovation.

4.4.1. Before construction or extensive renovation of children's living areas begins, an organization shall submit to the Secretary for approval a copy of the site drawings and specifications for the architectural structure and mechanical work.

4.4.2. All extensively renovated and new structures shall comply with current standards of the Americans with Disabilities Act.

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

4.5. Inspections.

4.5.1. An organization shall permit the Secretary unrestricted access to the facility to conduct announced and unannounced inspections of all aspects of its operation and premises.

4.5.2. An organization shall permit review of the organization's case records, corporate and financial records, board minutes and employment records as requested by the Secretary.

4.5.3. An organization shall permit access to employees, members of the governing board and children receiving services from the organization as requested by the Secretary.

4.5.4. If an organization is accredited by an accreditation body, it shall supply copies of all relevant accreditation reports to the regulatory body within 10 days of receipt.

4.5.5. The Secretary shall inspect a licensed organization 30 to 90 days prior to the expiration of its license.

4.5.6. The Secretary shall deliver a written report to the organization within 10 working days of completion of an inspection.

4.6. Complaint Investigation.

4.6.1. Any person may file a complaint with the Secretary alleging violation of applicable laws or rules by an organization. A complaint shall state the nature of the complaint and the organization by name.

4.6.2. The Secretary may conduct unannounced inspections of organizations involved in a complaint and any other investigations necessary to determine the validity of a complaint.

4.6.3. At the time of the investigation, the investigator shall notify the administrative officer of the alleged reason for the complaint.

4.6.4. The Secretary shall provide to the organization a written report of the results of the investigation along with any violations.

4.6.5. The Secretary may provide to the complainant a description of the corrective action the organization is required to take and of any disciplinary action the Secretary may take.

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

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

4.6.8. The organization shall not discharge or discriminate in any way against a child or guardian, or employee who has been a complainant, on whose behalf a complaint has been submitted, or who has participated in an investigation process.

4.7. Reports and Records.

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

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

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

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

4.7.3.b. Information of a personal nature from a child or employee's file; and

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

4.7.4. The Secretary shall not make a report public until the organization has the opportunity to review the report and submit a Corrective Action Plan, if necessary.

4.8. Corrective Action Plans.

4.8.1. Within 10 working days after receipt of the licensing report, the organization shall submit to the Secretary for approval a written plan to correct all areas of non-compliance that are in violation of this rule. The plan shall specify:

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

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

4.8.1.c. The signature of the administrator or his or her designee.

4.8.2. The Secretary shall approve, modify, or reject the proposed corrective action plan in writing. The organization may make modifications in conjunction with the Secretary.

4.8.3. The Secretary shall state the reasons for rejection or modification of any corrective action plan.

4.8.4. The organization shall submit a revised corrective action plan within 10 working days whenever the Secretary rejects a Corrective Action Plan.

4.8.5. The organization shall immediately correct an area of non-compliance that risks the health or safety of child or other persons.

4.8.6. The Secretary shall determine if corrections have been made.

4.9. Waivers and Variances.

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

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

4.9.3. The waiver shall contain provisions for a regular review of the waiver.

4.9.4. When an organization fails to comply with the waiver agreement, the agreement is subject to immediate cancellation. The secretary shall determine compliance with the waiver agreement.

4.10. Penalties.

4.10.1. The Secretary may deny the organization's application for licensure or licensure renewal; revoke or modify a license; or prohibit admissions or reduce child census for one or more of the following reasons:

4.10.1.a. The Secretary makes a determination that fraud or other illegal action has been committed;

4.10.1.b. The organization violates federal, state, or local law relating to building, health, fire protection, safety, sanitation, or zoning, or payment of worker's compensation or employment security taxes.

4.10.1.c. The organization conducts practices that jeopardize the health, safety, well-being, or clinical treatment of a child;

4.10.1.d. The organization fails or refuses to submit reports or make records available as requested by the Secretary; or

4.10.1.e. The organization refuses to provide access to its location or records as requested by the Secretary.

4.10.2. Where a violation of this rule may result in serious harm to children under care, the Secretary may seek injunctive relief against any person, corporation, child welfare organization or government official through proceedings instituted by the attorney general, or the appropriate county

prosecuting attorney, in the circuit court of Kanawha County, or in the circuit court of any county where the children are residing or may be found.

4.10.3. Where the operation of a residential child care and treatment facility constitutes an immediate danger of serious harm to children served by the facility, the Secretary shall issue an order of closure terminating operation of the facility. A facility closed by the Secretary may not operate pending administrative or judicial review without court order.

4.11. Administrative and Judicial Review.

Any person, corporation, governmental official or child welfare organization, aggrieved by a decision of the Secretary made pursuant to this rule may contest the decision upon making a request for a hearing by the Secretary within 30 days of receipt of notice of the decision. Administrative and judicial review shall be made in accordance with the provisions of W. Va. Code §29a-5-1, *et seq.* Any decision issued by the Secretary may be made effective from the date of issuance. Immediate relief there may be obtained upon a showing of good cause made by a verified petition to the circuit court of Kanawha County or the circuit court of any county where the affected organization of child welfare organization may be located. The pendency of administrative or judicial review shall not prevent the Secretary from obtaining injunctive relief as provided for in 4.10.b. of this rule.

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

5.1. Rights and Responsibilities.

5.1.1. The organization shall inform all children and their family or guardians, or both, of their rights and responsibilities. Information on rights and responsibilities shall be tailored for each of the organization's services as appropriate and shall reflect the consequences of areas of non-compliance with programmatic rules, as well as limitation on individual rights occasioned by involuntary placement or court orders.

5.1.2. All persons served or their guardians as appropriate shall receive information about their rights and responsibilities that is:

5.1.2.a. Posted in a public area as appropriate;

5.1.2.b. Provided in writing;

5.1.2.c. Distributed during their initial contact with the organization or upon admission; and

5.1.2.d. Effectively and appropriately communicated to persons with special needs and in an age-appropriate manner.

5.1.3. Each child's record shall contain documentation that the individual received an explanation of his or her rights and responsibilities, initialed by the child or parent or guardian, or both.

5.1.4. Written rights shall include, but are not limited to:

5.1.4.a. Rules and behavioral expectations;

5.1.4.b. Factors that could result in discharge and termination unless clinically contraindicated;

5.1.4.c. Basic information about how to file complaints, grievances or appeals; and

5.1.4.d. Rights of persons in residential child care and treatment facilities as specified in subsection 5.4. of this rule.

5.1.5. The organization's policy and procedures shall ensure that:

5.1.5.a. The parent or guardian may refuse any service, treatment or medication unless mandated by law or court order; and

5.1.5.b. If the parent or guardian or transitioning youth or transitioning adult refuses a recommended service, treatment, or medication the organization informs the person of the consequences of the refusal, which may include termination or discharge.

5.2. Access and Eligibility.

5.2.1. The organization shall define its service population and the eligibility criteria for each of its services.

5.2.2. Organizational policy shall state that the organization does not discriminate by race, color, age, national origin or disability unless it is part of an individualized determination that the facts and circumstances of a particular case require the consideration of race, color, age, national origin or disability in order to advance the best interests of the child.

5.2.3. The organization shall have in place a policy detailing admissions procedure for each service and the procedures shall:

5.2.3.a. Minimize barriers to timely initiation of services;

5.2.3.b. Provide for initial screening or placement on a waiting list;

5.2.3.c. Allow the organization to give priority to children and families with urgent needs or in emergency situations as appropriate; and

5.2.3.d. Ensure that all persons are treated equitably.

5.3. Culturally Competent Practice.

5.3.1. The organization's policies, procedures and practices shall recognize, respect, and respond to the unique, culturally defined needs of persons and families within its service population.

5.4. Rights of Persons in Residential Child Care and Treatment Facilities.

5.4.1. A child or transitioning adult receiving services from the organization shall have basic rights including, but not limited to:

- 5.4.1.a. Adequate food, clothing, and shelter;
- 5.4.1.b. Adult guidance, support, and supervision;
- 5.4.1.c. Freedom from abuse, neglect, corporal punishment, and exploitation;
- 5.4.1.d. Education;
- 5.4.1.e. Services necessary to promote safety, permanency, and well-being;
- 5.4.1.f. Clean and safe surroundings;
- 5.4.1.g. Adequate medical care;
- 5.4.1.h. Visitation with family and significant others as specified in the plan of care or the child's case plan, or both, unless clinically contra-indicated or otherwise described in policy;
- 5.4.1.i. Communication with family and significant others by telephone, e-mail, texting, or other means of communication as specified in the plan of care or the child's case plan, or both, and under conditions described in policy;
- 5.4.1.j. Uncensored mail, unless there is reason to suspect it may contain unauthorized, dangerous, or illegal substances or materials or is clinically contra-indicated, or unless consent has been given by parent or guardian to inspect mail;
- 5.4.1.k. Freedom of thought, conscience, and religion;
- 5.4.1.l. Reasonable access to a legal representative, clergy, or spiritual advisor and representative of the placing organization, if applicable;
- 5.4.1.m. Reasonable access to personal funds, if managed by the organization, unless clinically contra-indicated;
- 5.4.1.n. Privacy, as reasonable for the child's age and functioning, unless clinically contra-indicated; and,
- 5.4.1.o. Participation in decisions regarding the services provided, unless clinically contra-indicated.

5.5. Confidentiality and Privacy Protections.

5.5.1. The organization shall conform to all federal and state requirements with regards to the confidentiality of children and families served (42 C.F.R. Part 2, Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, as amended, and W. Va. Code §49-5-101, as amended).

5.5.2. The organization shall have clearly stated procedures regarding the disclosure of information about children served. The policies shall be in compliance with all applicable state and federal laws and rules and regulations and shall include procedures for instances in which the child may be dangerous to himself, herself, or others.

5.5.3. The organization shall assure that any needed release of information is completed in full prior to obtaining the guardian's signature, for each instance where information is needed. A copy of all releases of information shall be placed in the case record.

5.5.4. The organization shall have a written policy or procedure regarding searches of children rooms or property that shall be respectful of privacy rights. The organization shall document any search stating the reason for the search and the outcome of the search.

5.5.5. The organization shall require employees to make every effort to preserve the child's right to privacy and personal dignity according to the age and functioning of the child;

5.5.6. The organization shall not use surveillance cameras or listening devices for routine observation of children in their bedrooms or restrooms unless required by judicial order or contract;

5.5.7. The organization shall provide a secure area or locker for a child's possessions if requested by the child; and

5.5.8. The organization shall prohibit:

5.5.8.a. Involuntary participation in public performances by children served by the organization.

5.5.8.b. Required or coerced use of public statements by persons served that express gratitude to the organization; and

5.5.8.c. Use of photographs, videotapes, audio-taped interviews, artwork or creative writing for the organization's marketing or fund-raising purposes without the informed written consent of the parent or guardian or the child if he or she has reached majority or has been adjudicated an emancipated adult.

5.6. Access to Case Records and Information Management.

5.6.1. Every child, his or her attorney and the child's parents or guardian shall have access to the child's case records to the extent permitted by state and federal law.

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

5.6.3. The organization shall have policy and procedures that protect electronically maintained data in compliance with federal standards.

5.7. Research Protections.

5.7.1. The organization shall have written policies regarding the participation of children and transitioning adults in research projects.

5.7.2. Organizational policy shall clearly state whether the organization conducts, participates in, or permits research involving persons served.

5.7.3. If an organization does research, it shall have a human subjects committee or an internal review board that reports to the administrator or a designated authority with policymaking functions; and

- 5.7.3.a. Reviews research proposals that involve persons served;
- 5.7.3.b. Makes recommendations regarding the ethics of proposed or existing research;
- 5.7.3.c. Makes recommendations as to whether or not to approve research proposals; and
- 5.7.3.d. Establishes a minimum frequency for monitoring of ongoing research activities.

5.7.4. Participation in research by children or their families is voluntary. The organization may not threaten to withdraw services or otherwise coerce persons or their guardians into participating and shall prohibit the use of financial incentives for recruiting research participants.

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

- 5.7.5.a. A statement that he or she voluntarily agrees to participate in the research project;
- 5.7.5.b. A statement that the organization will continue to provide services regardless of whether he or she agrees to participate in the research project;
- 5.7.5.c. An explanation of the nature and purpose of the research project;
- 5.7.5.d. A clear description of possible risks or discomfort associated with the research project;
- 5.7.5.e. A guarantee of confidentiality; and,
- 5.7.5.f. The signature of the parent or guardian or emancipated child.
- 5.7.5.g. The organization shall safeguard the identity and privacy of persons served in all phases of research conducted by or with the cooperation of the organization.

5.8. Grievance Procedures.

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

5.8.1. Be given to all persons served and their parents or guardians upon intake into service, and thereafter upon request or at the initiation of a grievance;

5.8.2. Include an internal appeal procedure and options for external appeal that shall include the regulatory body or the Federal Office of Civil Rights, or both;

5.8.3. 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 or in a separate file, with reference to the separate file to be noted in case record; and in the administrative file; and

5.8.4. Indicate that grievances may be filed either orally or in writing and that all employees of the organization are responsible for assisting any person who wishes to file a grievance.

5.9. Ethical Conduct.

5.9.1. The organization shall develop and implement written standards of ethical conduct for its governing board and its employees.

5.9.2. The organization shall not misrepresent or operate a service or program in any way that is misleading, deceptive, or illegal.

5.9.3. The organization shall require its employees to know and comply with policies and procedures established by the organization.

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

§78-3-6. Continuous Quality Improvement.

6.1. The organization shall describe in policy and procedure a well-defined process for assessing and improving its overall performance regarding safety, quality, and case review and compliance and shall identify standards that will promote quality outcomes for persons served.

6.1.1. The continuous quality improvement procedure shall be annually reviewed and updated by senior management and the governing body. Organizations may designate committees or individuals to carry out the continuous quality improvement process.

6.2. Safety.

6.2.1. The organization shall conduct a quarterly review of the use of service modalities or other organizational practices that involve risk or limit freedom of choice.

6.2.2. The organization shall conduct a documented, quarterly safety review of all facilities and buildings to ensure the safety, cleanliness, and appropriateness of each service environment. Outdoor facilities shall have a monitoring procedure that shall review at least quarterly all program environments and processes for safety and sanitation.

6.3. Case Review.

6.3.1. The organization shall conduct a quarterly case review consisting of at least 10 percent of all open cases and of cases closed that quarter, chosen using a generally accepted standardized sampling methodology. Records from all program or unit sites shall be sampled.

6.3.2. Employees who conduct case reviews shall evaluate quality and the presence or absence of required documents, and the clarity and continuity of the documents.

6.3.3. Written procedures for case review shall ensure that workers do not review cases in which they have been directly involved.

6.3.4. Based on the case record review, the reviewer shall prepare a document summarizing case record areas of non-compliance. The organization is responsible for documenting follow-up on areas of non-compliances.

6.3.5. The organization shall document efforts to remediate identified patterns of non-compliance through re-training or increased supervision efforts.

6.4. Quality.

6.4.1. The organization shall have a process that establishes standards and measures outcomes relative to those standards for each of its facilities on an ongoing basis.

6.4.2. The organization shall analyze outcome data at least annually as part of a self-assessment in order to determine program effectiveness. Results of findings shall be presented to the governing body.

6.4.3. The organization shall have a systematic, documented method of assessing child satisfaction.

6.5. Feedback Mechanisms.

6.5.1. The organization shall submit annual summary results of the safety, case review and quality evaluation processes to the governing body.

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

6.5.3. The organization shall use the findings of its continuous quality improvement processes to:

- 6.5.3.a. Identify problems or service deficits;
- 6.5.3.b. Determine possible causes when data reveal issues of concern;
- 6.5.3.c. Problem solve and develop plans to correct areas of concern or deficit;
- 6.5.3.d. Implement and monitor the effectiveness of corrective plans; and
- 6.5.3.e. Modify the corrective plans, as necessary.

§78-3-7. Governing Body and Organization.

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

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

7.3. All members of the governing body shall be provided:

7.3.1. A formal orientation to the organization and responsibilities of membership of the governing body, which shall be documented;

7.3.2. Written information that specifies the member's fiduciary and other responsibilities of the organization;

7.3.3. Annual reports of the activities of the organization; and

7.3.4. Reports from all regulatory bodies.

7.4. The Governing Body shall:

7.4.1. Identify in writing the mission of the organization and develop a plan to meet that mission;

7.4.2. Ensure that all planned or provided services are consistent with the organization's mission and plan;

7.4.3. Oversee the organization's operations and services;

7.4.4. Determine whether services are within the organization's capabilities and resources;

7.4.5. Adopt administrative, employees, and program policies that are reviewed at least every two years;

7.4.6. Review and approve a budget prior to the beginning of the fiscal year;

7.4.7. Annually review and formally accept the financial audit;

7.4.8. Employ an administrator and delegate authority to that person to employ and dismiss employees, implement board policies, and manage day-to-day operation of the organization;

7.4.9. Permit the administrator or his or her designee to attend all meetings of the governing body and committee, with the exception of those held for the purpose of reviewing the performance, status, or compensation of the administrator.

