

B. State-owned or operated nursing facilities will be paid a prospective reimbursement rate. The payment rate for each of these facilities will be the nursing facility's allowable cost from the most recent filed Medicaid cost report trended forward to the midpoint of the rate year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1476 (June 2002), repromulgated LR 28:1793 (August 2002), amended LR 30:53 (January 2004).

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

David W. Hood  
Secretary

0401#087

## RULE

### Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Psychiatric Residential Treatment Facilities Licensure  
(LAC 48:I.Chapter 90)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts LAC 48:I.Chapter 90 as authorized by R.S. 40:2181-2191. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### Title 48

#### PUBLIC HEALTH? GENERAL

#### Part I. General Administration

#### Subpart 3. Licensing

#### Chapter 90. Psychiatric Residential Treatment Facilities (under 21)

#### Subchapter A. General Provisions

#### §9001. Purpose

A. The purpose of this Chapter 90 is to provide for the development, establishment and enforcement of statewide standards for the care of residents in Psychiatric Residential Treatment Facilities (PRTFs) participating in the Louisiana Medicaid Program, to ensure maintenance of these standards, and to regulate conditions in these facilities through a program of licensure which shall promote safe and adequate treatment of residents of PRTFs participating in the Louisiana Medicaid Program.

B. In addition to requirements stated herein, all licensed PRTFs shall comply with applicable local, state, and federal laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:54 (January 2004).

#### §9003. Definitions

A. The following defines selected terminology used in connection with this Chapter 90.

*Abuse?* any one of the following acts which seriously endangers the physical, mental or emotional health of the resident:

a. infliction, attempted infliction, or, as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the resident;

b. exploitation or overwork of a resident;

c. involvement of the resident in sexual activity constituting a crime under the laws of this state.

*Accreditation?* official notification given the provider of compliance to standards established by either:

a. the Joint Commission on *Accreditation* of Healthcare Organizations;

b. the Commission on *Accreditation* of Rehabilitation Facilities;

c. the Council on *Accreditation* of Services for Families and Resident; or

d. any other comparable nationally recognized accrediting organization.

*Administrator?* (see *chief executive officer*)

*Behavior Management?* techniques, measures, interventions and procedures applied in a systematic fashion to promote positive behavioral or functional change fostering the resident's self-control, and to prevent or interrupt a resident's behavior which threatens harm to the resident or others.

*Cessation of Business?* when a PRTF participating in the Louisiana Medicaid Program stops providing services to the community.

*Change of Ownership (CHOW)?* the sale or transfer whether by purchase, lease, gift or otherwise of a PRTF by a person/corporation of controlling interest that results in a change of ownership or control of 30 percent or greater of either the voting rights or assets of a PRTF or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the PRTF.

*Chief Executive Officer (CEO) or Administrator?* the person responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

*Clinical Director?* the person who has responsibility for the psychiatric aspects of the program and who has to provide full-time coverage on an on-site or on-call basis.

*CMS?* the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

*Core Mental Health Disciplines?* academic training programs in psychiatry, psychology, social work and psychiatric nursing.

*Department?* the Department of Health and Hospitals.

*Discipline?* the ongoing practice of helping residents develop inner control so they can manage their own behavior in an appropriate and acceptable manner.

*Documentation*—written evidence or proof, including signatures of appropriate staff and date, must be maintained on site and available for review.

*DSS?* the Department of Social Services.

*Emergency Safety Intervention?* the use of restraint or seclusion as an immediate response to an emergency safety situation.

*Emergency Safety Situation?* unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an *emergency safety intervention*.

*Governing Body?* the board of trustees, owner or person(s) designated by the owner with ultimate authority and responsibility (both moral and legal) for the management, control, conduct, and functioning of the PRTF.

*Group (or Unit)?* refers to the residents who share a common space and relate to one primary staff person (who may be assisted by others) on a consistent or daily basis.

*HSS?* the Department of Health and Hospitals, Health Standards Section.

*License?* the legal authority to operate as a PRTF participating as a Louisiana Medicaid Program.

*Licensed Mental Health Professional (LMHP)?* an individual who meets one of the following education and experience requirements:

a. a physician duly licensed to practice medicine in the state of Louisiana and has completed an accredited training program in psychiatry; or

b. a psychologist licensed as a practicing psychologist under the provisions of R.S. 28:2351-2370; or

c. a social worker who holds a master's degree in social work from an accredited school of social work and is a licensed clinical social worker under the provisions of R.S. 37:2701-2718, as amended; or

d. a nurse licensed as a registered nurse in the state of Louisiana by the Board of Nursing; and

i. is a graduate of an accredited master's level program in psychiatric mental health nursing with two years of post-masters supervised experience in the delivery of mental health services; or

ii. has a master's degree in nursing or a mental health-related field with two years of supervised post masters experience in the delivery of mental health services;

e. a licensed professional counselor who is licensed as such under the provision of R.S. 37:1101-1115 and has at least two years post master's supervised experience delivering services in the mental health-related field.

*Mechanical Restraint?* any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

*Mental Health Professional (MHP)?* an individual who is supervised by a LMHP and meets the following criteria as documented by the provider:

a. has a Master of Social Work degree; or

b. has a Master of Arts degree, Master of Science degree or a Master of Education degree in a mental health-related field; and

i. has a minimum of 15 hours of graduate level course work and/or practicum in applied intervention strategies/methods designed to address behavioral, emotional and/or mental problems. These hours may have been obtained as a part of, or in addition to, the master's degree.

*Mental Health-Related Field?* academic training programs based on the principles, teachings, research and body of scientific knowledge of the *core mental health disciplines*. To qualify as a related field, there must be substantial evidence that the academic program has a

curriculum content in which at least 70 percent of the required courses for graduation are based on the knowledge base of the *core mental health disciplines*. Programs which may qualify include, but are not limited to, sociology, criminal justice, nursing, marriage and family counseling, rehabilitation counseling, psychological counseling and other professional counseling.