7.4.10. Initiate a continuous quality improvement program and direct needed changes based on the results;

- 7.4.11. Annually review facility needs related to risk management;
- 7.4.12. Maintain a long-range plan and review it annually;
- 7.4.13. Maintain minutes and records generated from all meetings, including members who were present or absent;
- 7.4.14. Annually visit each organizational site;
- 7.4.15. Annually review facility needs related to capital improvements; and
- 7.4.16. Meet at least twice annually.

7.7. Administrator.

- 7.7.1. The administrator shall be responsible for the organization's daily operations.
- 7.7.2. The administrator shall perform the duties as prescribed by the governing body.

7.8. Conflicts of Interest.

- 7.8.1. The organization shall have a policy that defines and limits conflicts of interest.
- 7.8.2. All persons employed by or volunteering for the organization, the governing body, and consultants shall follow the policy.

7.9. Administrative File for the Organization.

7.9.1. An organization shall maintain an administrative file and make it available upon request of the appropriate governmental organization. It shall contain the following information and documents:

- 7.9.1.a. The governing structure including the charter and articles of incorporation as appropriate;
- 7.9.1.b. The most recent audit and financial statement;
- 7.9.1.c. The by-laws or other legal basis for its existence;
- 7.9.1.d. The name and position of persons authorized to sign agreements and submit official documentation to the appropriate government organization;
- 7.9.1.e. The governing body structure and its composition with names and addresses and terms of membership as appropriate;
- 7.9.1.f. Existing purchase of service agreements;
- 7.9.1.g. Insurance coverage (all types) including bonding documents if appropriate; and

7.9.1.h. A master list of all clinical and social service professionals used by the organization, either as employees or contractors.

§78-3-8. Risk Management.

8.1. The organization shall purchase appropriate types of insurance.

8.2. Legal Compliance.

The organization shall comply with all applicable federal, state, and local laws, rules and regulations associated with all aspects of service delivery and operations and shall possess all relevant and appropriate licenses.

8.3. Security of Information.

8.3.1. The organization shall have policies and procedures regulating access to, storage of, and retention of records of employees and persons served that are in compliance with all state requirements. Regulatory agencies shall be allowed access to all information as necessary to fulfill their statutory duties.

8.3.2. The organization shall ensure that records can be located at any time.

8.3.3. The organization shall have procedures to protect service and organizational records, from destruction by fire, water, loss, or other damage and from other unauthorized access.

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

8.3.5. The organization shall retain children's records for a minimum of five years following the child's 18th birthday.

8.3.6. The organization shall have a policy regarding disposal of records that respects confidentiality and security of child information.

8.3.7. The format of electronically transmitted data shall comply with all applicable legal standards and requirements.

8.4. Contractual Relationships.

8.4.1. The organization shall use written contracts with contractors of non-clinical services and professional contractors of clinical services.

8.4.2. If the organization arranges contractually for the provision of clinical services, the organization shall have a written agreement that specifies:

8.4.2.a. Services to be provided;

8.4.2.b. Provision of appropriate liability or malpractice insurance either by the contractor or contracting party;

8.4.2.c. Procedures for exchange of information;

8.4.2.d. Definition of the clients to be served and the services to be provided;

8.4.2.e. Timelines for provision of service;

8.4.2.f. Terms of payment;

8.4.2.g. Assurances that the contracting party shall adhere to state and federal requirements of confidentiality; and

8.4.2.h. Expected outcomes as appropriate.

8.4.3. The organization shall ensure all contracted professional services are certified or licensed in the service they are providing and evidence of a criminal history fingerprint-based background check.

8.4.4. If the organization contracts for professional services with a licensed practitioner who serves children in his or her own location, the organization shall ensure the professional is licensed in the service they are providing.

8.4.5. The organization shall ensure that contractual vendors are oriented to and adhere to the organization's policies and procedures regarding professional practices and confidentiality.

§78-3-9. Financial Management System.

9.1. The organization shall have a written budget, approved by the governing body, that shall serve as a plan for managing its financial resources for the fiscal year.

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

9.3. The organization shall have annual financial statements prepared in accordance with generally accepted accounting principles (GAAP).

9.4. Financial Accountability.

9.4.1. The organization shall make available an annual report of fiscal, statistical, and service data that includes summary information regarding its financial position.

9.4.2. The organization shall ensure that an administratively independent auditor conducts an annual audit.

9.4.3. An organization that assumes fiduciary responsibility for client funds or disburses other child funds, such as maintenance or allowance funds, shall have written operational procedures that ensure:

9.4.3.a. Separate individual accounting of funds with monthly statements to the child and his or her parent or guardian. Funds managed on behalf of clients shall not be commingled with organizational funds;

9.4.3.b. Protection of child assets, including a bond sufficient to cover all child accounts, unless the aggregate value of the child accounts is less than \$500; and

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

§78-3-10. Management of Human Resources.

10.1. Deployment of Employees.

10.1.1. The organization shall retain sufficient numbers of qualified individuals to:

10.1.1.a. Efficiently and effectively meet the demand for all services it provides; and

10.1.1.b. Provide and coordinate the services that are within the organization's scope and mission.

10.1.2. The organization shall ensure that sufficient, licensed, or certified professional clinical employees are employed or available on a consistent basis to provide, at a minimum, that:

10.1.2.a. All intakes and diagnostic assessments are completed by suitably trained and experienced professional employees;

10.1.2.b. Professional employees are available and mandated to provide direct supervision and consultation to direct care employees, professional interns, and paraprofessionals at a ratio appropriate to the number of employees or interns supervised and the demands of the population served;

10.1.2.c. Professional employees or employees under supervision for licensure or certification according to state law is available and mandated to provide direct service to children and transitioning adults for those organizations providing therapy services (individual, group and family) or medical services, or both; and

10.1.2.d. Employees are available in sufficient quantity and with sufficient credentials to address the needs of the child as identified by the assessment and interdisciplinary team process.

10.1.3. The organization shall identify an individual at each program site responsible for overall administration of the program at that site.

10.2. Personnel Practices.

10.2.1. The organization shall have policies that comply with all federal and state statutes, rules, and regulations regarding employment practices.

10.2.2. The minimum age of any person serving as an employee for organizations serving children aged 13 and older shall be 20 years of age.

10.2.3. If the age of the population served at an organization is uniformly 12 years and under, the minimum age of the employees serving the population shall be 18 years.

10.2.4. If the program serves transitioning adults up to age 21, the ages of the employees providing direct care shall be at least three years older than the age of the eldest child.

10.2.5. The organization shall submit a request for a criminal history background check and a protective services records check to the WV CARES unit of the Department for each potential employee or independent contractor prior to permitting that employee or independent contractor to work with children.

10.2.6. The organization will obtain a WV CARES self-disclosure application and consent form signed by the potential employee or independent contractor indicating any past criminal conviction or pending charges.

10.2.7. Documentation of the completed criminal history background check shall be maintained with the personnel file of the applicant. Documentation shall include a fitness determination of eligibility from the WV CARES unit and a variance or waiver that has been granted by the Secretary if the applicant has convictions of disqualifying offenses or pending charges.

10.2.8. The organization must demonstrate compliance with all provisions of the WV CARES Act and its Legislative rule, 69CSR10. The organization may not allow employees or independent contractor to work in a group residential child care and treatment facility prior to receiving the results of the check.

10.2.9. Organizational policy shall prohibit the engagement of any employee, volunteer, or independent contractor who has a history of substantiated adult or child abuse or neglect.

10.2.10. Organizational policy shall prohibit engagement or retention of either employees, contractors, or volunteers who have a history of convictions for, or are on parole or probation for, a WV CARES disqualifying offense.

10.2.11. The organization shall have a policy and mandatory training process for all employees for compliance with mandatory reporting requirements regarding allegations of abuse or neglect of children as described in W. Va. Code §49-2-801.

10.2.12. The organization shall have a written job description and selection criteria for each position or group of similar positions that includes the qualifications, expectations and responsibilities required of employees. Job descriptions shall be readily available to employees.

10.2.13. The organization shall designate a supervisor for each separate service or program.

10.2.14. The organization shall employ persons who are qualified according to the job description and selection criteria for the positions they occupy. An organization employing any person who does not possess the usual qualifications for the position in which he or she is employed shall have a written statement justifying reasons for employing this person.

10.2.15. The organization shall verify the credentials of all organization employees and individuals, who are contract employees of the organization, including:

10.2.15.a. Education and training;

10.2.15.b. Relevant experience; and

10.2.15.c. State licensing or certification requirements for their respective disciplines, if any.

10.2.16. If the job description allows less than full licensure for individuals eligible for professional licensure or certification, the organization shall demonstrate that:

10.2.16.a. A person with requisite credentials provides appropriate supervision to the employees; and

10.2.16.b. The employees are actively working toward licensure or certification, or both.

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

10.3. Volunteers.

10.3.1. The organization shall have a policy that specifies the roles and responsibilities that volunteers may assume.

10.3.2. The organization shall ensure that volunteers receive regular supervision to provide assistance, directions for activity and support.

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

10.3.4. The organization shall ensure that volunteers understand the responsibilities of the position and the time commitments required prior to formal assignment.

10.3.5. The organization shall formally train volunteers in confidentiality prior to beginning their duties and shall maintain documentation of the training.

10.3.6. The organization shall have a policy requiring volunteer screening that shall include the same criminal history and protective services background checks as required for employees and independent contractors.

10.3.7. The organization shall not use any volunteer who would not pass the criminal history and protective services background checks or security requirements as an employee or independent contractor.

10.4. Students and Student Interns or Residents.

10.4.1. Students covered by this rule are those individuals serving an academic placement of more than 30 hours on site per three-month quarter. Students serving less than 30 hours per quarter shall be continually supervised by another employee and may not work alone with children.

10.4.2. The organization shall have a policy that specifies the roles and responsibilities that students may assume.

10.4.3. The organization shall ensure that students receive regular documented supervision to provide assistance, directions for activity and support.

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

10.4.5. The organization shall formally train students in confidentiality prior to beginning their duties and shall maintain documentation of the training.

10.5. Employee, Volunteer, and Student Records.

10.5.1. The organization shall maintain personnel records for all employees, students, and volunteers. These records shall be reviewed annually and updated as necessary, and contain, as appropriate:

10.5.1.a. Identifying information and emergency contacts;

10.5.1.b. An application for employment, volunteer, or student service;

10.5.1.c. A job description or contract;

10.5.1.d. Reference verification;

10.5.1.e. Documentation of education and licensure or certification;

10.5.1.f. Documentation of relevant training as appropriate;

10.5.1.g. Documentation of employee orientation including training in confidentiality;

10.5.1.h. Documentation of criminal history and protective services background checks; and

10.5.1.i. Performance evaluations (except students and volunteers) and documentation relating to performance, including disciplinary actions and termination summaries, as appropriate.

10.5.2. Each organization shall have a record, stored separately, containing medical information on each employee, volunteer, or student. The medical records shall include:

10.5.2.a. An initial tuberculosis screening before assumption of duties and a screening every five years thereafter; and

10.5.2.b. Results of random drug screens if required by organization policy.

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

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

11.1. Orientation of New Employees.

11.1.1. The organization shall ensure that each new employee, volunteer, and student receive an orientation within the first 10 business days of employment and shall document that orientation in the individual's personnel record.

11.1.2. The organization shall orient all new employees on the following:

11.1.2.a. An organizational chart that delineates lines of accountability and authority at all levels of the organization;

11.1.2.b. The objectives and process of the organization's continuous quality improvement program;

11.1.2.c. The organization's policies and procedures on confidentiality and disclosure of information on persons served, including penalties for violation of these policies and procedures and an orientation to federal confidentiality requirements as they apply to the organization;

11.1.2.d. The legal rights of persons served;

11.1.2.e. Mandatory reporting procedures for suspected abuse and neglect;

11.1.2.f. Appropriate identification and documentation of incidents;

11.1.2.g. The responsibility to abide by organizational and professional ethics;

11.1.2.h. Fire drills; and

11.1.2.i. Procedures regarding medical and psychiatric emergencies, including necessary notification of guardians and others.

11.2. Employee Training and Content.

11.2.1. The organization shall provide training to clinical and direct care employees in the following health related topics within 30 days of employment:

11.2.1.a. Basic medical needs and problems of the population served, including management of sick children and symptoms of common medical problems, such as allergy reactions, diabetes, and asthma;

11.2.1.b. Basic first aid (completed according to OSHA-approved pediatric first aid requirements and adult requirements as appropriate) and medication reactions (including desired and undesired effects). This training must be updated every three years;

11.2.1.c. Cardio-Pulmonary Resuscitation (CPR) Adult Training is required every two years and First Aid certification every three years, specific to population served (adult, child or infant);

11.2.1.d. Supervision of self-administration of medication as applicable including typical medications prescribed, appropriate dosages and schedules and common side effects. This training shall be updated annually;

11.2.1.e. Basic de-escalation techniques and passive restraints. This training must be updated annually;

11.2.1.f. The organization's protocols for universal disease precautions and providing services to children with contagious and infectious diseases. This training must be updated annually;

11.2.1.g. The organization's procedures regarding the duty to warn others of impending harm due to threats made by a resident of the organization's program. The procedures shall include, at a minimum, the requirement that verbal communication of the treatment to the potential victim occur immediately;

11.2.1.h. Appropriate management of suicidal threats or behaviors;

11.2.1.i. The organization shall inform all employees in writing of its policy defining and prohibiting corporal and degrading punishment.

11.2.1.j. The organization shall train appropriate employees on procedures for maintaining a safe, hygienic, and sanitary environment. Procedures shall address:

11.2.1.j.1. Steps to retard the spread of infection in bathrooms, bedding, and food; and

11.2.1.j.2. Proper storage of cleaning supplies and hazardous materials.

11.2.2. Additionally, program employees with direct care responsibilities shall be trained within 90 days of employment on the following:

11.2.2.a. Sensitivity to differences in cultural norms and values as appropriate;

11.2.2.b. Management of children attempting to escape supervision or who are away from supervision;

11.2.2.c. Sensitivity to sexual identity including lesbian, gay, bisexual, transgender, and questioning youth;

11.2.2.d. Family dynamics, including human growth and development;

11.2.2.e. Proper documentation techniques; and

11.2.2.f. Basic therapeutic or behavior management techniques.

11.2.2.g. Children's trauma stress experiences, to include:

11.2.2.g.1. Impact on development, behavior, and relationships;

11.2.2.g.2. Understanding the types of trauma;

11.2.2.g.3. Understanding the influence of cultural factors;

11.2.2.g.4. Recognizing how on-going stressors impact child traumatic stress;

11.2.2.g.5. Responding to crises with interventions; and

11.2.2.g.6. Strategies and interventions to promote resiliency and health.

11.2.2.h. Food handler's certification as necessary and appropriate.

11.2.3. Employees shall be trained at the time of admission to serve any child with special needs such as dietary restrictions, use of an epinephrine auto-injector, rescue inhalers, diabetic monitoring mechanisms, etc.

11.2.4. The organization shall document all employee training provided to employees, including a survey by the employee that indicates that he or she feels adequately trained to do their job.

11.2.5. Until the training is completed, the employee may not work unless accompanied at all times by an employee who is experienced and knowledgeable in these areas.

11.3. Supervision.

11.3.1. The organization shall have a system of employee supervision that is tailored to the organization's model of service delivery and uses individual or group, or both, supervision on a regularly scheduled basis.

11.3.2. The organization shall adjust supervisory assignments, frequency, and duration in response to the findings and recommendation of the continuous quality improvement processes.

§78-3-12. Service Environment.

12.1. The organization shall meet all applicable federal, state, and local health, building, safety, and fire codes.

12.2. Food Services.

12.2.1. Food shall be stored, prepared, and served according to local health department regulations.

12.2.2. Use of paper or disposable plates, beverage containers, and utensils are to be limited and not used in day-to-day meal service. Outdoor therapeutic educational programs are exempt from this requirement when operating in the field.

12.3. Transportation.

12.3.1. An organization that provides transportation in its vehicles for children as part of a service shall have procedures for ensuring:

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

12.3.1.b. Adequate passenger supervision relative to the ages, sexes, behavioral challenges, and disabilities of the children;

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

12.3.1.d. First aid kits in each organizational vehicle;

12.3.1.e. Proper and timely maintenance of vehicles;

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

12.3.1.g. Sufficient liability insurance;

12.3.1.h. Adequate aisle space in vans transporting wheelchair-bound children;

12.3.1.i. Secure anchoring for wheelchairs except in automobiles; and

12.3.1.j. Annual validation of driver licenses.

12.3.2. An organization that permits the transportation of persons served in vehicles that belong to employees shall require:

12.3.2.a. Passenger insurance coverage either through the organization's insurance or the driver's automobile liability insurance;

12.3.2.b. Proof of insurance;

12.3.2.c. Age-appropriate passenger restraints for all passengers;

12.3.2.d. Annual validation of the driver's license; and

12.3.2.e. Current registration and inspection validated annually.

12.4. Organization Safety and Security.

12.4.1. The organization shall have a schedule of regular inspection and maintenance activity to ensure the safety of its premises, equipment, and fixtures.

12.4.2. The organization shall have fire extinguishers reviewed by a qualified professional annually.

12.4.3. The organization shall not maintain any firearm or chemical weapon on the grounds or within the structures of the facility.

12.4.4. All power-driven equipment used by a facility shall be kept in safe and good repair. The equipment shall be used by children only under the supervision of an employee and according to state code. Lawn mowers shall be stored in areas separated with one-hour fire rated material.

12.4.5. The organization shall have a Safety Committee or designated safety and maintenance officer whose function is to perform regular documented inspections for identification of potentially

hazardous conditions (e.g., harmful water temperatures, improper use of small appliances, stairs without handrails, etc.) and items in need of repair or maintenance. At no time shall those inspections be less than quarterly.

12.5. Emergency Response.

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

12.5.1.a. Address the needs of any special population served by the organization;

12.5.1.b. Specify evacuation procedures including an evacuation site, parties to notify, and emergency items to take when evacuating;

12.5.1.c. Describe relocation plans for the service or program if it becomes necessary;

12.5.1.d. Specify appropriate responses to medical emergencies; and

12.5.1.e. Require notification of the child's parent or guardian and other appropriate authorities at the earliest opportunity.

12.5.2. Residential facilities shall conduct monthly fire drills rotating all shifts at least once per quarter and shall meet legal requirements for fire drills as specified by the State Fire Marshal. Participation shall be mandatory for all employees and children. Organizations that do not operate by shifts (e.g., outdoor therapeutic educational programs) shall have monthly fire drills at various times of the day and night.

12.5.3. The organization shall have procedures for dealing with injuries, accidents, and illnesses. The organization shall ensure that a communication device and first aid supplies are readily available in all organization buildings.

12.5.4. The organization shall have procedures in place for dealing with:

12.5.4.a. Persons who are injured, lost or absent from care without permission; and

12.5.4.b. Persons who threaten violence or harm to themselves or employees providing care and/or supervision.

12.5.5. The organization shall assign an employee to orient each newly arrived child to organization emergency procedures and the location of emergency exits as appropriate during the first full day of the child's stay at the organization. The employee shall file a written confirmation in the child's case record that the orientation has taken place.

12.5.6. The organization shall ensure that all employees have immediate access to current poison control information or procedures for referral for emergency medical attention.

12.6. Contagious and Infectious Diseases.

12.6.1. The organization shall have a procedure in place for minimizing the risk of exposure to airborne and blood-borne pathogens by implementing the use of Universal Safety Precautions. Procedures shall comply with related standards of the Centers for Disease Control and the Occupational Safety and Health Administration.

12.6.2. The organization shall develop policies and procedures to prevent and control the spread of HIV/AIDS, hepatitis, tuberculosis, and other contagious or infectious diseases and shall review and update those policies as necessary or every two years at a minimum.

12.6.3. The organization shall have policies that ensure that employees with direct contact with children:

12.6.3.a. Receive a tuberculosis risk assessment or test prior to assumption of duties and at least every five years thereafter, as well as after incidents of exposure or manifestation of symptoms of tuberculosis; and

12.6.3.b. Demonstrate completion of an approved treatment when test results are positive.

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

12.6.4.a. Require that food service employees do not prepare or serve food if they have symptoms of acute illness or an open, untreated wound;

12.6.4.b. Set forth minimum dishwashing and laundry water temperatures to kill bacteria; and

12.6.4.c. Conform with the requirements for food service as specified by the Department's rule, "Food Establishments," 64CSR17, including as appropriate, current food handler's cards.

12.6.5. The organization shall immediately notify the health officer of the county in which it is located of any known or suspected cases of communicable diseases that are required by law to be reported.

12.7. Building Exteriors and Grounds.

12.7.1. An organization shall ensure that buildings, grounds, and recreational areas owned or leased by the organization are maintained in good repair and free from reasonable danger to health or safety.

12.7.2. Children and transitioning adults shall have access to outdoor recreational space and suitable recreational equipment that is in good repair and free from defects.

12.8. Interior Space.

12.8.1. Each living unit of an organization shall contain space for the free and informal use of children in care.

12.8.2. Dining areas shall be arranged so as to allow children, employees, and guests to eat together in small groups.

12.8.3. Dining areas shall be well-lighted, ventilated and appropriately furnished.

12.8.4. Except for outdoor therapeutic educational programs, there shall be a minimum of 60 square feet per occupant in bedrooms. Bedrooms for single occupants shall have a minimum of 70 square feet.

12.8.5. No more than four children may occupy a designated bedroom space.

12.8.6. The bedroom space shall have a direct source of natural light.

12.8.7. Except for outdoor therapeutic educational programs, each child shall have his or her own bed with sufficient linens and covers. Linen shall be changed at least weekly, but more frequently if necessary. Cots or other portable beds are not to be used on a routine basis. The uppermost mattress of any bunk bed in use shall be far enough from the ceiling to allow the occupant to sit up in bed.

12.8.8. Each child shall have his or her own dresser or other storage space for private use, and a designated space for hanging clothes and placing possessions.

12.8.9. Bathrooms and plumbing fixtures shall be kept clean and maintained in good repair.

12.8.10. Water temperatures in sinks, showers, and bathtubs shall not exceed 120 degrees Fahrenheit. There shall be a safe and adequate supply of potable hot and cold running water. Water from any source other than a public water supply shall be tested annually by the appropriate state or local authority in accordance with state or local law.

12.8.11. Fixtures in bathrooms shall be situated so as to be accessible to the average sized child of the household. If the organization serves individuals with physical challenges, accessible or adapted equipment shall be provided and there shall be sufficient space in the bathroom to permit employee assistance if necessary.

12.8.12. A facility shall have one toilet, one lavatory and one bathtub or shower for every six children, at a minimum.

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

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

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

12.8.15. No locks shall be placed on any door that hinders the exit of a person from that area. Locks may be used to restrict access to certain areas but must not require a key to exit. Upon written approval by the Secretary, a facility may use delayed-egress electrically locking systems. The facility shall submit a written request that includes (i) the area(s) where the delayed-egress electrically locking systems

will be used; (ii) documentation from State Fire Marshal that the delayed-egress electrically locking systems complies with all building and fire codes; and (iii) the reason the delayed-egress electrically locking system is necessary to serve the children in the facility. The Secretary shall determine if the needs of the children served by facility require this level of restriction given the need for children to maintain normalcy. The Secretary may revoke the approval at his or her sole discretion.

12.8.16. Kitchens used for meal preparation shall be provided with the necessary equipment for the preparation, storage, serving and cleanup of all meals for all the children and employees regularly served by the kitchen. All equipment shall be maintained in working order. Kitchens serving more than eleven children shall meet all applicable provisions of the Department's rule, "Food Establishments," 64CSR17. Kitchens serving less than twelve may use a family-type kitchen provided that:

12.8.16.a. Food shall be protected from contamination during storage, preparation, and service;

12.8.16.b. Food contact utensils and equipment shall be of appropriate material, easily cleaned and maintained in good repair;

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

12.8.16.d. Kitchen sinks shall have at least two bowls. If a dishwasher is used, the temperature shall reach a level sufficient to sanitize dishes. If no dishwasher is used, proper sanitation treatments in the washing process shall be used.

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

12.8.17.a. A bed shall be provided in employee quarters for live-in employees or house parents.

12.8.17.b. Employees shall not share bedrooms with children.

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

12.8.19. An organization shall have securely locked storage spaces for all potentially harmful materials. Poisonous or toxic materials shall be stored in locked storage spaces not used for any other purpose.

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

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

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

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

12.8.24. The use of candles is prohibited.

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

12.8.26. On ground pools shall be in a secured area and shall comply with the Department's rule, Recreational Water Facilities, 64CSR16.

12.8.27. Windows shall have insect screening unless the facility is centrally air-conditioned. The screening should be readily removable in emergencies and shall be in good repair. All exterior doors shall be close fitting and self-closing.

§78-3-13. Initial Assessment and Plan of Care.

13.1. Multidisciplinary Team.

In all instances in which there is a legally designated Multidisciplinary Team (MDT), the organization's assessments and care plans shall be provided to the DHHR representative of the MDT for the purpose of maintaining consistency in assessment, treatment and placement planning. The MDT is responsible by statute for overseeing the assessment and case planning process for all children who are in the custody of the Department. The organization shall supply a representative to the MDT who is familiar with the child, his or her current status and his or her progress in treatment. The Department of Health and Human Resources designee assigned as the child's representative to the MDT is responsible for approving plans of care designed by the organization. This approval shall include permissions for treatment.

13.2. Initial Assessment.

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

13.2.1. For children and transitioning adults who have comprehensive assessments completed within six months prior to admission, further assessments are not required, unless circumstances have significantly changed, or the assessments are incomplete.

13.2.2. The organization shall have a comprehensive assessment procedure for children entering the organization's care. Clinical assessments shall be completed by an appropriately licensed or certified clinical professional or an individual under supervision for the licensure. Other assessments may be completed by employees meeting the requirements of their scope of practice. All assessments comprising the comprehensive assessment shall be completed prior to the development of the plan of care and shall include as appropriate and available:

13.2.2.a. Demographic information including custody status;

13.2.2.b. Presenting problems and reason for referral;

- 13.2.2.c. A history of treatment;
 - 13.2.2.d. A medical history;
 - 13.2.2.e. A social history;
 - 13.2.2.f. The potential need for use of restrictive behavior management interventions;
 - 13.2.2.g. A developmental history;
 - 13.2.2.h. An educational or vocational history;
 - 13.2.2.i. A legal history;
 - 13.2.2.j. A substance abuse history;
 - 13.2.2.k. A mental status examination;
 - 13.2.2.l. An assessment of independent living and adaptive living skills;
 - 13.2.2.m. A summary of the child's strengths;
 - 13.2.2.n. A summary of family strengths and weaknesses; and
 - 13.2.2.o. A summary of presenting problems or potential focus for treatment as identified through the assessment.
- 13.2.3. When appropriate to the needs of the person served, the assessment shall include:
- 13.2.3.a. A review of adaptive behavior or a functional assessment, or both.
 - 13.2.3.b. A review of the need for assistive technology, auxiliary aids and services and other special accommodations;
 - 13.2.3.c. Nutritional and dietary needs;
 - 13.2.3.d. Special or unique behavioral issues; and
 - 13.2.3.e. A review of academic, cognitive, and vocational testing or assessments, if available.
- 13.2.4. Each assessment shall consider any unique aspects of the person's racial, ethnic, and cultural background, and the need for any special service approaches resulting from that assessment.
- 13.2.5. The assessment shall result in a written integrated summary of findings and recommendations that shall guide the organization's treatment efforts. The integrated summary of findings shall include:
- 13.2.5.a. Recommendations for dental, visual, and other health screenings or treatment;

13.2.5.b. A diagnosis, stated in terms as provided is the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, if applicable;

13.2.5.c. Recommendations for further assessment as appropriate;

13.2.5.d. Recommendations for clinical behavioral health treatment, if applicable;

13.2.5.e. Recommendations for interventions to be made in the home environment, as necessary and appropriate;

13.2.5.f. Preliminary recommendations for placement and aftercare upon discharge;

13.2.5.g. Recommendations for family visitation unless contraindicated clinically or legally;
and

13.2.5.h. Any recommendations for rights restrictions.

13.2.6. The organization shall have a policy establishing timelines for completion of a full assessment that shall take into account urgency of child need, expected duration of treatment, and timelines for plan of care. The timelines shall facilitate provision of an appropriate range of services at the earliest opportunity depending on the unique needs of the individual and the expected duration of services. Exceptions to those timelines shall be fully documented and justified in the clinical record.

13.2.7. When the organization is required to accept assessments from another organization or subcontracting entity, it shall review each assessment for sufficiency and conduct additional assessments if the product does not meet the standard.

13.2.8. The organization shall have a written practice to incorporate families into the assessment and service-planning process unless clinically or legally contra-indicated.

13.3. Initial Plan of Care.

13.3.1. The organization shall develop an initial plan of care within 72 hours of placement that includes the following:

13.3.1.a. List of medications prescribed prior to admission and continued until the assessment process is completed;

13.3.1.b. A summary of assessments needed for the development of a full diagnostic and treatment perspective and recommendations;

13.3.1.c. A description of specific, short-term individual or group interventions to be provided prior development of a master plan of care;

13.3.1.d. A description of educational services to be provided prior to the development of a master plan of care, if any;

13.3.1.e. A description of any behavioral interventions or protocols considered likely to be necessary prior to the completion of the master plan of care; and

13.3.1.f. A description of acute or chronic medical problems that may require treatment prior to the completion of the master plan of care.

13.3.2. The initial plan of care shall be developed whenever possible by a team representative of the professionals performing the assessments, the child (if cognitively capable of participating), the guardian, and the parents of the child if appropriate. The plan shall include a written description of the services to be provided. The initial plan of care shall be approved in writing by the parent or legal guardian and the individual served if that individual is considered sufficiently mature to understand the document. The organization shall obtain the guardian's consent for treatment if the guardian is not present for the development of the initial plan of care. If the organization is required to have the DHHR's consent and does not within 10 business days, the organization must document all reasonable efforts to obtain the consent, including contacting the appropriate chain of command.

13.3.3. If the expected length of stay is 30 days or less, the initial plan of care shall guide the team's efforts throughout the child's stay with the organization and shall be modified as necessary and appropriate. If, however, the expected length of stay is to be greater than 30 days, the team shall meet prior to the end of that time period to develop a master plan of care.

13.3.4. If a child requires a specific therapeutic support plan or a protocol for employees to use in dealing with an inappropriate behavior, the plan or protocol shall be in writing, shall be in terms that make it clear to direct care employees and shall have the consent of the parent or guardian. The plan shall include:

13.3.4.a. The behaviors to be monitored and modified;

13.3.4.b. The precise action to be taken by employees if the behavior occurs; and

13.3.4.c. Documentation employees are responsible for supplying, if any.

13.4. Master Plan of Care.

13.4.1. The plan of care planning and review team shall be an interdisciplinary team consisting of the employees involved in providing services to the child (including at a minimum a licensed or certified master's level professional), the parents, the guardian (if other than parent), and the child him or herself, if the child is of sufficient developmental age to appreciate the content of the review. Unless clinically or legally contraindicated in writing, both parents shall be considered members of the care planning team regardless of the identification of a guardian. The child or guardian may request the presence of any other individuals they feel may add to the process. However, the organization is not responsible for bearing any costs related to the presence of other resources. Teachers or other external providers of service while the child is receiving services from the organization should be invited to team meetings and considered part of the team. The organization is responsible for ensuring that all members of the team receive adequate notification of team meetings, both by telephone, if possible, and in writing. The organization shall document its efforts to obtain participation by team members and any lack of attendance. The organization shall also document efforts to obtain informed consent for treatment from the parent or legal guardian if the guardian does not attend the team meeting. If the organization is required to have

the DHHR's consent and does not within 10 business days, the organization must document all reasonable efforts to obtain the consent, including contacting the appropriate chain of command.

13.4.2. The master plan of care shall:

13.4.2.a. Use the summary and recommendations of the assessment process;

13.4.2.b. Contain plans for maintaining or strengthening the relationship between the person served and his or her family if clinically and legally appropriate;

13.4.2.c. Identify the ultimate goal of services (e.g., return to home, foster care, independent living, post-secondary education, etc.);

13.4.2.d. Identify the services the organization intends to provide to meet the needs of the child and child's family as revealed by the comprehensive assessment, including a list of general goals tied to the problems identified in the assessment; and desired measurable objectives for each goal stated in terms that are understandable to the child and guardian;

13.4.2.e. Contain a description of the interventions to be provided in order to achieve the stated objectives, including:

13.4.2.e.1. List of medications prescribed by the child's medical practitioner. Medications may be altered by the physician or qualified medical practitioner during the interval between development and review of the care plan without modification of the care plan itself, however, notes made and signed by the physician or qualified medical practitioner shall be present in the record to document what changes were made and why within one week of alteration of a medication regimen; and

13.4.2.e.2. A description of therapeutic interventions intended to achieve the outcomes to include behavior support plans or therapy plans, or both, as necessary and appropriate;

13.4.2.f. Identify the title or position of persons responsible for providing each intervention;

13.4.2.g. Identify the frequency of the intervention;

13.4.2.h. Identify any outside providers, such as therapists, that the organization has arranged to treat the child and the goals of the interventions;

13.4.2.i. Include educational, vocational, and health services, including dietary, provided to the client; and

13.4.2.j. A proposed discharge plan.