*Mental Health Service Delivery Experience?* *mental health service delivery experience* at the professional or paraprofessional level delivered in an organized mental health or psychiatric rehabilitation setting such as a psychiatric hospital, day treatment or mental health case management program or community mental health center.

*Mental Health Specialist (MHS)?* a person who delivers direct care services under the direct supervision of a LMHP or MHP and who meets one or more of the following five criteria as documented by the provider:

a. has a Bachelor of Arts degree in a *mental health-related field*; or

b. has a Bachelor of Science degree in a *mental health-related field*; or

c. has a bachelor's degree and is a college student pursuing a graduate degree in a *mental health-related field* and has completed at least two courses in that identified field; or

d. has a high school degree or a GED and has four years experience providing direct services in a mental health, physical health, social services, education or correctional setting.

*Minor?* a *minor* as defined under state law and, for the purpose of this Chapter, includes a resident who has been declared legally incompetent by the applicable state court.

*New Construction?* any of the following started after January 1, 2004:

a. new buildings to be used as a PRTF;

b. additions to existing buildings to be used as a PRTF;

c. conversions of existing buildings or portions thereof for use as a PRTF;

d. alterations other than minor alterations to an existing PRTF.

*OCS?* the Department of Social Services, Office of Community Services.

*OSFM?* the Office of State Fire Marshal.

*OYD?* the Department of Public Safety and Corrections, Office of Youth Development.

*Personal Restraint?* the application of physical force, without the use of any device, for the purpose of restraining the free movement of a resident's body. The term *personal restraint* does not include briefly holding without undue force a resident in order to calm or comfort him/her, or holding a resident's hand to safely escort a resident from one area to another.

*Psychiatric Residential Treatment Facility (PRTF)?* a facility other than a hospital, that provides psychiatric services, as described in 42 CFR Part 441 Subpart D, to individuals under age 21, in a residential setting.

*Restraint?* a *personal restraint*, *mechanical restraint*, or drug used as a *restraint* as defined in this §9003.

*Seclusion?* the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

*Serious Injury?* any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

*Staff?* those individuals with responsibility for managing a resident's health or participating in an *emergency safety intervention* and who are employed by the facility on a full-time, part-time or contract basis.

*Time Out?* the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:54 (January 2004).

## Subchapter B. Licensing

### §9013. Licensing Process

A. Initial Licensing. The Department of Health and Hospitals (DHH) is the only authority for PRTFs participating in the Louisiana Medicaid Program in the State of Louisiana.

1. Any person, organization or corporation desiring to operate a PRTF shall make application to DHH on forms prescribed by the department. Such forms may be obtained from:

Hospital Program Manager  
Department of Health and Hospitals  
Health Standards Section (HSS)  
P.O. Box 3767, Baton Rouge, LA 70821

2. An initial applicant shall as a condition of licensing:

a. submit a completed initial PRTF packet and other required documents, including attestation in writing, that the facility is in compliance with CMS's standards governing the use of restraint and seclusion, as contained in this Chapter 90. This attestation must be signed by the facility administrator;

b. submit the required nonrefundable licensing fees by certified check or money order. No application will be reviewed until payment of the application fee. Except for good cause shown, the applicant must complete all requirements of the application process within 90 days of initial submission of the application material. Upon 10 days prior notice, any incomplete or inactive applications shall be closed. A new application will be accepted only when accompanied by a nonrefundable application fee.

3. When the required documentation for licensing is approved and the building is approved for occupancy by the OFSM, a survey of the facility by representatives of HSS shall be conducted at the department's discretion to determine if the facility meets the standards set forth in this Chapter 90.

4. No new PRTF, except one that is accredited and is licensed by DSS as a controlled intensive care facility or unit, shall accept residents until the PRTF has written approval and/or a license issued by HSS.

5. No licensed bed shall be placed in a room that does not meet all resident room licensing criteria and which has not been previously approved by HSS.

### B. Issuance of License

1. The agency shall have authority to issue two licenses as described below.

a. Full License-issued only to those PRTFs that are in substantial compliance with these licensure regulations governing PRTFs. The license shall be issued by the department for a period of not more than 12 months for the premises named in the application, as determined by the department.

b. If a PRTF is not in substantial compliance with these licensure regulations, the department may issue a provisional license up to a period of six months if there is no immediate and serious threat to the health and safety of residents.

2. The PRTF license is not assignable or transferable and shall be immediately void if a PRTF ceases to operate or if its ownership changes.

C. Licensing Renewal. Licenses must be renewed at least annually. A PRTF seeking renewal of its license shall:

1. complete all forms and return them to the department at least 15 days prior to the expiration date of their current license;

2. submit the annual fees or the amounts so specified by state law. All fees shall be submitted by certified check or money order and are nonrefundable. All state-owned facilities are exempt from fees;

3. the renewal packet shall be sent by the department to the PRTF 45 days prior to the expiration of their license. The packet shall contain all forms required for renewal of the license;

4. the PRTF shall accept only that number of residents for which it is licensed unless prior written approval has been secured from the department.

D. Display of License. The current license shall be displayed in a conspicuous place in the PRTF at all times.

### E. Increases in Capacity

1. The PRTF will notify the department in writing 14 days prior to an increase in capacity.

2. The PRTF will complete the required paperwork and submit the appropriate documents.

3. A fee of \$25 plus \$5 per licensed unit being added or the amounts so specified by state law in the future shall be submitted to the department. This fee shall be paid by a certified check or money order.

4. At the discretion of the department, signed and dated attestations in compliance with these standards may be accepted in lieu of an on-site survey.

5. Written approval of the increase in capacity must be obtained before residents can be admitted to these additions.

### F. Decrease in Capacity

1. The PRTF will notify the department in writing 14 days prior to the decrease in capacity.

2. The PRTF will complete the required paperwork and submit the appropriate documents.

3. A fee of \$25 or the amounts so specified by state law in the future shall be submitted to the department. This fee shall be paid by a certified check or money order.

G. Individual licenses shall not be required for separate buildings and services located on the same or adjoining grounds or attached to the main PRTF if they are operated as an integrated service of the PRTF.

H. Duplicate and Replacement Licenses. A \$5 processing fee, or the amount so specified by state law in the future, shall be submitted by the PRTF for issuing a duplicate facility license with no changes.

I. When changes to the license, such as a name change, address change or bed reduction are requested in writing by the PRTF, a fee of \$25 or the amounts so specified by state law in the future, shall be submitted.

J. Facility within a Facility

1. If more than one health care provider occupies the same building, premises, or physical location:

a. all treatment facilities and administrative offices of one health care provider shall be clearly separated from any treatment facilities or administrative offices of any other health care provider located in and/or on the same building, premises or physical location by a clearly delineated and cognizable boundary;

b. treatment facilities shall include, but not be limited to, recipient beds, wings and operating rooms;

c. administrative offices shall include, but not be limited to, record rooms and personnel offices;

d. there shall be clearly identifiable and distinguishable signage;

e. if more than one health care provider occupies the same building, premises or physical location, each such health care provider shall have its own entrance. The separate entrance shall have appropriate signage and shall be clearly identifiable as belonging to one health care provider. Nothing prohibits a health care provider occupying the same building, premises or physical location as another health care provider from utilizing the entrance, hallway, stairs, elevators or escalators of another health care provider to provide access to its separate entrance;

f. staff of the PRTF within a hospital shall not be co-mingled with the staff of the host hospital for the delivery of services within any given shift.

K. Change of Ownership

1. Examples of Actions Which Constitute a Change of Ownership

a. Unincorporated Sole Proprietorship. Transfer of title and property to another party constitutes a change of ownership.

b. Corporation. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes a change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

c. Partnership. In the case of a partnership, the removal, addition or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law, constitutes a change of ownership.

d. Leasing. The lease of all or part of the provider facility constitutes a change of ownership of the leased portion.

2. No later than 15 days after the effective date of the CHOW, the prospective owner(s) or provider representative shall submit to the department a completed application for PRTF licensing, and the bill of sale.

L. Fire Protection. All PRTFs shall comply with the Rules, established fire protection standards and enforcement policies as promulgated by the Office of State Fire Marshal, including handicapped accessibility requirements. It shall be the primary responsibility of the Office of State Fire Marshal to determine if applicants are complying with those requirements. No license shall be issued or renewed without the applicant furnishing a valid inspection report from the Office of State Fire Marshal stating that the applicant is complying with their provisions.

1. Prior to new construction, additions, conversions or major alterations, PRTFs shall submit construction documents (see Subsection N, Plan Review) to the OSFM for review. All PRTFs shall submit in writing to the OSFM request for an occupancy review for Life Safety Code. This submission is to request the occupancy type they are requesting. PRTFs requesting to be reviewed and approved as a residential board and care facility by OFSM shall not have exit doors and doors of egress locked. PRTFs that are reviewed and approved as limited care facilities may be permitted to have locked doors after an appeal with OFSM.

M. Sanitation and Resident Safety. The PRTF shall comply with the Rules, Sanitary Code and enforcement policies as promulgated by the Office of Public Health (OPH). It shall be the primary responsibility of the OPH to determine if applicants are complying with those requirements. No initial license shall be issued without the applicant furnishing a certificate from OPH stating that the applicant is complying with their provisions. A provisional license may be issued to the applicant if OPH issues the applicant a conditional certificate.

N. Plan Review. Construction documents (plans and specifications) are required to be submitted and approved by both the OFSM and the Department of Health and Hospitals as part of the licensing procedure and prior to obtaining a license.

1. Submission Plans

a. Submittal Requirements

i. One set of the final construction documents shall be submitted to the OFSM for approval. The Fire Marshal's approval letter and final inspection shall be sent to the DHH Division of Engineering and Architectural Services.

ii. One set of the final construction documents shall be submitted to DHH Division of Engineering and Architectural Services along with the appropriate review fee and a "plan review application form" for approval.

b. Applicable Projects. Construction documents require approval for the following type of projects:

i. new construction;

ii. new hospitals;

iii. changes in service(s)/hospital type;

iv. major alterations.

c. Design Criteria. The project shall be designed in accordance with the following criteria:

i. the current edition of *NFPA 101-Life Safety Code*;

ii. the latest adopted edition of the *International Building Code*;

iii. the *American with Disabilities Act? Accessibility Guidelines for Buildings and Facilities (ADAAG)*, current edition;

iii. the current Louisiana Department of Health and Hospitals' *Licensure Standards for Psychiatric Residential Treatment Facilities*;

iv. The latest adopted edition of the *Louisiana State Plumbing Code*.

d. Construction Document Preparation

i. Construction documents submitted to DHH shall be prepared only by a Louisiana licensed architect or licensed engineer as governed by the licensing laws of the state for the type of work to be performed.

ii. Construction documents submitted shall be of an architectural or engineering nature and thoroughly illustrate the project that is accurately drawn, dimensioned, and contain noted plans, details, schedules and specifications. At a minimum the following shall be submitted:

- (a). site plans;
- (b). floor plan(s). These shall include architectural, mechanical, plumbing, electrical, fire protection, and if required by code, sprinkler and fire alarm plans;
- (c). building elevations;
- (d). room finish, door, and window schedules;
- (e). details pertaining to ADA requirements;
- (f). specifications for materials;
- (g). an additional set of basic preliminary type,

legible site plan and floor plans in either 8-1/2 x 11; 8-1/2 x 14 or 11 x 17 format. (These are for use by DHH in doing the final inspection of the facility and should include legible names).

2. Waivers

a. The secretary of the DHH may, within his/her sole discretion, grant waivers to building and construction guidelines. The facility must submit a waiver request in writing to the Division of Engineering and Architectural Services. The facility must demonstrate how patient safety and quality of care offered is not comprised by the waiver. The facility must demonstrate their ability to completely fulfill all other requirements of service. DHH will make a written determination of the requests. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related to the waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:56 (January 2004).