13.5. Review of Master Plan of Care.

13.5.1. The organization shall have a procedure regarding regular review of the plan of care. The procedure shall dictate schedules of review of the plan depending on the average or projected length of stay for the child. At no time shall the schedule allow a period of review to extend more than 90 days except as permitted in sections for each provider type.

13.5.2. Reviews shall always be performed prior to discharge and at critical treatment junctures.

13.5.3. The review shall be the result of a conference of all members of the child's care team including the guardian. Participation by team members and guardians may be telephonic, video conferencing, or, when appropriate, submitted in writing and included in the progress summary (e.g., by educational employees). The organization is responsible for documenting efforts to notify each team member in a timely fashion of the review.

13.5.4. Changes to the plan of care shall be the result of recommendations by the interdisciplinary team and shall be dated and approved in writing by the members of the team including the child (as developmentally appropriate) and his or her guardian.

13.5.5. Reviews shall be conducted by the interdisciplinary team and shall be in writing. They shall consist of:

13.5.5.a. A review of each outcome objective and its current status;

13.5.5.b. Identification of problems that are preventing progression;

13.5.5.c. Suggestions for dealing with those problems;

13.5.5.d. Modifications to be made to the care plan;

13.5.5.e. A review of any therapeutic service provided by an outside provider, to include a written report from that provider if he or she is not present for the review meeting;

13.5.5.f. A summary of all interventions provided to date;

13.5.5.g. A review of any incidents in which the recipient of service may have been involved since the prior review;

13.5.5.h. A review of the discharge plan and the permanency plan; and

13.5.5.i. A review of the effectiveness of each psychotropic medication the child is taking at the time of the review.

13.6. Permanency Plans.

The organization shall assist the MDT in the development of a permanency plan for each recipient of service, when required by statute.

§78-3-14. Service Delivery.

14.1. Program Description.

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

14.1.1. The goals of the program;

- 14.1.2. The expected outcomes of the program;
- 14.1.3. The services provided by the program;
- 14.1.4. The usual staffing of the program including ratios and overall credentialing;
- 14.1.5. Characteristics of children appropriately served by the program; and
- 14.1.6. Restrictions in access to the program, if any.

14.2. Involvement of Families and Guardians.

14.2.1. The organization shall document efforts to involve families of biological origin and foster and adoptive families in developing, modifying and reviewing plans of care unless contraindicated by the court or unless clinically contraindicated in writing in the child record, regardless of custody.

14.2.2. When residential or other out-of-home services cannot be provided close to a child's home, the organization shall document efforts to maintain family ties and involve the family in plan of care and delivery.

14.2.3. The organization is responsible for notifying parents and guardians of:

- 14.2.3.a. Interdisciplinary team meetings;
- 14.2.3.b. Changes in the plan of care; and
- 14.2.3.c. Critical incidents and significant changes in the child's condition.

14.2.4. The notification shall be completed within one working day after the event and documented.

14.2.5. If the organization cannot obtain guardian or parental participation and permission for treatment after documented efforts to do so, it shall not be held in violation of regulatory standards regarding permission and participation. However, the organization shall continue to document on-going efforts to include parents and guardians in the treatment process.

14.3. Behavioral and Therapeutic Interventions. An organization that uses therapeutic interventions shall:

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

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

14.3.3. Apply interventions in a caring and humane manner; and

14.3.4. Carefully describe and document interventions in the client record and in the plan of care.

14.4. Discipline.

14.4.1. The organization shall outline and follow its practices regarding discipline of persons served and this policy shall prohibit the following:

14.4.1.a. Corporal punishment (physical hitting or physical punishment inflicted in any manner upon the body);

14.4.1.b. Physical exercises such as running laps or pushups when used solely as a means of punishment;

14.4.1.c. Requiring or forcing the child to take an uncomfortable position for an extended period of time or forcing the child to repeat physical movements when used solely as a means of punishment;

14.4.1.d. The use of aversive conditioning such as electric shock devices, sound, heat, cold, light, water, noise, hot pepper, pepper sauce, pepper spray or ammonia;

14.4.1.e. Interventions that involve withholding nutrition, sleep, or hydration;

14.4.1.f. Punitive work assignments;

14.4.1.g. Sanctioning by peers, except as part of an organized therapeutic self-government program that is conducted in accordance with written policy and is supervised directly by employees;

14.4.1.h. Punishment of the group for an individual child's behavior except as it involves a brief delay to initiation of the next activity or to ensure safety of the employees and children or as part of a therapeutic program using logical and natural consequences as a means of discipline;

14.4.1.i. Punishment that subjects the child to verbal abuse, ridicule, or humiliation;

14.4.1.j. Excessive denial of on-grounds program services or denial of any essential program service solely for disciplinary purposes;

14.4.1.k. Denial of visiting or communication privileges with family solely as a means of punishment;

14.4.1.l. Enforced silence for long periods of time;

14.4.1.m. Exclusion of the child from entry to the residence;

14.4.1.n. Assignment of unduly physically strenuous or harsh work;

14.4.1.o. Use of physical restraint involving peers;

14.4.1.p. Use of physical restraint outside commonly accepted systematic methods of passive physical control applied in an appropriately de-escalating fashion; or

14.4.1.q. Use of any technique of manual or physical restraint as an ongoing intervention for inappropriate or undesired behavior except in situations involving significant risk of harm to self or others if the restraint is not used.

14.4.2. The organization shall discontinue use of any intervention if it:

14.4.2.a. Produces adverse side effects such as illness, physical damage, or injury; or

14.4.2.b. Is ineffectual or detrimental to meeting service goals and objectives.

14.5. Medication Control and Administration.

14.5.1. Medication shall be prescribed and monitored by a licensed physician, dentist, physician's assistant, or advanced practice registered nurse. The organization is responsible for physicians and other medical employees contracted for service just as it is responsible for physicians considered to be employees.

14.5.2. Organizations that administer medication using approved medication assistive personnel shall comply with the Department's rule, "Delegation of Medication Administration and Health Maintenance Tasks to Approved Medication Assistive Personnel," 64CSR60.

14.5.3. A child entering a facility with properly bottled and labeled medications may continue on those medications with appropriate consents, until such time as the organization can obtain current physician's orders, either from the organization's physician or the child's physician, to continue the medications will be in accordance with the medical licensing requirements and standards.

14.5.4. When medication is prescribed or administered, the organization shall:

14.5.4.a. Obtain the written consent of the parent or legal guardian and the child over age 12 unless the child is incapable of supplying informed consent or there are compelling and documented clinical or legal reasons to overlook the child's lack of consent.

14.5.4.a.1. When the medication is a psychotropic, except for medications the child is prescribed and taking prior to entering the program, the following information shall be provided to the parent or guardian, or both:

14.5.4.a.1.A. Specification of conditions the medication is to address, such as mood swings, irritability, etc.;

14.5.4.a.1.B. Efforts to address condition without medication;

14.5.4.a.1.C. The expected length of time on medication;

14.5.4.a.1.D. Necessary medical testing needed to determine proper usage of the medication; and,

14.5.4.a.1.E. How often symptoms will be evaluated to determine effectiveness of the medication.

14.5.4.b. Fully explain the benefits and possible side effects of the proposed medication (except in cases of routine refill, changes within a class of medications or dosage changes); and

14.5.4.c. Obtain approval from the parent or legal guardian in advance to dispense medication unless there is documented inability to reach the guardian within a reasonable period of time relative to the urgency of the need for the medication, which shall be documented. In the case of all other prescribed medication, the guardian will be notified, within one next business day, of the medication prescribed, the reason, and the date the medication began.

14.5.5. The organization shall have a written procedure directing the administration and storage of prescribed and over-the-counter medications to include:

14.5.5.a. An individual record for those children who receive medications to include:

14.5.5.a.1. Medications administered;

14.5.5.a.2. The date medications were administered;

14.5.5.a.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

14.5.5.a.4. The individual administering the medication;

14.5.5.b. A record of all appointments for medication management including unscheduled or canceled visits;

14.5.5.c. A record of missed medications and the reason;

14.5.5.d. Protocols for the administration of over-the-counter medications that includes individualized approval by a physician or qualified medical practitioner; and

14.5.5.e. Prescription medications shall be properly labeled and packaged and include:

14.5.5.e.1. The name of the person served;

14.5.5.e.2. The dosage and the name of the medication;

14.5.5.e.3. The name of the prescribing physician; and

14.5.5.e.4. An expiration date.

14.5.6. The organization shall have written procedures that govern:

14.5.6.a. The safe disposal of discontinued, out-of-date, or unused medications, syringes, medical waste, or medication; and

14.5.6.b. Provision for locked, supervised storage of medications with access limited to authorized employees.

14.5.6.c. Medication errors as described under subsection 3.46 of this rule.

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

14.5.8. Organizations shall have, at a minimum, a consulting registered nurse whose responsibilities shall include as necessary:

14.5.8.a. Generating and reviewing monthly Medication Administration Records;

14.5.8.b. Matching physician's orders to the medication administration records;

14.5.8.c. Observing employees supervising self-administration of medications at least quarterly;

14.5.8.d. Assisting interdisciplinary teams to develop educational goals for children taking regularly prescribed medications and participating in a supervised self-administration protocol;

14.5.8.e. Instructing employees in dietary or medication administration issues as necessary;

14.5.8.f. Responding to emergency calls from employees on medical issues, and;

14.5.8.g. Conducting ongoing assessments of each child's health needs to include existing medical conditions, dietary issues, and medications.

14.5.9. The nursing employees of the organization shall assess each child or youth for the ability to self-medicate with supervision if the organization allows such administration before the youth is admitted into the program. Children not capable of participating in a plan shall have medications administered by licensed nursing employees or approved medication assistive employees as set forth in the Department's rule, "Delegation of Medication Administration and Health Maintenance Tasks to Approved Medication Assistive Personnel," 64CSR60. This requirement does not apply to organizations that operate shelters with a no refusal policy.

14.5.10. Medications may be self-administered under supervision of employees under the following conditions:

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

14.5.10.b. The child is assessed by nursing staff as being cognitively capable of learning these skills.

14.5.10.c. Medication is kept in a secure location with limited access to employees only except at dosage times;

14.5.10.d. Employees are fully trained as to the purpose, most common side effects and dangers of each medication prescribed for children in the facility, and can identify each medication on sight;

14.5.10.e. Employees are trained in emergency procedures for overdose or abreactions;

14.5.11. The organization shall assess the effect of medication on the child at regular intervals and base its assessment on:

14.5.11.a. Documentation by clinical employees of the person's behavior in the case record;

14.5.11.b. The observations of the child, employees, and significant others; and

14.5.11.c. Any commonly recommended medical tests necessary to determine the impact and safety of the medication on the persons served (e.g., blood levels, etc.).

14.5.12. Organizations with a length of stay longer than one year shall document attempts to titrate psychotropic medications to the lowest possible level while still achieving symptom control prior to discharge.

14.6. Medication as Chemical Restraint.

An organization shall not use chemical restraints unless permitted otherwise by its specific rules.

14.7. Case Records.

14.7.1. The organization shall maintain a case record for each child served that shall be retained for a minimum of 5 years following the child's 18th birthday.

14.7.2. Case records are confidential and access to case records is limited to:

14.7.2.a. The child and as appropriate, his or her parent, guardian, or attorney, unless legally contraindicated;

14.7.2.b. Employees authorized to see specific information on a "need-to-know" basis; and

14.7.2.c. Others outside the organization whose access to the information contained in case records is permitted by law.

14.7.3. When not being used by authorized employees, case files should be returned to a secure area.

14.7.4. The case record shall comply with all legal requirements and contain, at a minimum:

14.7.4.a. Biographical or other identifying information;

14.7.4.b. Copies of custody and guardianship papers and court orders if appropriate and possible within the time frame of the program;

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- 14.7.4.c. Reasons for referral and admission date;
 - 14.7.4.d. Assessment information;
 - 14.7.4.e. A master plan of care including goals and objectives of service;
 - 14.7.4.f. Behavior support plans or therapy plans, or both, if any;
 - 14.7.4.g. Reviews of the master plan of care as appropriate;
 - 14.7.4.h. Reports from outside or contracted providers of service to the child;
 - 14.7.4.i. Copies of all signed, written consent forms;
 - 14.7.4.j. Routine documentation of ongoing services;
 - 14.7.4.k. Documentation of incidents or investigations or reference to a separate incident file for each incident or investigation;
 - 14.7.4.l. Documentation of any therapeutic physical restraints used by the organization with the child in question;
 - 14.7.4.m. Documentation of medication administration for prior months;
 - 14.7.4.n. Educational records, such as report cards, individual education plans, and class schedules, as available considering average program length;
 - 14.7.4.o. Recommendations for ongoing or future service needs and assignment of aftercare or follow-up responsibility if needed and appropriate will be outlined in the discharge summary; and
 - 14.7.4.p. A discharge summary will be entered within 30 days of termination or discharge.
- 14.7.5. The organization shall document a reasonable effort to obtain required materials.
- 14.7.6. When necessary and appropriate, the case record shall also include:
- 14.7.6.a. Legal evidence of custody;
 - 14.7.6.b. Court ordered restrictions on the rights of persons served;
 - 14.7.6.c. Psychological, medical, toxicological, diagnostic, or psychosocial evaluations;
 - 14.7.6.d. Copies of all written orders for medications or special treatment procedures such as diet and physical therapy;
 - 14.7.6.e. Regular reports from contracted service providers serving the child or family; and
 - 14.7.6.f. Other information essential for delivering service to the child.

14.7.7. Only authorized employees may make entries into case records and all entries shall be:

14.7.7.a. Specific, factual, and pertinent to the nature of the service and the needs of the persons served; and

14.7.7.b. Completed, signed, or electronically identified and dated by the person who provided the service.

14.7.8. Case records shall be clearly legible, kept up-to-date from intake through termination and contact entries shall be made within one working day, unless the group is away from the main facility, in which case entries shall be made within one working day, of return to the main facility or program site.

14.8. Termination or Discharge.

14.8.1. Discharge plan shall be developed with the creation of the plan of care.

14.8.2. Termination or discharge shall occur when:

14.8.2.a. The child achieves the goals of his or her plan of care or is no longer in need of out-of-home care;

14.8.2.b. The child has reached maximum benefit or cannot benefit further from services provided by the organization;

14.8.2.c. The guardian terminates treatment;

14.8.2.d. The child no longer meets eligibility criteria;

14.8.2.e. The child refuses to meet program standards or requirements; or

14.8.2.f. The child completes court-ordered treatment.

14.8.3. The organization and interdisciplinary team, guardian, placement organization (such as the court), multidisciplinary team, and the person or family shall jointly plan for termination or discharge. Prior to discharge, the team shall meet to review and document the child's progress in treatment, describe continuing problems and issues and develop specific recommendations for aftercare and follow-up. The aftercare and follow-up plans or recommendations shall be provided to the child and his or her parent and guardian upon discharge.

14.8.4. The organization shall enter a discharge summary into the case record upon termination of service within 10 days of termination or discharge that:

14.8.4.a. Includes recommendations for any needed future services; and

14.8.4.b. Provides a summary of services received while in care and an assessment of service effectiveness.

14.9. Educational Services.

14.9.1. The organization shall access an educational program for each school-age child in care.

14.9.2. All children in residential child care shall be enrolled in an educational or vocational program (depending on age and the child's expressed desire) and provided with an educational or vocational plan, as appropriate, that is integrated into his or her plan of care and complies with the requirements set forth by the State Department of Education.

14.9.3. When appropriate and unless clinically, programmatically, or educationally contraindicated, children and transitioning adults shall be enrolled in the public school system. Organization employees shall maintain regular contact with school employees at a frequency appropriate for the severity and type of each child's problems and service needs. The organization shall have a practice describing the method and frequency of contact.

14.9.4. The organization shall collaborate with the public or private school so that information can be exchanged freely, and problem behaviors addressed consistently across all environments.

14.10. On-Ground Schools.

14.10.1. On-ground schools shall be operated by the State Department of Education or a county board of education. Outdoor therapeutic educational programs are exempt from this requirement and shall comply with the requirements set forth in section 22 of this rule.