**§9015. Psychiatric Residential Treatment Facility Closure**

A. A cessation of business is deemed to be effective with the date on which the PRTF stopped providing services to the community as a Louisiana Medicaid Program.

1. The PRTF must notify the department in writing 30 days prior to the effective date of closure.

2. The PRTF shall submit a written plan for the disposition of resident's clinical records for approval by the department. The plan shall include the following:

a. provisions that comply with state laws on storage, maintenance, access and confidentiality of the closed PRTF's resident medical records;

b. an appointed custodian who shall provide physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

c. public notice on access in the newspaper, with the largest circulation, in close proximity of the closing PRTF, at least 15 days before the effective date of closure;

d. the effective date of closure.

3. The PRTF must return the original license to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:58 (January 2004).

**§9017. Denial, Revocation or Non-Renewal of License and Appeal Procedure**

A. When a facility is unable or unwilling to comply with requirements or has failed to adequately protect the health and safety of residents, the department can deny the application, revoke the license, or refuse to renew the license.

B. The department may deny an application for a license, or refuse to renew a license or revoke a license for any of the following reasons:

1. failure to be in substantial compliance with the PRTF licensure regulations;

2. failure to provide therapeutic residential intervention services essential to the care of emotionally disturbed residents;

3. failure to uphold patient rights whereby violations may result in harm or injury;

4. failure of agency to protect patients/persons in the community from harmful actions of the agency employees; including, but not limited to health and safety, coercion, threat, intimidation and harassment;

5. failure to notify proper authorities of all suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause harm to the patient;

6. failure to maintain staff adequate to provide necessary services to current active residents;

7. failure to employ qualified personnel;

8. failure to remain fully operational at any time for any reason other than a disaster;

9. failure to submit fees including but not limited to annual fee, renewal fee, provisional follow-up fee, or change of agency address or name, or any fines assessed by DHH;

10. failure to allow entry to the PRTF or access to any requested records during any survey;

11. failure to protect patients from unsafe skilled and/or unskilled care by any person employed by the agency;

12. failure of the agency to correct violations after being issued a provisional license;

13. agency staff or owner has knowingly, or with reason to know, made a false statement of a material fact in:

a. application for licensure;

b. data forms;

c. clinical record;

- d. matters under investigation by the department;
- e. information submitted for reimbursement from any payment source;
- f. the use of false, fraudulent or misleading advertising;
- g. that the agency staff misrepresented or was fraudulent in conducting agency business;
- h. convictions of a felony by an owner, administrator, or clinical director as shown by a certified copy of the record of the court of conviction of the above individual; or if the applicant is a firm or corporation, of any of its members or officers;

14. failure to comply with all reporting requirements in a timely manner; and

15. at the initial licensure survey, an agency has more than five violations of any minimum standards or if the violations are determined to be of such a serious nature that they may cause or have the potential to cause actual harm.

C. If an agency's license, whether full or provisional, is revoked, or denied renewal, and the applicant or licensee does not request an administrative reconsideration of the violation(s) which support the department's actions and/or does not appeal such action, the facility must cease operation on the effective date of the action.

D. Notice and Appeal Procedure. The applicant or licensee shall receive 30 days notice in writing of the decision and the grounds for such proposed action.

E. Administrative Reconsideration. The applicant or licensee may request an administrative reconsideration of the violation(s) which support the department's actions. This reconsideration shall be conducted by a designated official(s) of the department who did not participate in the initial decision to impose the actions taken. Reconsideration shall be made solely on the basis of documents before the official and shall include the survey report and statement of violations and all documentation the agency submits to the department at the time of the agency's request for reconsideration. Correction of a violation shall not be a basis for reconsideration. This is not a formal hearing. Oral presentations can be made by the department's spokesperson(s) and the agency's spokesperson(s). This process is not in lieu of the appeals process and does not extend the time limits for filing an administrative appeal. The designated official shall have authority only to affirm the decision, to revoke the decision, to affirm part and revoke part, or to request additional information from either the department or the agency.

1. If an agency's license is revoked, or denied renewal and the applicant or licensee requests an administrative reconsideration and the department's decision is affirmed, and the applicant or licensee does not appeal such action, the facility must cease operation on the effective date of the designated official's decision to support the department's actions.

F. Appeal Process. Upon refusal of DHH to grant a license as provided in the current state statutes, or upon revocation or suspension of a license, or the imposition of a fine, the agency, institution, corporation, person, or other group affected by such action shall have the right to appeal such action by submitting a written request to the secretary of the department within 30 days after receipt of the

notification of the refusal, revocation, suspension of a license or imposition of a fine.

1. If an agency's license is revoked, or denied renewal and the applicant or licensee requests an appeal of the department's action and the result of the appeal supports the department's action, the facility must cease operation on the effective date of the designated official's decision to support the department's action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:58 (January 2004).

### **Subchapter C. Organization and Administration**

#### **§9027. General**

A. Purpose and Organizational Structure. The purpose of the PRTF shall be clearly defined in a statement filed with the department. The statement includes the:

- 1. program philosophy;
- 2. program goals and objectives;
- 3. ages, sex and characteristics of residents accepted for care;
- 4. geographical area served;
- 5. types of services provided;
- 6. description of admission policies; and
- 7. needs, problems, situations or patterns best addressed by the provider's program.

B. House Rules. The provider shall have a clearly written list of Rules governing conduct for residents in care and shall document that these Rules are made available to each staff member, resident, and where appropriate, the resident's parent(s) or legal guardian(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:59 (January 2004).

#### **§9029. Governing Body**

A. The PRTF must have either an effective governing body or individual(s) legally responsible for the conduct of the PRTF operations. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

B. The governing body shall:

- 1. establish PRTF-wide policy;
- 2. adopt bylaws;
- 3. appoint a chief executive officer or administrator;
- 4. designate a psychiatrist who is either board-eligible or certified in child psychiatry as the clinical director to assume responsibility for the psychiatric aspects of the program and to provide full-time coverage on an on-site or on-call basis;
- 5. maintain quality of care; and
- 6. provide an overall institutional plan and budget.