14.10.2. Therapeutic support plans developed in the residential setting shall be continued in the on-ground educational setting and vice versa. The educational program and the residential program shall communicate on a regular basis to ensure that this occurs and shall exchange data and information regularly. The organization shall have a practice and an interorganizational or interoffice agreement specifying how the organizations or offices will interact and the frequency of that interaction.

14.11. Groups and Groupings.

14.11.1. The organization shall ensure that therapeutic activities and groups shall be of an appropriate size to promote the success of the activity. Living areas are limited to no more than 12 children.

14.11.2. Children shall have the right to be housed with children of the same approximate ages, developmental levels, and social needs. This separation shall be a matter of organizational practice.

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

14.11.2.b. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

14.12. Employment Opportunities.

The organization may involve the child in voluntary maintenance of the facility so long as those work programs do not replace the organization's need for housekeeping and maintenance employees. Household "chores" may be required as a condition of participation in the program or as a method of

moving to a more privileged level of programming. Descriptions of the employment opportunities should be included in the organization's descriptions. All employment opportunities shall be evaluated for their therapeutic or habilitative value. The organization shall pay the child for an activity at a level required by state or federal law if there is no therapeutic or rehabilitative value in the activity. Money earned in an employment opportunities belongs to the child, although the organization may maintain control of the money until the child's discharge, using an accurate and on-going method of tracking disbursements and deposits, made available to the child or guardian upon request. Employment opportunities other than household "chores" shall be evaluated and approved by the interdisciplinary team.

14.13. Daily Schedules.

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

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

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

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

14.13.1.d. Available at all times to the employees and child; and

14.13.1.e. Comprehensive of all waking hours while allowing a reasonable amount of recreational, study and quiet time.

14.13.2. The daily schedules are not required to be archived in the child's file.

14.14. Employee Supervision.

14.14.1. At all times, the organization shall have sufficient employees to allow the number of children being served to be adequately supervised, taking into consideration the complexity of the needs of the children. The organization shall consider appointments requiring employee supervision, employee leave, possible illness of children and any other relevant factor when scheduling employee and child activities.

14.14.2. Except as otherwise provided by this rule, children shall be supervised at all times. Short breaks in direct supervision shall be therapeutically indicated or necessary for the child to gain independence. The supervision of each child shall be determined in relation to normalcy and the reasonable and prudent parent standard. The supervision level must be documented in the child's treatment plan that shall detail specific activities geared to support the youth's treatment needs. Generic treatment plans will not meet the intent of this regulation.

14.14.3. Youth actively working toward independence shall be permitted short breaks in supervision to pursue recreation, employment or educational opportunities that complement his or her plan of care.

14.14.4. The organization shall have a procedure regarding employee supervision that ensures the safety, supervision and security of children who are acutely disturbed or suicidal, or both.

14.14.5. The organization shall have a procedure regarding supervision of children in off grounds activities that shall maximize the supervision and safety of children participating in the activities.

14.14.6. The organization shall ensure that when children leave a facility for overnight visits, there is a procedure for signing or being checked in and out of the program. The checklist or sign-in sheet shall be dated and shall include time in and out, the person responsible for the child, as appropriate, and the location at which the child may be contacted if necessary.

14.15. Special Services and Populations.

14.15.1. If an organization provides specialized services to a unique population (e.g., children with issues of substance abuse, children with developmental disabilities, sexually reactive children) the organization shall ensure that:

14.15.1.a. The service and clinical model reflects knowledge and use of the best practices available in the field;

14.15.1.b. Clinical and professional employee are appropriately trained and when possible certified or licensed in the area of service provided;

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

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

14.15.1.e. The facility is suitably secure and employee ratios suitably high to ensure the supervision and safety of children served during a crisis.

14.15.2. If an organization accepts into service a child with unusual clinical or programmatic needs, or both, the organization is responsible for adapting its routine practices to meet the needs of the child in care to the greatest extent possible. If it becomes evident that the child cannot benefit from the program, even with the adaptations the organization is able to make, the organization is responsible for assisting the department in identifying a more suitable placement at the earliest opportunity in conjunction with the guardian or multidisciplinary team, or both.

14.15.3. A residential program that specializes in serving children and transitioning adults with developmental disabilities or intellectual disabilities shall ensure that employees are trained to properly provide habilitation services and supervision in the following areas as appropriate for the population served:

14.15.3.a. Feeding;

14.15.3.b. Communication with nonverbal individuals;

- 14.15.3.c. Use of community recreation options;
- 14.15.3.d. Management of self-abusive and aggressive behavior;
- 14.15.3.e. Adaptive living skills;
- 14.15.3.f. Person first language and attitudes;
- 14.15.3.g. Therapeutic behavioral supports; and
- 14.15.3.h. Implementation of normalcy.

14.15.4. When serving individuals with developmental disabilities for more than 30 days, the program shall provide supportive services to help them fully interact with the community and achieve maximum independence. If the organization provides or contracts for the provision of therapeutic services such as individual therapy, it shall ensure that therapeutic interventions are adapted for the developmental functioning of the child.

14.15.5. An organization that provides services to children with developmental disabilities shall adhere to and implement normalcy and adapt the organization's therapeutic facilities to meet the developmental needs of the child.

14.15.6. The organization shall provide children with co-occurring presenting issues with specialized services to meet their needs as identified in the comprehensive assessment. The organization shall arrange for detoxification and inpatient services to meet any emergency needs of children.

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

14.15.8. If the organization specializes in co-occurring presenting issues, employee training shall comprehensively address the latest information, theories, and techniques in:

- 14.15.8.a. Identification, diagnosis and treatment of alcohol and drug abuse;
- 14.15.8.b. The concept of chemical dependency as a disease; and
- 14.15.8.c. Prevention activities that address both primary and relapse prevention.

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

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

14.15.9.b. Obtain either directly or by contract or referral specialized treatment interventions or services as appropriate; and

14.15.9.c. Consider the child's history when making determination regarding housing and supervision in order to ensure the safety of all the children.

14.15.10. If the organization specializes in the treatment of children with sexualized behaviors:

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

14.15.10.b. Employees shall be specially trained in the supervision and treatment of sexualized behaviors in children; and

14.15.10.c. Professional employees shall be trained and certified as appropriate in the treatment of sexualized behaviors in children or shall be in the process of obtaining certification and properly supervised by certified employees.

14.15.11. If the organization discovers that a child is pregnant and it is not a Maternity and Parenting Program, it shall provide or make referral for the following health services, at a minimum, until other arrangements are made;

14.15.11.a. Fetal alcohol syndrome screening;

14.15.11.b. Prenatal care;

14.15.11.c. Well-baby care; and

14.15.11.d. Parenting skills instruction.

14.16. Health Services.

14.16.1. The organization shall have a procedure in place to ensure emergency medical care for all its children on a 24-hour basis.

14.16.2. Each child shall have upon admission or receive within 72 hours of admission a current medical screening by a qualified medical practitioner (EPSDT). The screening shall document:

14.16.2.a. A general history of the child's and family's health;

14.16.2.b. The patient's current medications;

14.16.2.c. Allergies;

14.16.2.d. Pertinent medical problems requiring nursing attention;

14.16.2.e. Current risk and safety factors;

14.16.2.f. Nutritional status;

14.16.2.g. Immunization status, and

14.16.2.h. Sleep patterns.

14.16.3. In facilities with stays of longer than 30 days duration, appropriate dental assessments shall be conducted at least annually to include provision of any routine dental care as recommended by the evaluating dentist.

14.16.4. Health services shall also include, in facilities with stays of longer than 30 days duration, age appropriate instruction regarding:

14.16.4.a. Pregnancy prevention,

14.16.4.b. AIDS/HIV and STD prevention,

14.16.4.c. Nutrition;

14.16.4.d. Laboratory or other diagnostic work as prescribed by a physician; and,

14.16.4.e. Other general information about the prevention and treatment of disease.

14.16.5. Educational services shall also be provided regarding psychotropic medications and mental health as age appropriate and necessary. When possible, the family of origin or expected family of projected placement shall be educated as well.

14.17. Clothing.

14.17.1. The organization shall ensure that each child in care has adequate, clean, well fitting, attractive, and seasonable clothing as required for health, comfort, and physical well-being and as appropriate to age, sex and individual needs. The child shall be encouraged to participate in the selection of clothing.

14.17.2. A child's clothing shall not be shared in common.

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

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

14.17.5. The organization shall ensure that discharge plans make provisions for clothing needs at the time of discharge. All personal clothing shall go with a child when he or she is discharged, or arrangements shall be made if the child was not able to leave with his or her personal belongings.

14.18. Personal Belongings.

The organization shall allow a child to bring personal belongings to the program and to acquire belongings. However, the organization shall, as necessary, limit or supervise the use of these items.

Provisions shall be made for the protection of a child's property. The organization shall provide a list of items that are not appropriate for the child to have at the program upon intake.

14.19. Personal Hygiene.

14.19.1. Procedures to ensure that children receive assistance and education in personal care, hygiene and grooming appropriate to their age, gender identity, race and culture shall be established.

14.19.2. The organization shall ensure that children are provided with all necessary toiletry items.

14.19.3. A child shall be permitted a reasonable degree of freedom in selecting a style of wearing his or her hair and clothing.

14.20. Religion and Culture.

14.20.1. Children shall have the opportunity to participate in religious activities and services in accordance with their own faith. The organization, when necessary, shall arrange transportation.

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

14.20.3. The organization shall involve children in cultural or ethnic activities, appropriate to their own cultural or ethnic background.

§78-3-15. Restrictive Behavioral Interventions.

15.1. Legal Compliance.

15.1.1. Restrictive behavior management techniques include restraint (physical, mechanical, or chemical) and seclusion. The organization shall have a policy with specific procedures to govern the use of these techniques. The policy shall delineate the circumstances under which these techniques may be used and shall describe which techniques may be used in precise language. Unless indicated otherwise in this rule, restraints are to be used only in an emergency when there is imminent risk of the child physically harming himself or herself or others, including employees. Non-physical interventions are the first choice as an intervention unless safety issues demand an immediate physical response. Restrictive behavior management techniques are not to be used as a part of an approved plan of care.

15.1.2. Group restraints incorporating peers as restrainers or observers are prohibited in any treatment environment.

15.1.3. Seclusion, chemical and mechanical restraints shall be used only in facilities with explicit permission to do so as described in this rule (i.e. psychiatric residential treatment facilities and intermediate care facilities).

15.2. General Guidelines.

15.2.1. Restrictive behavior management techniques shall be used only in emergency situations to protect individuals from harming themselves or others and not as part of an on-going plan of care.

15.2.2. Use of the techniques shall conform to federal guidelines unless the guidelines are less stringent than those described in this rule.

15.2.3. The organization shall maintain comprehensive data on the use of any restrictive behavior management practices, collected individually for each organization or program it manages, and shall summarize and review that data quarterly. An annual report shall be made to the governing body by the safety committee or officer.

15.2.4. At admission, each child shall be assessed for his or her potential need for use of restrictive behavior management interventions. The assessment shall include:

15.2.4.a. The potential for risk of harm to himself, herself, or others;

15.2.4.b. Antecedents (if known) to out of control behavior;

15.2.4.c. Effectiveness (if known) of previous use of these interventions;

15.2.4.d. Psychological or social factors such as psychosis, claustrophobia or; a history of sexual or physical abuse that would influence the use of the practices; and

15.2.4.e. Medical factors that might put the person at risk in a restraint.

15.2.5. If the child is judged likely to require the use of restrictive behavior management techniques, employees shall be alerted to any considerations identified in the assessment and trained appropriately.

15.2.6. The organization shall ensure and document that the parent or legal guardian:

15.2.6.a. Received notification in writing at the time of admission that these interventions are used by the organization;

15.2.6.b. Received a copy of the behavior management protocol; and

15.2.6.c. Was notified immediately if a restraint was used unless the guardian has requested otherwise.

15.2.7. The organization shall prohibit the following:

15.2.7.a. Use of restrictive behavior management techniques in non-crisis or emergency situations, as a form of coercion or discipline, or for the convenience of employees;

15.2.7.b. Excessive or inappropriate use of restrictive behavior management techniques; and

15.2.7.c. The application of restrictive behavior management interventions by other persons served or any person other than trained, qualified employees.

15.2.8. The condition of the restrained or secluded person shall be monitored. Consciousness, respiration, agitation, mental status, skin color and skin integrity should be monitored continuously.

15.2.9. Employees identified as medical professionals should have the authority to prevent a specific intervention based on health issues.

15.2.10. Properly trained employees should have the authority to stop a specific behavioral intervention based on health issues.

15.2.11. The employee shall discontinue restrictive behavior management interventions immediately if they produce adverse side effects such as illness, severe emotional or physical stress or physical damage and obtain immediate medical treatment for the child.

15.3. Training.

15.3.1. All employees with direct contact with children shall receive documented training in the organization's restrictive behavior management practices.

15.3.2. All direct care, supervisory and clinical employees shall receive initial and ongoing competency-based training on the organization's restrictive behavior management policies, procedures, and practices appropriate for the type of program.

15.3.3. The training shall include:

15.3.3.a. Recognizing situations, including medical conditions that may lead to a crisis;

15.3.3.b. Recognizing unique situations that preclude the use of restraints (medical issues, sexual reactivity, etc.);

15.3.3.c. Understanding how employee behavior can influence the behavior of persons served; and

15.3.3.d. Using appropriate methods for de-escalating volatile situations, including verbal techniques, mediation, distraction and diversion and other non-restrictive ways of dealing with aggressive or out of control behavior.

15.4. Physical Restraint.

15.4.1. Written procedures shall govern the use of physical restraint. They shall specify that:

15.4.1.a. Physical restraint may be used only in emergency or crisis situations to protect individuals from harming themselves or others;

15.4.1.b. Employees shall use the least restrictive, safest, and most effective methods generally accepted in the field;

15.4.1.c. Physical restraint may be used in each instance only when less restrictive measures have proven to be ineffective or in an immediately dangerous situation that precludes the use of other interventions;

15.4.1.d. The decision to use physical restraint shall take into account an analysis that determines that the risk of the individual's behavior to himself, herself or others outweighs the potential risk of the use of physical restraint. This analysis shall be documented as soon as possible after the use of the restraint;

15.4.1.e. Physical restraint shall be discontinued as soon as possible;

15.4.1.f. All direct service employees shall have access to a copy of written policies and procedures regarding the appropriate and limited use of physical restraint;

15.4.1.g. A continuing monitoring system shall be kept documenting the names of employees restraining children, the names or identifiers for children restrained, the date and the time of restraint, other individuals involved, the circumstances and reasons for physical restraint, the amount of time the child is restrained, less restrictive measure utilized, and documentation of supervisory review and clinical justification;

15.4.1.h. Use of physical restraint shall be documented in the person's case record;

15.4.1.i. Use of a physical restraint shall result in completion of a report;

15.4.1.j. Significant injuries occurring during a physical restraint shall be reported to the Institutional Investigative Unit under mandatory reporting requirements; and

15.4.1.k. The organization shall have documentation of notification of the parent or guardian unless he or she indicates in writing that he or she does not wish the notification or unless the parent or guardian has specified parameters for notification (i.e., in case of injury during restraint).

15.4.2. The organization shall have designated staff who shall review each incident of physical restraint no later than one working day after its use.

15.4.3. Physical restraint may not be used:

15.4.3.a. To force a child into compliance;

15.4.3.b. In response to cursing or screaming;

15.4.3.c. For refusal to participate in an activity; or

15.4.3.d. For failure to join a group activity.

15.4.4. The use of physical restraints shall be discontinued as soon as possible and shall be limited to guidelines of the crisis intervention model the organization follows and state and federal law.

15.4.5. Employees shall make periodic attempts to free the child during the period in which the restraint is employed.

15.4.6. If the restraint extends longer than recommended guidelines, the organization shall document the reason for the extended restraint and describe action taken to prevent further use of extended physical restraint.

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

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

15.4.7.b. Identify antecedent behaviors and modify the care plan as appropriate; and

15.4.7.c. Analyze how the incident was handled.

15.4.8. Employees and designated supervisory employees shall discuss necessary changes to procedures or employee training, or both, in order to preclude further restraints to the maximum extent possible. Recommendations shall be documented.

§78-3-16. Critical Incidents and Crisis Management.

16.1. Abuse and Neglect.

16.1.1. The organization shall have a procedure regarding identification and reporting of instances of alleged abuse or neglect of children in its care that shall be in compliance with W. Va. Code §49-2-801 *et seq.*

16.1.2. Definitions of abuse and neglect and procedures regarding reporting of abuse and neglect shall be consistent with those established by state law.

16.1.3. The employees, volunteers and management of any organization are considered to be mandatory reporters by State Law and are required to report any and all allegations of abuse and neglect to the appropriate state authorities as required in W. Va. Code §49-2-801 (Part VIII). All allegations of abuse and neglect shall be immediately reported to the Institutional Investigative Unit of the Department via a telephone call to the Child Abuse Hotline. Within 48 hours of the incident, the organization shall prepare a written incident report that shall be available to the Institutional Investigative Unit upon request. The Institutional Investigative Unit will inform the organization if an investigation of the incident shall be conducted. If the Institutional Investigative Unit indicates that there shall be no Institutional Investigative Unit investigation the allegation shall be downgraded to a critical incident and the organization shall proceed with a full investigation.

16.1.3.a. The organization shall limit internal assessment of an incident to ensuring the safety of the children in placement without compromising the Department's subsequent investigation.

16.1.4. All incidents that have harmed or may have represented potential harm to a child or children shall result in the completion of an incident form. Incidents suspected of being subject to mandatory reporting requirements as defined by W. Va. Code §49-2-801, *et seq.* shall be reported to the Institutional Investigative Unit according to organization policy and procedures. This shall include medication errors with negative outcome for the child and any injuries occurring in the course of a restraint.

16.1.5. The organization shall cooperate fully in an investigation of any incident and shall provide all information requested by the Department.

16.1.6. Any investigations completed by the organization shall be maintained and made available to the state regulatory agency.

16.1.7. In all cases, the organization shall take the actions necessary to protect the child from further harm until an investigation is completed. An incident involving the alleged sexual abuse or physical abuse causing a serious physical injury to a child by an employee of the organization requires that the employee be removed from direct service work with children until the investigation is completed. Otherwise, the organization shall have a procedure in place for management of employees alleged to have abused or neglected a child that may include any or all of the following:

16.1.7.a. Removal from duty pending investigation;

16.1.7.b. Increased supervision to ensure child safety;

16.1.7.c. Transfer to a substantially different area of the organization with different children (higher developmental functioning, different sex, etc.);

16.1.7.d. Transfer to a different more closely supervised shift;

16.1.7.e. Transfer to different job responsibilities that does not include contact with children; and

16.1.7.f. Other appropriate actions as indicated by the circumstances.

16.2. Critical Incidents.

16.2.1. The organization is responsible for monitoring and investigating any incident that may have had the potential for harming a child emotionally or physically with the exception of those incidents investigated by the Institutional Investigative Unit. Critical incidents include but are not limited to the following:

16.2.1.a. Attempted suicide with some potential for being lethal;

16.2.1.b. Behavior likely to lead to serious injury or significant property damage;

16.2.1.c. Fire resulting in injury;

16.2.1.d. Major involvement with law enforcement authorities;

16.2.1.e. Possession of illicit substances including alcohol;

16.2.1.f. Possession of weapons;

16.2.1.g. Injury resulting in hospitalization or medical treatment;

16.2.1.h. Significant reaction to a medication or food;

16.2.1.i. Medication errors with negative outcome that the Institutional Investigative Unit determines it will not investigate;

16.2.1.j. Dietary errors resulting in negative outcome for the child;

16.2.1.k. Extended and unauthorized absence;

16.2.1.l. Significant injuries of unknown origin; and

16.2.1.m. Any other incident judged by employees, management or other individual to be significant and to potentially have a negative impact on the child.

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

16.2.3. All critical incidents shall be documented, then investigated by a designated member of the organization's safety committee, or similar committee. The investigation shall result in a report that will be reviewed by the administrator or his or her designee within five working days of the occurrence of the incident or within five days of notification by the Institutional Investigative Unit that it will not investigate. The report shall describe the incident, possible antecedents, consequences, witnesses, time of day, length of the incident, the individuals involved and any other information necessary for quality improvement and risk management. Whenever possible, all witnesses should be interviewed, and the results of the intake documented.

16.2.4. All facilities will also encounter incidents that are not necessarily critical in nature, but that will require investigation. Again, lack of employee oversight shall always be evaluated as an issue. If that lack led to a negative outcome for the child, it shall be upgraded to mandatory reporting. Injuries of unknown origin shall also always be evaluated and considered for potential of abuse in protected populations.

16.2.5. If a pattern of non-critical incidents is identified, the organization shall refer to the quality assurance team for a thorough investigation of incidents typical of the pattern.

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

16.2.7. Incident reports shall be completed prior to the end of the shift of the reporter or individual involved. The program supervisor shall review and sign off on the report within one working day. The organization shall immediately make reports to the Institutional Investigative Unit when appropriate. Written reports shall follow within 48 hours. Internal investigations shall be completed within five days of the incident or within five days of notification by the Institutional Investigative Unit that it will not investigate, depending on the nature of the incident.

16.2.8. The organization shall regularly and at least every 90 days submit all incident reports either to the organization's safety committee or officer for review. That review shall result in an annual report to the governing body and shall be used to improve quality and safety of care to the children in service.

16.3. Emergency Medical Services.

16.3.1. The organization shall have written procedures for directing employees in case of medical emergencies.

16.3.2. All employees shall have access to the procedures and to a list of emergency numbers.

16.3.3. All employees shall be trained in emergency medical procedures.

16.3.4. Residential direct care employees shall have at a minimum the availability of telephone contact with supervisory employees on a 24-hour basis. Telephone numbers for supervisory employees and schedules of on-call responsibility shall be readily available to all employees at all times.

16.4. Deaths.

All children's deaths shall be reported to law enforcement, the Institutional Investigative Unit through DHHR Centralized Intake and the licensing specialist, the child's DHHR caseworker, the Office of Health Facility Licensure and Certification, the coroner of the county in which the organization is located, and to other state or federal agencies as required by law within 24 hours.

§78-3-17. Group Residential Child Care and Treatment.

17.1. Employee Ratios and Training.

17.1.1. Employees, for the purposes of this section, are those individuals who are:

17.1.1.a. Fully oriented and trained according to organizational policy; and

17.1.1.b. Have job responsibilities that pertain only to the provision of child care, treatment and supervision.

17.1.2. The group residential program shall have a policy regarding care and supervision of children that ensures that:

17.1.2.a. Children receive adequate supervision for their age, developmental functioning, and emotional and behavioral needs; and

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

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

17.1.3.a. Minimum employee-to-child ratios as described within specific program rules shall be maintained at all times; and

17.1.3.b. Additional or back-up care employees shall be available for emergency situations or to meet special needs presented by the persons in care.

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

17.1.5. As appropriate to the ages and needs of persons in care, the organization shall ensure that one or more trained professional employees are on duty or available via an on-call system on a 24-hour basis to provide continuous supervision to each residential living unit within a residential program.

17.1.6. The organization that uses a house parent model shall have a policy that ensures the safety and supervision of children at night.

17.2. Environmental Issues.

17.2.1. To the maximum extent possible, the organization providing group residential services shall be non-institutional in appearance and practices. Each child or transitioning adult shall be permitted to have personal space, personal possessions, and a place to store those possessions unless clinically contraindicated. Each child is expected to assume some responsibility for an aspect of care of living environment (cleaning, cooking, etc.) on an ongoing basis.

17.2.2. The organization shall ensure that residential living units within the milieu consist of no more than 12 children. The size of the groups shall be dictated by their function and some may be smaller than 12 members. Group therapeutic and residential living activities should be conducted in an appropriately sized group format, taking into consideration best practice standards for the gender, developmental status, and diagnosis of the members.

17.2.3. Children shall have clearly identifiable schedules and activities. Each child shall have a schedule that identifies therapy times, chore or work assignments, school hours, and other activities.

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

17.2.5. The residential program that permits pets shall have a veterinary evaluation and vaccinations as recommended by the veterinarian in writing.

17.2.6. Service elements unique to the population:

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

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

17.2.6.a.2. The child's vehicle, if any, is appropriately licensed and insured; and

17.2.6.a.3. The child receives permission in writing from his or her parent or guardian.

17.2.6.b. The organization shall have a written plan of basic daily routines that shall be available to all employees and updated regularly.

17.2.6.b.1. Children shall participate in planning daily routines.

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

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

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

18.1. Service Description.

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

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

18.1.3. Children's emergency shelter care is responsible for making reasonable efforts to assist individuals to find appropriate placement if admission is impossible because of census, program description, or client variables.

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

18.1.4.a. Establish the child's legal status;

18.1.4.b. Conduct a brief interview to ascertain the circumstances of the need for admission;

18.1.4.c. Notify the parent or guardian of the admission unless the Shelter documents that the child;

18.1.4.c.1. Is an emancipated minor;

18.1.4.c.2. Has reached age of majority; or

18.1.4.c.3. Could be endangered as a result of notification.

18.1.4.d. Notify the local representative of the Department; and

18.1.4.e. Obtain authorization to provide care for the child if appropriate and necessary.

18.1.4.f. The child shall be informed of the planned notification that shall occur immediately after admission.

18.1.5. Stays in the shelter are voluntary unless the child has been ordered into the facility by a legal entity with authority to do so. If a child voluntarily enrolled as a participant chooses to leave the facility, employees shall document efforts to persuade him or her to remain or to arrange safe alternative

placement, or both. If in the employee's assessment, the child is not capable of adequate self-protection, the employee will take action as delineated by the Department's policy.

18.1.6. Children in Shelter care shall be supervised at all times unless the child is engaged in an activity away from supervision authorized by the clinical team (e.g., home visit, public school, employment, etc.). The shelter shall ensure that when children leave the building, there is a procedure for signing or being checked in and out. The checklist or sign-in sheet shall be dated and shall include the time in/out, the person responsible for the child, as appropriate, and the location at which the child may be contacted if necessary.

18.1.7. The shelter shall have policies and procedures for expelling an individual from a shelter. Policies and procedures shall be described in an understandable fashion to the individual at admission and he or she shall also receive a copy of policies regarding standards of conduct in the shelter at that time. Policies and procedures shall:

18.1.7.a. Define the reasons or conditions for which an individual may be expelled;

18.1.7.b. Delineate a clearly defined process for expulsion, including timely due process provisions;

18.1.7.c. Describe the conditions or process for re-admission to the shelter; and

18.1.7.d. Require that all reasonable efforts be made to provide an appropriate alternative placement.

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

18.1.8.a. Sleeping accommodations;

18.1.8.b. Food;

18.1.8.c. Clothing;

18.1.8.d. Personal hygiene supplies and facilities;

18.1.8.e. Crisis intervention;

18.1.8.f. Case management and assistance;

18.1.8.g. A mailing address;

18.1.8.h. Information and referral for services;

18.1.8.i. Linkage to medical services;

18.1.8.j. Eyes-on supervision;

18.1.8.k. Supportive group counseling;

18.1.8.l. Supportive individual counseling;

18.1.8.m. Access to recreational activities; and

18.1.8.n. Educational assistance, if necessary.

18.1.9. The Shelter shall:

18.1.9.a. Provide prompt admission;

18.1.9.b. Emphasize short term stay by working aggressively to arrange more appropriate alternative placement;

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

18.1.9.d. Provide sex trafficking prevention programming that shall include (i) education about sex trafficking including what it is and the prevalence of it; (ii) education about understanding one's vulnerabilities and how to protect self from traffickers; (iii) education about how to enhance the child's existing support system of family, friends, and community; (iv) education about services for housing, homelessness prevention, and educational support; and (v) education to prevent running away.

18.1.9.e. Promote continued contact and communication between a parent or guardian and his or her child unless legally or clinically contraindicated; and

18.1.9.f. Assist in developing supportive aftercare or other services to ameliorate the problems that led to the need for the shelter.

18.1.10. Shelters are exempt from subsection 14.9. (educational services) of this rule. Shelters shall:

18.1.10.a. Informally evaluate educational needs upon admission of school-age children;

18.1.10.b. Arrange admission to the public school system; and

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

18.2. Employee Ratios and Training.

The Shelter shall have the following employees who are trained on prudent parenting standards:

18.2.1. Direct care employees who provide continuous supervision for children 24 hours per day at ratio of not less than 1-to-5 with one employee present at all times in each residential living unit and one employee present at all times who is authorized to apply the reasonable and prudent parent standards to decisions involving the participation of the child in age- or developmentally-appropriate activities;

18.2.2. A shelter manager to provide coordination and supervision of employees and operations, possessing a minimum of a bachelor's degree and two years' experience in working either in management or with children and families;

18.2.3. A consulting licensed psychologist, available as needed by employees or the children;

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

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

18.2.5.a. Performing nursing assessments on each child within five working days of admission;

18.2.5.b. Completing medication administration records for each child, updated as necessary;

18.2.5.c. Monitoring medication administration including supervising Approved Medication Assistance employees if necessary;

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

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

18.2.5.f. Monitoring medication availability, storage, record-keeping, and disposal and medication errors.

18.3. Treatment Teams.

Shelter treatment teams shall consist of the child if developmentally appropriate, a direct care employee, the case manager, and the shelter manager at a minimum. The consulting psychologist shall review and approve all activities of the treatment team if he or she was not an active participant. When appropriate for children with medical issues, the consulting nurse shall also be a member of the team or shall approve the team's activities in writing. The organization shall notify parents or guardians and the child's social worker and request they participate in team activities unless timelines for team activities prohibit such involvement or parental or guardian participation is not clinically or legally appropriate. The social worker shall receive a copy of the team's actions within 24 hours if not a direct participant.

18.4. Care Plans.

18.4.1. Shelters are exempt from the plan of care subsections 13.3. and 13.4. of this rule as long as the child is present in the facility less than 30 days. If the child is present in the facility for 30 or more days, a master plan of care shall be developed as required by subsection 13.4. of this rule and all other aspects of the rule apply with regard to service delivery, master plans of care, and reviews of plans of care.

18.4.2. Upon admission, the Shelter shall complete the collection of any background material and history available either from the child, a social worker, or a parent or guardian. From that information, the Shelter shall develop an intake plan that shall describe the following:

18.4.2.a. Further testing, evaluation, or collection of information necessary to complete the comprehensive assessment of the child and tentative timelines for completion of that assessment;

18.4.2.b. Safety plans or behavioral protocols, if necessary, to deal with any predictable inappropriate behaviors (e.g., need for eyes on at all times, employee-to-child ratio of 1-to-1, likelihood of sexual reactivity, etc.);

18.4.2.c. Plans for referrals for the necessary medical screenings; and

18.4.2.d. Permission to administer properly bottled prescription and non-prescription medications brought in by the child.

18.4.3. The intake plan shall be completed within 24 hours and approved by the admitting parent or guardian within 72 hours.

18.4.4. Within seven days, the shelter shall develop a list of problems identified in the assessment. The list may include not only behavioral health problems but also legal, familial, financial, medical, and academic problems, among others. The shelter shall determine through an interdisciplinary team meeting those problems that the shelter intends to address prior to discharge and those problems that may need to be addressed in an aftercare plan. At all times, consideration shall be given to improving the child's relationship with his or her family unless clinically or legally contraindicated.

18.4.5. The shelter shall provide objectives for each problem that it has determined that it shall address prior to discharge.

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

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

18.4.8. If an objective includes an individual or group therapy intervention, the intervening organization or provider, whether the shelter's employee or a contractual or other provider to whom the organization refers, shall be responsible for developing a specific therapy plan that describes the processes the therapist intends to use, in specific language, and the skills to be learned or behaviors to be increased or reduced by the child. If necessary, a plan or protocol shall be provided to direct care employees to attempt to generalize behaviors discussed in therapy to the shelter environment. Outside providers shall be responsible for providing written feedback to the shelter prior to discharge, in writing, regarding progress made in therapy or lack thereof and rationale for the lack of progress.

18.4.9. Physicians or qualified medical practitioners providing services to children in the shelter, whether by contractual or referral relationship, shall be responsible for communicating with the shelter nurse regarding medication changes, and for providing written records regarding changes in medications and the rationale for the changes.

18.4.10. The shelter shall provide a nationally recognized behavioral health program for known victims of sex trafficking; and

18.4.11. The programming shall provide opportunities for children to experience some of the same normalizing experiences as their peers not in foster care.

18.5. Behavior Plans.

18.5.1. If a child requires a specific behavior support plan or a protocol for employees to use in dealing with an inappropriate behavior, the plan or protocol shall be in writing and shall be in terms that make it clear to direct care employees:

18.5.1.a. The behaviors to be monitored and modified;

18.5.1.b. The precise action to be taken by employees if the behavior occurs; and

18.5.1.c. The documentation employees are responsible for supplying, if any.

18.6. Reviews of Plans of Care.

The treatment team shall meet to review progress in implementing the plan of care and to modify it, as necessary, on a monthly basis when a youth stays beyond 30 days. The plan of care shall be a flexible document to which may be added additional problems or objectives, as they become identified in the assessment process. Other problems may be resolved, and objectives discontinued as they become irrelevant or are achieved. A copy of any revisions to the plan shall be sent to the child's social worker for approval if the social worker is not available for the team meeting. Parents or guardians shall also receive amendments unless clinically or legally contraindicated.