C. The governing body and/or their designee(s) shall develop and approve policies and procedures which define and describe the scope of services offered. They shall be revised as necessary and reviewed at least annually.

D. There shall be an organizational chart that delineates lines of authority and responsibility for all PRTF personnel.

E. Representation at Hearings. The PRTF shall, when required by law, have a representative present at all judicial,

educational, or administrative hearings that address the status of a resident in the care of the provider.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:59 (January 2004).

### **§9031. Administrative Policy and Records**

A. Policy shall be clearly written, current, and available for residents, parents or custodians, staff, and licensing staff to review.

B. Policy shall be reviewed annually by the governing board.

C. Policy shall include, but is not limited to, areas governing:

1. admission and discharge;
2. personnel;
3. volunteers;
4. grievance procedures;
5. behavior management;
6. use of restraint and seclusion;
7. mandatory reporting of abuse;
8. administering medication;
9. confidentiality of records;
10. participation of residents in activities related to fundraising and publicity;
11. participation of residents in research projects;
12. the photographing and audio or audio-visual recording of residents; and
13. emergency procedures.

#### **D. Admission Policy**

1. The PRTF shall:
  - a. only accept residents for placement from the parent(s), legal guardian(s), custodial agency or a court of competent jurisdiction;
  - b. not admit more residents into care than the number specified on the provider's license;
  - c. ensure that the resident, the resident's parent(s) or legal guardian(s) and others, as appropriate, are provided reasonable opportunity to participate in the admission process and decisions. Proper consents shall be obtained before admission.

2. Notification of Facility Policy. At admission, the facility must:

a. inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

b. communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;

c. obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

d. provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

i. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate state protection and advocacy organization.

3. Intake Evaluation. The PRTF shall accept a resident into care only when a current diagnostic evaluation, not over one 1 year old, has been completed.

a. The diagnostic evaluation shall include examination of the medical, psychosocial, social, behavioral and developmental aspects of the recipient's situation and reflect the need for services of a PRTF. Each medical evaluation must include:

- i. diagnoses;
- ii. summary of medical findings;
- iii. medical history;
- iv. mental and physical functional capacity;
- v. prognosis; and
- vi. physician's recommendations.

#### **E. Behavior Management**

1. The PRTF shall develop and maintain a written behavior management policy which includes:

- a. goals and purposes of the behavior management program;
- b. methods of behavior management;
- c. a list of staff authorized to administer the behavior management policy; and
- d. methods of monitoring and documenting the use of the behavior management policy.

2. Prohibitions. The facility policy shall prohibit:

- a. shaking, striking, spanking or other cruel treatment;
- b. harsh, humiliating, cruel, abusive or degrading language;
- c. denial of food or sleep;
- d. work tasks that are degrading or unnecessary and inappropriate to the resident's age and ability;
- e. denial of private familial and significant other contact, including visits, phone calls, and mail, as a means of punishment;
- f. use of chemical agents, including tear gas, mace, or similar agents;
- g. extreme physical exercise;
- h. one resident punishing another resident;
- i. group punishment; and
- j. violating a resident's rights.

3. The PRTF must satisfy all requirements contained in this Chapter regarding the use of restraint or seclusion, including application of time out.

#### **F. Resident Abuse**

1. The provider shall have comprehensive written procedures concerning resident abuse including:

a. a description of ongoing communication strategies used by the provider to maintain staff awareness of abuse prevention, current definitions of abuse and neglect, and mandated reporting requirements to the Office of Community Services Resident Protection Agency;

b. a procedure for disciplining staff members who abuse or neglect a resident;

c. procedures for insuring that the staff member involved in suspected resident abuse or neglect does not work directly with the resident involved or any other resident in the program until the investigation is complete.

2. Any case of suspected resident abuse or neglect shall be reported immediately to the HSS and, unless prohibited by state law, the state-designated protection and advocacy system.

3. Staff must report any case of suspected resident abuse or neglect to both HSS and the state-designated protection and advocacy system by no later than close of business the next business day after a case of suspected resident abuse or neglect. The report must include:

- a. the name of the resident involved in the suspected resident abuse or neglect;
- b. a description of the suspected resident abuse or neglect;
- c. date and time the suspected abuse or neglect occurred;
- d. steps taken to investigate abuse and neglect; and
- e. action taken as a result of the incident.

4. In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the suspected resident abuse or neglect.

5. Staff must document in the resident's record that the suspected resident abuse or neglect was reported to both HSS and the state-designated protection and advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record.

**G Reporting of Serious Occurrences.** The facility must report each serious occurrence to both HSS and, unless prohibited by state law, the state-designated protection and advocacy system. Serious occurrences that must be reported include a resident's death or a serious injury to a resident.

1. Staff must report any serious occurrence involving a resident to both HSS and the state-designated protection and advocacy system by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility. The facility must conduct an investigation of the serious occurrence to include interviews of all staff involved, findings of the investigation, and actions taken as a result of the investigation.

2. In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

3. Staff must document in the resident's record that the serious occurrence was reported to both HSS and the state-designated protection and advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

4. **Reporting of Deaths.** In addition to the reporting requirements contained in Paragraphs 1-4 of this Subsection, facilities must report the death of any resident to the CMS regional office. The staff must:

- a. report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death;

b. document in the resident's record that the death was reported to the CMS regional office.

**H. Fundraising and Publicity.** The PRTF shall have a written policy regarding participation of residents in activities related to fundraising and publicity. Consent of the resident and, where appropriate, the resident's parent(s) or legal guardian(s) shall be obtained prior to participation in such activities.

I. The PRTF shall have written policies and procedures regarding the photographing and audio or audio-visual recordings of residents.

1. The written consent of the resident and, where appropriate, the resident's parent(s) or legal guardian(s) shall be obtained before the resident is photographed or recorded for research or program publicity purposes.

2. All photographs and recordings shall be used in a manner that respects the dignity and confidentiality of the resident.

**J. Research.** The PRTF shall have written policies regarding the participation of residents in research projects. No resident shall participate in any research project without the express written consent of the resident and the resident's parent(s) or legal guardian(s).

**K. Administrative Records**

1. The records and reports to be maintained at the facility and available for survey staff to review are:

- a. resident's clinical record;
- b. personnel records;
- c. criminal history investigation records;
- d. orientation and training hour records;
- e. menus of food served to residents;
- f. fire drill reports acceptable to the OFSM as defined by the most current adopted edition of the *NFPA 101, Life Safety Code*;
- g. schedules of planned recreational, leisure or physical exercise activities;
- h. all leases, contracts and purchase-of-service agreements to which the provider is a party;
- i. all written agreements with appropriately qualified professionals, or state agencies, for required professional services or resources not available from employees of the provider;
- j. written policies and procedures governing all aspects of the provider's activities to include:
  - i. behavior management;
  - ii. emergency evacuation;
  - iii. smoking policy.

**L. Clinical Record.** Information obtained by the department from any applicant or licensee regarding residents, their parents, or other relatives is deemed confidential and privileged communication. The names of any complainants and information regarding a child abuse report or investigation is kept confidential.

1. The PRTF shall ensure the confidentiality of resident records, including information in a computerized medical record system, in accordance with the HIPAA Privacy Regulations (Title 45, Part 164, Subpart E of the *Code of Federal Regulations*) and any Louisiana state laws and regulations which provide a more stringent standard of confidentiality than the HIPAA privacy regulations. Information from, or copies of records may be released only

to authorized individuals, and the PRTF must ensure that unauthorized individuals cannot gain access to or alter resident records. Original medical records shall not be released outside the PRTF unless under court order or subpoena or in order to safeguard the record in the event of a physical plant emergency or natural disaster.

a. The provider shall have written procedures for the maintenance and security of clinical records specifying who shall supervise the maintenance of records, who shall have custody of records, and to whom records may be released. Records shall be the property of the provider, and the provider as custodian shall secure records against loss, tampering or unauthorized use.

b. Employees of the PRTF shall not disclose or knowingly permit the disclosure of any information concerning the resident or his/her family, directly or indirectly, to any unauthorized person.

c. When the resident is of majority age and noninterdicted, the provider shall obtain the resident's written, informed permission prior to releasing any information from which the resident or his/her family might be identified, except for authorized state and federal agencies.

d. When the resident is a minor or is interdicted, the provider shall obtain written, informed consent from the parent(s) or legal guardian(s) prior to releasing any information from which the resident might be identified, except for accreditation teams, authorized state and federal agencies.

e. The provider shall, upon written authorization from the resident or his/her parent(s) or legal guardian(s), make available information in the case record to the resident, his counsel or the resident's parent(s) or legal guardian(s).

f. If, in the professional judgment of the clinical director, it is felt that information contained in the record would be injurious to the health or welfare of the resident, the provider may deny access to the record. In any such case the provider shall prepare written reasons for denial to the person requesting the record and shall maintain detailed written reasons supporting the denial in the resident's file.

g. The provider may use material from case records for teaching for research purposes, development of the governing body's understanding and knowledge of the facility's services, or similar educational purposes, provided names are deleted, other identifying information are disguised or deleted, and written authorization is obtained from the resident or his/her parent(s) or legal guardian(s).

2. Retention. PRTF records shall be retained by the PRTF in their original, microfilmed or similarly reproduced form for a minimum period of 10 years from the date a resident is discharged.

a. Graphic matter, images, x-ray films, nuclear medicine reports and like matter that were necessary to produce a diagnostic or therapeutic report shall be retained, preserved and properly stored by the PRTF in their original, microfilmed or similarly reproduced form for a minimum period of five years from the date a resident is discharged. Such graphic matter, images, x-ray film and like matter shall be retained for longer periods when requested in writing by any one of the following:

i. an attending or consulting physician of the resident;

ii. the resident or someone acting legally in his/her behalf;

iii. legal counsel for a party having an interest affected by the resident's medical records.

3. The written record for each resident shall include:

a. administrative, treatment and educational data from the time of admission until the time the resident leaves the facility, including intake evaluation notes and physician progress notes;

b. the name, home address, home telephone number, name of parent(s) or legal guardian(s), home address and telephone number of parent(s) or legal guardian(s) (if different from resident's), sex, race, religion, birth date and birthplace of the resident;

c. other identification data including documentation of court status, legal status or legal custody and who is authorized to give consents;

d. placement agreement;

e. resident's history including educational background, employment record, prior medical history and prior placement history;

f. a copy of the resident's individual service plan and any modifications to that plan;

g. progress reports;

h. reports of any incidents of abuse, neglect, accidents or critical incidents, including use of passive physical restraints;

i. reports of any resident's grievances and the conclusions or dispositions of these reports. If the resident's grievance was in writing, a copy of the written grievance shall be included;

j. a summary of family visits and contacts including dates, the nature of such visits/contacts and feedback from the family;

k. a summary of attendance and leaves from the facility;

l. written notes from providers of professional or specialized services; and

m. discharge summary at the time of discharge.

4. All resident's records shall be available for inspection by the department.

#### M. Quality Assessment and Improvement

1. The governing body shall ensure that there is an effective, written, ongoing, facility-wide program designed to assess and improve the quality of resident care.

2. There shall be a written plan for assessing and improving quality that describes the objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation and improvement activities. All organized services related to resident care, including services furnished by a contractor, shall be evaluated. The services provided by each LMHP shall be periodically evaluated to determine whether they are of an acceptable level of quality and appropriateness.

3. Assessment of quality shall address:

a. resident care problems;

b. cause of problems;

c. documented corrective actions; and

d. monitoring or follow-up to determine effectiveness of the corrective actions taken.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:60 (January 2004).