18.7. Planning for Discharge.

The treatment team of the shelter shall begin planning for discharge at admission. When possible, seven days prior to discharge the child, his or her parent or guardian (as appropriate and possible), the child's social worker (if any) and the treatment team shall meet to develop a discharge plan. Issues to consider in developing the plan are:

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

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

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

18.7.4. Any other relevant and compelling information or considerations.

§78-3-19 High-Quality Group Residential Child Care Programs for Vulnerable Children.

19.1. Staffing and Training.

19.1.1. In addition to the requirements for employee training prescribed in section 11 of this rule, all employees shall be trained on prudent parenting standards and on interacting with victims of sex trafficking;

19.1.2. The agency shall have, at a minimum, at least one staff member on-site who is authorized to apply the reasonable and prudent parent standard to decisions involving the participation of the child in age or developmentally appropriate activities;

19.1.3. The agency shall provide a nationally recognized behavioral health program for known victims of sex trafficking;

19.1.4. Children shall be cared for and supervised at the following levels:

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

19.1.4.b. Additional or back-up care employees shall be available for emergency situations or to meet special needs presented by the persons in care; and

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

19.2. Service Elements.

19.2.1. The organization shall provide sex trafficking prevention programming for all children placed that shall include the following components:

19.2.1.a. Education about sex trafficking (what it is and prevalence);

19.2.1.b. Understanding one's vulnerabilities and how to protect self from traffickers;

19.2.1.c. Enhancement of existing support system (family, friends, community);

19.2.1.d. Development of support system when one does not exist;

19.2.1.e. Service linkage, as needed, for housing, homelessness prevention, educational support;

19.2.1.f. Runaway prevention programming.

19.2.2. The programming will provide opportunities for children to experience some of the same normalizing experiences as their peers not in foster care.

§78-3-20 Qualified Residential Treatment Programs.

20.1. Accreditation Requirements. A qualified residential treatment facility shall be appropriately accredited as required by federal standards.

20.2. Employee Ratios.

20.2.1. The minimum employee-to-child ratio for a qualified residential treatment program shall be 1-to-4 during waking hours. During nighttime sleeping hours, the ratio shall be 1-to-8. During all hours there shall be capability to increase employee ratio in response to acuity. The ratio shall meet the standard set forth in the agency's programming description.

20.2.2. The organization shall have registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice as defined by state law who are:

20.2.2.a. On-site according to the treatment model; and

20.2.2.b. Available 24 hours a day, seven days per week.

20.3. Employee Training and Credentials.

20.3.1. In addition to the requirements for employee training prescribed in section 11 of this rule, the organization will ensure all employees are trained on prudent parenting standards;

20.3.2. The organization shall have, at a minimum, at least one staff member on-site who is authorized to apply the reasonable and prudent parent standard to decisions involving the participation of the child in age or developmentally appropriate activities;

20.4. Assessments and Plans of Care.

20.4.1. The organization shall ensure that staff participate as a member of the family and permanency team and multidisciplinary treatment team processes;

20.4.2. Staff shall participate with the family and permanency team in the development of the 30-day assessment by the qualified individual that will satisfy the initial assessment requirements as described in subsection 13.2 of this rule;

20.4.3. Clinical staff shall incorporate the long and short-term goals identified by the qualified individual in the development of initial and master plans of care as described in sections 13 and 14 of this rule; and

20.4.4. Clinical staff shall conduct any other assessments indicated by the child's medical or psychiatric, or both, needs during development of the plans of care, including the ability to self-medicate with supervision.

20.5. Treatment Services.

20.5.1. The organization shall provide the following services in addition to those described in this rule:

20.5.1.a. Individualized medically necessary services for the population of children they serve;

20.5.1.b. Family engagement activities will be conducted with the child's family during the treatment process; and

20.5.1.c. At least six months of family-based after-care services after a child's discharge.

20.6. Planning for Aftercare.

20.6.1. The family and permanency team shall begin planning for discharge during the development of the long and short-term goals.

20.6.2. At least 30 days prior to discharge the child and family permanency team shall meet to develop the plan for after-care services. Issues to consider in developing the plan are:

20.6.2.a. Remaining problems to be addressed;

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

20.6.2.c. Recommendations for behavioral, medical, or socially necessary services to support the needs of the child and family to prevent re-entry.

§78-3-21. Program-specific Rules for Maternity and Parenting Facilities.

21.1. Maternity Care.

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

21.1.1. Appropriate health care and health education;

21.1.2. Education needs specific to the pregnant or parenting youth;

21.1.3. Nutritional guidance and support;

21.1.4. Counseling services specific to making decisions and planning for his or her child;

21.1.5. Parenting educational services; and

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

21.2. Appropriate Health Care and Health Education.

21.2.1. The organization shall provide or arrange for health services to the expectant and parenting youth that includes:

21.2.1.a. A written health summary, including family medical history, immunizations, surgical procedures, and childhood illnesses;

21.2.1.b. A general medical examination that will occur at the time of admission, and an obstetrical/gynecological examination for the pregnant youth within the first two weeks of admission or sooner if the youth is considered to be high risk;

21.2.1.c. Thorough medical supervision of the pregnancy, including all needed prenatal care; testing and post-natal care shall be done by an appropriately licensed health care professional with a specialization in women's health; and

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

21.2.2. Registered nursing employees with obstetrical/gynecological experience are to be available on the grounds at least 12 hours per day, with 24-hour availability onsite.

21.2.3. The pregnant or parenting youth shall receive ongoing health education with age-appropriate instruction regarding pregnancy prevention, HIV/AIDS prevention, and general information about the prevention and treatment of disease.

21.2.4. The organization shall be located within 15 minutes of a hospital or birthing center that provides maternity care and labor and delivery services.

21.2.5. Standing medical orders for pregnant youth shall be carefully evaluated and shall take into consideration cautions necessary for pregnant youth.

21.2.6. All pregnant or parenting youth shall have access to educational services as appropriate:

21.2.6.a. All pregnant or parenting youth, once assessed, shall participate in some type of educational service such as GED classes, public school, or alternative education;

21.2.6.b. Child care services shall be in close proximity to the education facilities; and

21.2.6.c. Supportive services for child care shall be available to assure that the youth can have necessary study time.

21.3. Nutritional Guidance and Support.

21.3.1. All parenting and pregnant youth will be assessed at a minimum within the first 30 days of admission by a registered dietitian unless dietary problems are indicated at admission.

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

21.3.3. All pregnant and parenting youth shall receive counseling services specific to parenting and alternative choices, on an ongoing basis.

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

21.3.5. Supportive counseling services will be extended to the family of the young woman, the biological father (unless contra-indicated by court order) and the family of the biological father.

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

- 21.3.6.a. Personal growth and maturity;
- 21.3.6.b. Interpersonal relationships;
- 21.3.6.c. Early childhood development;
- 21.3.6.d. Infant stimulation, cognitive development, and bonding/attachment;
- 21.3.6.e. Safety and accident prevention, including First Aid and CPR;
- 21.3.6.f. Physical care, nutrition, and health of infants and young children;
- 21.3.6.g. Signs and symptoms of child abuse and neglect;
- 21.3.6.h. Time, budget, and household management;
- 21.3.6.i. Community resources that provide assistance; and
- 21.3.6.j. Child care use and how to choose providers.

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

21.3.8. The organization shall maintain an environment conducive to the safety of a child (infant through toddler) and a pregnant or parenting youth.

21.3.9. The facility shall contain at least one area for routine medical examination, counseling, and treatment for clients. This area shall be private and in adherence with all universal precautions, Occupational Safety and Health Administration (OSHA) standards and best medical practice.

21.3.10. All living areas shall be maintained in good repair and meet the Child Product Safety Commission (CPSC) guidelines.

21.3.11. The exposure of the pregnant teen and infant to cleaning supplies and pesticides should be limited. The organization shall be cognizant of the possible side effects of exposure and limit it accordingly.

21.4. Baby Care.

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

- 21.4.1.a. Appropriate health care;
- 21.4.1.b. Appropriate daily care; and
- 21.4.1.c. Appropriate daily stimulation.

21.4.2. An organization shall also provide:

- 21.4.2.a. A warm and child friendly environment; and
- 21.4.2.b. Employees specifically trained to meet the needs of infants through toddlers.

21.4.3. The organization shall document that all babies receive a thorough assessment prior to leaving the hospital or at the time of admission to the organization.

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

21.4.5. The organization shall have policy and procedures to assure that the health and well-being of the child is protected once he or she leaves the hospital.

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

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

21.4.8. Appropriate daily care:

21.4.8.a. The organization shall ensure that all babies have the necessities to meet their basic daily needs.

21.4.8.b. The organization shall ensure the basic needs of the baby are consistently met;

21.4.8.c. All babies under twelve months of age shall have a feeding and diet plan prescribed by the physician.

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

21.4.9.a. Prepared bottles shall be capped and clearly labeled with the child's name, contents, and the date prepared;

21.4.9.b. Prepared bottles shall be refrigerated in a separate section of the refrigerator and accessible only to employees;

21.4.9.c. Breast milk shall be stored in containers specific to the purpose;

21.4.9.d. Breast milk or formula when it remains at a temperature higher than forty-one (41) degrees Fahrenheit for more than one hour shall be discarded;

21.4.9.e. Refrigerated breast milk shall be used within 48 hours of receipt, frozen breast milk within two weeks of receipt and deep-frozen breast milk within three months of receipt;

21.4.9.f. Formula bottles shall be used within time frames established by the manufacturer and listed on the package; and

21.4.9.g. A microwave oven is not permitted for the heating of breast milk or formula bottles.

21.4.10. Solid food, including cereals are not to be placed in a bottle unless prescribed by a physician.

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

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

21.4.13. All babies shall receive daily stimulation to encourage the emotional, physical, and intellectual development of the child. This includes:

21.4.13.a. Holding, rocking, and playing whenever possible, including while bathing, dressing, and carrying the child;

21.4.13.b. Encouraging positive communications and language development by making eye-to-eye contact with the child, singing, talking, reacting to the child's sounds, naming objectives, reading stories, and playing musical games;

21.4.13.c. Paying attention to crying and meeting the immediate needs of the child;

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

21.4.13.e. Providing a child who is awake with play equipment and opportunities to play freely on a clean floor.

21.4.14. The organization shall ensure that all products containing potentially hazardous chemicals, including identified poisons, medications, certain cleaning supplies, and art supplies not clearly labeled as "nontoxic", are inaccessible to all children in a locked cabinet away from food, and when possible, stored in their original containers and never in containers originally designed for food.

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

21.4.16. The organization shall ensure that when an electrical appliance is used, an adult is present at all times to supervise the use of the appliance.

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

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

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

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

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

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

21.4.19.b. Pacifiers attached to a string or ribbon that is 6 inches or more in length shall not be placed around a child's neck or affixed to the child's clothing; and

21.4.19.c. No child is to have access to a string or cord that is 6 inches or more in length and attached to a fixed object, such as a window shade, nor access to any other potentially dangerous hanging item, such as a tablecloth.

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

21.4.21. The organization shall ensure the safety of the child during transportation. The driver or qualified employee shall ensure that each child three years of age and under is secured in an approved child safety seat.

21.4.22. The organization shall ensure that the overall environment of the children's area of the facility is clean, pleasant in appearance, well-lighted and conducive to the development of children.

21.5. Employee Training.

21.5.1. The organization shall ensure that all employees are specifically trained to meet the needs of the very young child.

21.5.2. All employees shall be trained within the first 30 days of employment on basic infant care. Prior to completion of the training, the new employees shall be scheduled to work only with fully trained employees.

21.5.3. At a minimum, all employees shall be trained in:

21.5.3.a. Child development;

21.5.3.b. Infant CPR and first aid;

21.5.3.c. Basic child care;

21.5.3.d. Sick baby care; and

21.5.3.e. Parenting skills.

21.6. Children shall be cared for and supervised at the following levels:

21.6.1. A minimum of employee-to-child ratio of 1-to-6 shall be maintained during waking hours when children are on the grounds with a minimum of one employee present per residential living unit at all times when more than one child is present in the living unit;

21.6.2. Additional or back-up care employees shall be available for emergency situations or to meet special needs presented by the persons in care; and

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

§78-3-22. Outdoor Therapeutic Educational Programs.

22.1. Employee Ratios.

22.1.1. Employee ratios to children shall be appropriate for the activity in which the group is engaged.

22.1.2. Employee ratios for high risk activities shall be a minimum of four employees to 10 children. (4-to-10).

22.1.3. The employee-to-child ratio for away from main camp on low risk activities shall be a minimum of 3-to-10.

22.1.4. In main camp, the employee ratio shall be a minimum of two employees to 10 children (2-to-10).

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

22.1.6. At night:

22.1.6.a. Under normal weather conditions, each gender shall sleep separately with one counselor assigned to each sex. In cases of extreme weather, sexes may be in the same building or structure but the employees on duty shall functionally separate them;

22.1.6.b. There shall be a minimum of one employee per sleeping group. That employee may be sleeping when the group is in the main camp or in the field. When the group is in the main camp,

at least one employee shall be awake and monitoring children at all times. The organization shall have a policy regarding employee ratios to ensure the safety and security of children at night when away from the main camp.

22.2. Credentials of Employees.

22.2.1. Direct care employees shall have a minimum of a high school diploma or GED and skills, certifications, and abilities unique to the environment, such as residential child care experience, search and rescue certification, wilderness survival skills, camping skills, etc. Direct care employees shall be responsible for group supervision and monitoring on a day to day basis, including teaching basic living skills, role modeling effective individual and group problem-solving skills and anger management, and completing daily documentation as required.

22.2.2. Individuals providing counseling service must meet the DHHR Bureau for Medical Service's policy on clinical supervision or have the credentials to perform counseling services.

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

22.3. Employee Training.

22.3.1. All employees responsible for the direct care of children shall be trained in the following areas in addition to those cited in section 11 of this rule:

22.3.1.a. Water procurement, preparation, and conservation;

22.3.1.b. Shelter construction;

22.3.1.c. Food preparation and storage in the field;

22.3.1.d. Fire site preparation and fire building;

22.3.1.e. Low-impact wilderness expedition and environmental conservation skills and procedures;

22.3.1.f. Sanitation procedures related to food, water, and waste;

22.3.1.g. Management of health issues unique to the outdoor therapeutic educational program environment including acclimation to the environment and environmental elements;

22.3.1.h. Basic training in rescue and water safety for those employees responsible for water activities. A minimum of one adult so trained shall be present at all times at all water activities;

22.3.1.i. Navigation skills including map and compass use and contour navigation;

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

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

22.3.2. All new employees shall be accompanied at all times by experienced employees during the first month of employment in the field and until all required trainings have been completed, whichever is later.

22.4. Service Elements.

22.4.1. The organization shall have an on grounds educational program that is of sufficient quality to allow students to transfer educational credits to their County of origin. A teacher certified to teach in the state of West Virginia shall be coordinating and providing oversight to the educational program. Whenever possible, the educational program shall be accredited by an appropriate educational accreditation body.

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

- 22.4.2.a. Backpacking;
- 22.4.2.b. Hiking;
- 22.4.2.c. Tent building and other construction;
- 22.4.2.d. Ropes courses;
- 22.4.2.e. Van trips;
- 22.4.2.f. Off property outings;
- 22.4.2.g. Canoe trips or white-water rafting;
- 22.4.2.h. Swimming or wading;
- 22.4.2.i. Mountain biking;
- 22.4.2.j. Skiing;
- 22.4.2.k. Soloing; and
- 22.4.2.l. Rock climbing.

22.4.3. The policy shall discuss the following:

- 22.4.3.a. Employee to child ratios for the activity;
- 22.4.3.b. Employee training and certification prerequisites for participation.

22.4.3.c. Child training prerequisites for participation, including safety training;

22.4.3.d. Special equipment or provisions required for the activity including safety equipment such as life jackets, safety ropes, helmets, etc., and food, water, etc. as necessary and appropriate;

22.4.3.e. Evacuation plans if they should become necessary during an activity;

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

22.4.3.g. The documentation necessary for the activity.

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

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

22.4.6. General safety considerations:

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

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

22.4.6.c. Adequate food and water shall be available to employees and children at all times in all activities;

22.4.6.d. Equipment shall be regularly inspected as a matter of policy by the safety committee or its designee for signs of wear or damage and the inspections shall be documented and monitored;

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

22.4.6.f. Soloing activities shall only be conducted with the written consent of a licensed mental health clinician who has personally evaluated the child within 24 hours prior to the onset of the solo activity. At all times, employees shall be in earshot of a distress call if it is necessary and shall conduct random face to face checks of the status and condition of the child on intervals not to exceed six hours; and

22.4.6.g. The organization shall have a policy to ensure safety and security of children who are acutely disturbed or suicidal, or both.

22.5. Abrogation of Client Rights.

While items of clothing may not be withheld as a punishment, children may be prevented from access to certain items of clothing (such as belts) as a safety measure. The criterion shall be whether the potential safety created by the restriction outweighs the harm of the restriction. The organization shall have a written policy regarding restriction of access to articles of clothing, approved by the governing body.

22.6. Environmental Issues.

22.6.1. The environment of an outdoor therapeutic educational program is by definition limited in its handicapped accessibility. The organization shall have an admissions policy that clearly describes its degree of accessibility to clients with physical handicaps. The organization shall make a reasonable effort to enable family members with physical handicaps to access children, family therapy interventions and program sites.

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

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

- 22.6.3.a. Unique adaptations to dietary requirements as appropriate;
- 22.6.3.b. Sanitation and infection control;
- 22.6.3.c. Waste management;
- 22.6.3.d. Food storage and handling;
- 22.6.3.e. Maintenance of safe body temperature;
- 22.6.3.f. Clothing and footwear;
- 22.6.3.g. Field equipment;
- 22.6.3.h. Communication with the main campus or management on an on-going and emergency basis;
- 22.6.3.i. Medication storage and security away from camp;
- 22.6.3.j. Disaster and severe weather plan including procedures for evacuation; and
- 22.6.3.k. Procedures to follow for runaways and elopements.

§78-3-23. Intermediate Care Facilities for the Intellectually Disabled or Developmentally Disabled.

23.1. Compliance.

Intermediate care facilities for children with intellectual disabilities and developmental disabilities shall comply with the federal Conditions of Participation (42 C.F.R. § 440.150 *et seq.* and § 483.410 through 483.480) except where state licensing standards are more stringent and apply.

23.2. An intermediate care facility for the intellectually disabled or developmentally disabled may accept a 17-year old into an adult group home under the following conditions:

23.2.1. The average age, developmental levels and social needs of the adult residents in the home is approximately that of the child unless the prospective child and the other adult residents of the home have developmental disabilities that are severe or profound or the adult residents are non-ambulatory, nonverbal or have multiple physical handicaps;

23.2.2. The home has arranged educational programming for the child that is as normative as possible;

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

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

23.2.5. None of the adult residents of the home have a history of sexual predation.

23.3. Restrictive behavior management techniques shall conform to federal guidelines for intermediate care facilities for the intellectually disabled or developmentally disabled.

§78-3-24. Psychiatric Residential Treatment Facility.

24.1 Compliance.

A psychiatric residential treatment facility for persons under 21 is a freestanding or physically distinct part of a psychiatric inpatient organization that provides services and treatment to children who do not need acute care but require intensive and coordinated services in a residential setting in a manner consistent with federal requirements. A psychiatric residential treatment facility provides a continually, medically supervised interdisciplinary program of behavioral health treatment.

24.2. Accreditation Requirements.

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

24.3. Employee Ratios.

24.3.1. The average employee-to-patient ratio for a psychiatric residential treatment facility shall be 1-to-3 during day and evening hours (one employee whose primary responsibility is providing direct care for every three children during the day and evening). During nighttime sleeping hours, the ratio shall be 1-to-6. During all hours there shall be capability to increase employee-to-patient ratio in response to acuity, extending to the provision of 1-to-1 care when necessary. Employees assigned to work a defined

unit and providing care to the children on that unit including nursing, teachers, and activity's therapists may be included in the employee-to-client ratio. Employees assigned to supervisory duties or whose duties cause them to be away from the unit (nursing supervisor) may not be included in the count.

24.3.2. The nursing coverage shall include a registered nurse during day and evening shifts with, at minimum, a licensed, practical nurse overnight.

24.3.3. There shall be a supervisor present on all shifts and employees shall have access to other administrative employees at all times.

24.4. Employee Training and Credentials.

24.4.1. All direct care employees shall have a minimum of a high school diploma or GED and professional employees shall have appropriate education and certification consistent with professional licensing standards.

24.4.2. In addition to the requirements for employee training prescribed in section 11 of this rule, direct care employees shall receive refresher training in emergency safety interventions twice a year that shall include both didactic and experiential activities.

24.5. Treatment Services.

The residential treatment facility shall provide the following clinical services:

24.5.1. A physician shall be available 24 hours a day, seven days a week to respond to medical and psychiatric emergencies;

24.5.2. A physician licensed in the state of West Virginia and board certified in psychiatry shall perform observation and assessment at least weekly; and

24.5.3. Routine assessments shall be performed by the physician to effectively coordinate all treatment, manage medication trials or adjustments, or both, minimize serious side effects, and provide medical management of all psychiatric and medical problems.

24.6. Assessments.

24.6.1. A comprehensive assessment process shall include evaluation of:

24.6.1.a. Psychiatric health;

24.6.1.b. Physical health;

24.6.1.c. Ability to self-medicate with supervision;

24.6.1.d. Psychosocial history;

24.6.1.e. Recreational activities;

24.6.1.f. Spiritual and cultural preferences and interests;

24.6.1.g. Behavioral and adaptive living skills, both strengths and deficits; and

24.6.1.h. Educational functioning.

24.6.2. An additional diagnostic assessment shall be provided as needed, either onsite or by using community providers.

24.6.3. All required clinical assessments shall be completed prior to the development of the plan of care. Assessments conducted within 30 days prior to admission by qualified professionals may be used if reviewed and approved for treatment planning by the responsible psychiatrist and Interdisciplinary Treatment Team.

24.6.4. A psychiatric evaluation shall be completed within 24 hours of admission and shall include:

24.6.4.a. The reason for admission;

24.6.4.b. The current clinical presentation;

24.6.4.c. Psychosocial stressors related to the recent illness;

24.6.4.d. A current or potential risk to self or others;

24.6.4.e. A history of the present illness;

24.6.4.f. A past psychiatric history;

24.6.4.g. A developmental assessment;

24.6.4.h. The presence or absence of physical disorders or conditions affecting the presenting problem;

24.6.4.i. An alcohol or drug history; and

24.6.4.j. A mental status examination.

24.6.5. A diagnosis on all five axes shall be given, based on the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

24.6.6. A physical health examination shall be provided within 24 hours of admission.

24.6.7. A Registered Nurse practitioner shall provide a health assessment within 24 hours of admission. The assessment shall document:

24.6.7.a. A general history of the patient's and family's health;

24.6.7.b. The patient's current medications;

- 24.6.7.c. Allergies;
- 24.6.7.d. Pertinent medical problems requiring nursing attention;
- 24.6.7.e. Current risk and safety factors;
- 24.6.7.f. Nutritional status;
- 24.6.7.g. Immunization status; and
- 24.6.7.h. Sleep patterns.

24.7. Plan of Care.

24.7.1. A preliminary plan of care shall be developed within 72 hours of admission.

24.7.2. The interdisciplinary team shall have 30 days to complete all assessments while providing any immediately necessary psychiatric and therapeutic treatment. Prior to the end of the 30-day period or when all initial assessments are completed, whichever comes first, the team shall complete a plan of care.

24.7.3. The plan of care shall be reviewed by the interdisciplinary team for effectiveness and shall be revised when major changes in treatment occur, or at least every 30 days.

24.8. Transfer Agreement.

The organization shall have a written transfer agreement with one or more hospitals that ensures that an individual can be transferred to an appropriate setting in a timely manner when transfer is necessary for more intensive psychiatric care or for emergency or specialized medical care.

24.9. Transitioning Adults.

The psychiatric residential treatment facility may serve individuals aged 18 to 21 so long as the transitioning adult is court ordered, voluntary or committed under the requirements of Chapter 27 of the West Virginia Code.

24.10. Restrictive Behavior Management.

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

§78-3-25. Therapeutic Residential School.

25.1. Employee Ratios and Training.

25.1.1. Employees, for the purposes of this section, is defined as those individuals who are:

- 25.1.1.a. Fully oriented and trained according to organizational policy; and

25.1.1.b. Have job responsibilities that pertain only to the provision of child care, treatment and supervision.

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

25.1.2.a. Children receive adequate supervision for their age, developmental functioning, and emotional and behavioral needs; and

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

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

25.1.3.a. A minimum employee-to-child ratio of 1-to-10 during the waking hours when children are on the grounds with a minimum of one employee present per residential living unit at all times;

25.1.3.b. The availability of additional or back-up care employees for emergency situations or to meet special needs presented by the child; and

25.1.3.c. An employee-to-child ratio of 1-to-12 during sleeping hours with a minimum of at least one employee per residential living unit to be awake at all times.

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

25.1.5. As appropriate to the ages and needs of children in care, the organization shall ensure that one or more trained professional employees are on duty or available via an on-call system on a 24-hour basis to provide continuous supervision to each residential living unit within a residential program.

25.1.6. The organization that uses a house parent model shall have a policy that ensures the safety and supervision of children at night.

25.2. Environmental Issues.

25.2.1. To the maximum extent possible, the organization providing therapeutic residential school services shall be non-institutional in appearance and practices. Each child or transitioning adult shall be permitted to have personal space, personal possessions, and a place to store those possessions unless clinically contraindicated. Each child is expected to assume some responsibility for an aspect of facility maintenance (cleaning, cooking, etc.) on an ongoing basis.

25.2.2. Group therapeutic and residential living activities should be conducted in an appropriately sized group format, taking into consideration best practice standards for the sex, developmental status, and diagnosis of the children.

25.2.3. Children shall have clearly identifiable schedules and activities, individualized for their strengths and needs. Each child shall have a unique schedule that identifies therapy times, chore or work

assignments, school hours, and other activities.

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

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

25.2.6. Service elements unique to the population:

25.2.6.a. If the organization permits children to operate vehicles while in placement, it shall do so under the following conditions:

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

25.2.6.a.2. The child's vehicle, if any, is appropriately licensed and insured; and

25.2.6.a.3. The child receives permission in writing from his or her parent or guardian, as appropriate.

25.2.6.b. The organization shall have a written plan of basic daily routines that shall be available to all employees and updated regularly.

25.2.6.b.1. Children shall participate in planning daily routines.

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

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

§78-3-26. Vulnerable and Transitioning Youth Group Homes and Programs without Behavioral Health Treatment.

26.1. Vulnerable and transitioning youth group homes and programs shall be exempt from the following provisions under this licensing rule: subdivision 12.9.4. (Interior Space Minimum Requirement for Youth Transitioning Private Living Spaces), paragraph 12.9.16.d. (Kitchen Sinks Requirement for Youth Transitioning Private Living Spaces), subsection 13.2. (Initial Assessment), subsection 13.3. (Initial Plan of Care), subsection 13.4. (Plan of Care), subsection 13.5. (Review of Plan of Care), subsection 14.14. (Daily Schedules), and subsection 14.16. (Special Services and Populations).

26.2. Vulnerable and transitioning youth group homes and programs shall also be exempt from the requirements in these provisions as they relate to the plan of care: subsection 14.2. (Involvement of Families and Guardians), subsection 14.3. (Behavioral and Therapeutic Interventions), subsection 14.5. (Medication Control and Administration), subsection 14.7. (Case Records), subsection 14.9. (Termination and Discharge), subsection 14.10. (Education Service), and section 15. (Restrictive Behavioral Interventions).

26.3. Vulnerable and transitioning youth group homes and programs shall develop the following

programs, procedures or polices, or both, and make them available to employees and residents:

- 26.3.1. The information and documentation required under this licensing rule;
- 26.3.2. Practices developed by the organization based upon departmental requirements;
- 26.3.3. Programming that provides for youth to move between tiers as needed.
- 26.3.4. Programming that utilizes the following guiding principles:
 - 26.3.4.a. Continued flexibility, innovation, and targeted and tailored services;
 - 26.3.4.b. Positive youth development;
 - 26.3.4.c. Adolescent brain development;
 - 26.3.4.d. Peer-to-peer relationships and role of adults; and,
 - 26.3.4.e. Transparency.
- 26.3.5. A complete and detailed description of the range of services offered and eligibility requirements for admission;
- 26.3.6. Description of life skills services that the program provides to youth;
- 26.3.7. Age requirements for youth with a minimum of age 15 and a maximum of age 21;
- 26.3.8. Specific, service training to employees providing transitional living services prior to their direct work with youth, including the following:
 - 26.3.8.a. Life skills assessment;
 - 26.3.8.b. Transition plan or futures plan development;
 - 26.3.8.c. Crisis response
 - 26.3.8.d. Advocacy to include training and knowledge of the Free Application for Federal Student Aid (FAFSA);
 - 26.3.8.e. Mentoring;
 - 26.3.8.f. Linkage and referral; and
 - 26.3.8.g. Adolescent brain development.
- 26.3.9. Programming to provide sex trafficking prevention programming that shall include:
 - 26.3.9.a. Education about sex trafficking including what it is and the prevalence of it;

26.3.9.b. Education about understanding one's vulnerabilities and how to protect self from traffickers;

26.3.9.c. Education about how to enhance the youth's existing support system of family, friends, and community;

26.3.9.d. Education about services for housing, homelessness prevention, and educational support; and

26.3.9.e. Education to prevent running away.

26.3.10. Description of the supervision ratio that is adequate to ensure safety and is appropriate for the youth's age and individual needs;

26.3.11. Additional support services as required for youth as indicated in the youth's transition plan and the program tier the youth is enrolled;

26.3.12. Initial assessment of a youth's life skills within 30 days of placement and an assessment of the youth's progress in acquiring basic living skills at a minimum of once every six months;

26.3.13. Transition plans that addresses each life domain developed within 60 days of placement and reviewed every 90 days;

26.3.14. Assessment of a youth's health and medical needs and ensures that any youth receives appropriate health screening and services, including medical and dental screening and services;

26.3.15. Training for youth on living wills, credit reports, health care surrogate, and reproductive health;

26.3.16. Procedures to ensure emergency services to youth while in transitional living that include:

26.3.16.a. Access to emergency services by the organization 24 hours a day, seven days a week;

26.3.16.b. A plan developed by the organization for emergency medical care and emergency evacuation;

26.3.16.c. Training by the organization upon placement on how to use the organization's emergency telephone answering system; and

26.3.16.d. An agency employee designated to respond in person to the youth, within an appropriate time frame for the youth's age and development, of the youth's call for assistance.

26.3.17. The determination of the appropriateness for living arrangements used for offsite transitional living that includes provisions that ensure:

26.3.17.a. Assistance provided for the youth to find a safe, affordable living arrangement;

26.3.17.b. Assessment that a dwelling complies with the State Fire Code and applicable health, zoning and building codes;

26.3.17.c. Assessment that a dwelling has indoor cooking and bathing facilities.

26.3.18. A process for developing appropriate aftercare or discharge plans for youth that contains a detailed description of the education, counseling and treatment that the child received at the out-of-home placement and it shall also propose a plan for education, counseling and treatment for the child upon the child's discharge. The plan shall also contain a description of any problems the child has, including the source of those problems, and it shall propose a manner for addressing those problems upon discharge. The aftercare or discharge plan will be incorporated into the youth transition plan.

26.3.19. A description of the grievance procedure for expressing and resolving complaints or concerns;

26.3.20. Daily schedules for youth for the following, but is not limited to; free time, community service, job preparation, education, driver's education, or basic living skills development;

26.3.21. The process on serving youth with developmental disabilities or intellectual disabilities shall ensure that employees are trained to properly provide habilitation services and supervision in the following areas as appropriate for the population served:

26.3.21.a. Feeding;

26.3.21.b. Communication with nonverbal individuals;

26.3.21.c. Use of community recreation options;

26.3.21.d. Management of self-abusive and aggressive behavior;

26.3.21.e. Adaptive living skills;

26.3.21.f. Person first language and attitudes;

26.3.21.g. Therapeutic behavioral supports; and

26.3.21.h. Implementation of normalcy.

26.3.22. The process for serving individuals with developmental disabilities with supportive services to help them fully interact with the community and achieve maximum independence.

26.4. A youth's case record shall contain:

26.4.1. Written permission from a guardian to be exempted from any medication administration regulation as outlined in the youth's transition plan and how it will assist the goal of independence, for youth under the age of 18;

26.4.2. Written permission from his or her parents or guardian for a youth under the age of 18 years to enter a scattered site transitional living arrangement;

26.4.3. A written service agreement with a youth entering a transitional living arrangement, and an alternate placement plan for a youth who is unsuccessful in an independent living arrangement;

26.4.4. A written assessment by an agency of a youth life skills prior to placing him or her in a transitional living arrangement or a life skills assessment completed within 30 days of admission;

26.4.5. Development or revision of a youth's transition plan within 60 days of admission, with follow-up reviews of the transition plan every 90 days; and

26.4.6. A monthly budget for each youth that outlines income, savings, and expenditures.