### **§9033. Notifications**

A. The facility shall comply with the notification requirements as outlined in this §9033.

1. The facility shall notify the department on the next working day in the event of:

- a. temporary or permanent closing of the facility due to natural or man-made disasters;
- b. a change in the administrator and/or clinical director;
- c. damage to the premises of the facility caused by fire, accident, or other elements that seriously affects the provision of services;

2. If a resident is absent without permission, the resident's parents or custodians are to be notified immediately.

B. The facility shall comply with the notification requirements as outlined in §9033 regarding:

1. any case of suspected resident abuse or neglect;
2. each serious occurrence; and
3. the death of a resident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:63 (January 2004).

### **Subchapter D. Human Resources**

#### **§9043. Personnel**

A. Personnel policy includes, but is not limited to, defining staff, essential job functions, qualifications, and lines of authority.

1. The PRTF shall have:

- a. a written plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members whether directly employed, contract or volunteer;
- b. written personnel policies and written job descriptions for each staff position;
- c. written employee grievance procedures; and
- d. written nondiscrimination policy that shall ensure that the provider does not discriminate in the employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, veteran's status or any non-merit factor in accordance with all state and federal regulations.

2. Staff Medical Requirement

a. The PRTF shall have policies and procedures that define how the facility will comply with current regulations regarding healthcare screenings of PRTF personnel.

b. The PRTF shall have policies and procedures and require all personnel to immediately report any signs or symptoms of a communicable disease or personal illness to their supervisor or administrator as appropriate for possible reassignment or other appropriate action to prevent the disease or illness from spreading to other residents or personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:63 (January 2004).

#### **§9045. Personnel Qualifications**

A. Employment Requirements. Staff shall meet the requirements outlined in this Subsection.

1. The chief executive officer (CEO) or administrator shall be qualified by an advanced degree from an accredited college or university in a mental health-related field, with at least five years of related experience.

2. The program manager shall be a LMHP with at least five years related direct service or administrative experience.

3. The clinical director shall be a psychiatrist who is either board-eligible or certified in child psychiatry, with experience appropriate to the level and intensity of services and the population to be served.

a. The governing body of the provider shall designate a psychiatrist as the clinical director.

4. Psychological services shall be provided by or supervised by a psychologist with a doctorate degree from an accredited program in clinical or counseling psychology and with appropriate post-graduate experience.

5. A registered nurse must be licensed to practice nursing by the Louisiana State Board of Nursing.

6. The physician who assumes 24-hour on-call medical responsibility shall be a board-certified physician.

#### **B. Staffing Definitions**

1. All experience requirements are related to paid experience. Volunteer work, college work/study or internship related to completion of a degree cannot be counted as work experience. If experience is in a part-time position, the staff person must be able to verify the amount of time worked each week. Experience obtained while working in a position for which the individual is not qualified may not be counted as experience.

2. All staff qualified, eligible and employed prior to January 1, 2004, may continue to provide services with the facility employing them. If any individual on staff changes facilities, the new staff requirements must be met.

#### **C. Criminal History Investigation and References**

1. The PRTF shall arrange, prior to employment, for a criminal history investigation, as required by R.S. 15:587.1. for:

- a. each applicant for employment, including all caregivers, substitutes, support staff, and any other person employed by the facility or program;
- b. others who have unsupervised access to children, such as volunteers, contracted staff, or janitors; and
- c. adults, including providers' spouses or adult children, who live in the facility.

2. Exceptions. Criminal history investigations are not required for:

- a. staff who move to a new facility operated by the same organization;
- b. parent volunteers who transport children on an irregular basis if the facility staff are present with children at all times;
- c. contracted staff who provide transportation, lessons, or other services if the facility staff are present with children at all times; and
- d. providers' children who become adults, age 18, during continuous residence at the licensed facility.

3. Staff criminal history investigations shall be maintained in a confidential manner, separate from the individual's personnel record.

#### D. Prohibitions

1. The facility is restricted from knowingly employing a person who:

- a. has entered a plea of guilty or nolo contendere, no contest, or has been convicted of:
  - i. any criminal activity involving violence against a person;
  - ii. child abuse or neglect;
  - iii. possession, sale, or distribution of illegal drugs;
  - iv. sexual misconduct and/or is required to register pursuant to the Sex Offenders Registration Act;
  - v. gross irresponsibility or disregard for the safety of others; or

2. The restrictions contained in this Subsection apply to employees and persons who provide services to the facility.

3. Persons who are employed by the facility or who provide services to the facility may not use or be under the influence of, alcohol or illegal drugs during hours of work.

4. If a staff member is alleged to have committed an act described in Subsection D.1 of this Section, the accused shall be removed from contact with children until the charges are resolved. However, if criminal charges are filed, the accused shall be removed from contact with children until the charges are resolved.

a. A person who has received a deferred sentence for any charge in Subsection D.1 of this Section shall be removed from contact with children for the duration of the deferment.

E. Orientation. Staff shall receive orientation within 30 days of employment.

1. Staff who will work with residents shall receive orientation before being assigned as the only staff responsible for residents.

2. Orientation includes, but is not limited to:

- a. confidentiality;
- b. grievance process;
- c. fire and disaster plans;
- d. emergency medical procedures;
- e. organizational structure;
- f. program philosophy;
- g. personnel policy and procedure;
- h. detecting and mandatory reporting of child abuse;
- i. detecting signs of illness or dysfunction that warrant medical or nursing intervention;
- j. basic skills required to meet the health needs and problems of the resident;
- k. crisis de-escalation and the management of aggressive behavior including acceptable and prohibited responses;
- l. physical restraint which is to include a practice element in the chosen method; and
- m. safe administration and handling of all medications including psychotropic drugs, dosages and side effects.

3. Orientation may be counted toward the total training hours for the first year.

F. The staff shall meet the following requirements for training.

1. Administrator and Clinical Director. The administrator and clinical director shall obtain a minimum of 12 clock hours of continuing education per calendar year. Hours are prorated at one hour per month for staff who has not been employed for a full year. The content pertains to the roles and responsibilities of the position.

2. Training for LMHPs and MHPs (excluding administrator and clinical director). LMHPs, MHPs and MHSs shall obtain a minimum of 12 clock hours of continuing education per calendar year. Hours are prorated at one hour per month for staff who has not been employed for a full year. The content pertains to the roles and responsibilities of the position. Content areas include, but are not limited to:

- a. crisis intervention;
- b. child/youth development;
- c. discipline;
- d. stress management;
- e. therapeutic relationship;
- f. therapeutic intervention; and
- g. abuse prevention, detection, and reporting.

3. All staff shall receive at least 40 hours of training, in addition to orientation training, during the first year of employment.

4. The facility must require staff to have ongoing education, training and demonstrated knowledge of:

- a. techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
- b. the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
- c. the safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress or injury in residents who are restrained or in seclusion.

5. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

6. Individuals who are qualified by education, training, and experience must provide staff training.

7. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

8. Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

9. All training programs and materials used by the facility must be available for review by CMS and HSS.

G Staff Evaluation. The provider shall complete an annual performance evaluation of all staff members. For any person who interacts with residents, the provider's performance evaluation procedures shall address the quality and nature of a staff member's relationships with residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:63 (January 2004).

## §9047. Personnel Responsibilities

A. The PRTF must meet minimum licensure requirements for staffing, staff qualifications and staffing ratios.

1. A PRTF that serves individuals from special risk populations shall modify staffing patterns to fit their increased needs.

2. The PRTF shall ensure that an adequate number of qualified staff members are present with the residents as necessary to ensure the health, safety and well-being of residents. Staff coverage shall be maintained in consideration of the time of day, the size and nature of the PRTF, the ages and needs of the residents, and shall assure the continual safety, protection, direct care and supervision of residents.

3. When residents are at school, work or recreation outside the facility, the provider shall have a plan ensuring the availability and accessibility of direct care staff to handle emergencies or perform other necessary direct care functions.

4. The PRTF shall make sufficient provisions for housekeeping and maintenance to ensure that staff is able to adequately perform direct care functions.

B. Staffing Requirements. The PRTF shall have the clinical leadership and sufficient staff on duty to meet the 24-hour, seven day per week treatment needs of recipients and shall establish policies, contracts and practices to assure:

1. availability of adequate psychiatric services to meet the following requirements:

a. provide medical oversight of all of the clinical aspects of care, and provide 24-hour, seven days per week psychiatric on-call coverage;

b. assess each resident's medication and treatment needs including administration of medication; prescribe medications or otherwise assure the case management and consultation services are provided to obtain prescriptions, and prescribed therapeutic modalities to achieve the resident's individual treatment plan's goals; and

c. participate in the facility's treatment plan team and Quality Management process;

2. sufficient supervision of all residents 24 hours a day.

C. The facility shall maintain a minimum ratio of one staff person for two residents (1:2) during awake hours.

D. The facility shall maintain a minimum ratio of one staff person for three residents (1:3) during sleeping hours. Staff shall always be awake while on duty.

E. At a minimum the following staff positions are required. However, the same person may occupy both the administrator/director position and the program manager position if the individual meets the qualifications for both positions.

1. Chief Executive Officer (CEO) or Administrator? responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

2. Program Manager? assists the chief executive officer (CEO) or administrator in the management of individual programs, the supervision of direct service workers, and/or the management of administrative programs.

3. Clinical Director

a. The governing body of the provider shall designate a psychiatrist as the clinical director to assume responsibility for the psychiatric aspects of the program and to provide full time coverage on an on-site or on-call basis.

b. The designated psychiatrist shall provide a monthly minimum of one hour of on-site clinical direction per resident.

c. The designated psychiatrist shall monitor and evaluate the quality and appropriateness of services and treatment provided by the facility's direct care staff.

4. The PRTF shall provide or make available adequate numbers of LMHPs, MHPs and MHSs whose care specialization is consistent with the following duties and requirements of a PRTF:

a. evaluate patients;

b. formulate written individualized treatment plans;

c. provide active treatment measures; and

d. engage in discharge planning.

5. A LMHP or MHP shall:

a. be designated and assigned as treatment plan manager for each resident and given responsibility for and authority over those activities detailed in the minimum licensure requirements, including:

i. supervision of the treatment plan;

ii. integration of the various aspects of the resident's program;

iii. recording of the resident's progress as measured by objective indicators and making appropriate changes/modifications; and

iv. serving as liaison between the resident, provider, family and community during the resident's admission to and residence in the facility, or while the resident is receiving services from the provider.

b. provide a minimum of three individual therapy sessions each week for each resident (a minimum weekly total of 120 minutes);

c. provide a minimum of two group therapy sessions per week for each resident;

d. have a maximum caseload not to exceed 12 residents.

6. The MHSs shall be under the supervision of LMHPs and/or MHPs to assist with the duties and requirements of a PRTF.

7. There shall be at least one LMHP or MHP supervisor for every nine staff members.

8. Each resident must have a minimum of one face-to-face contact with a psychiatrist each month, and additional contacts for individuals from special risk populations, and as clinical needs of the resident dictate.

9. The PRTF shall provide or have available a psychologist to provide psychological testing and psychological services, as necessary to assist in essential diagnostic formulations as requested, and participate in program development and evaluation of program effectiveness, in therapeutic interventions and in treatment plan team meetings.

10. Depending on the needs of the residents, the PRTF shall directly provide or arrange for the services of qualified professionals and specialists, including persons as necessary from the following areas:

- a. medicine and dentistry;
- b. nursing;
- c. disabilities;
- d. speech, occupational and physical therapies; and
- e. recreation.

11. The PRTF shall provide or have available a therapeutic activities program.

a. The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

b. The number of qualified therapists, support personnel and consultants shall be adequate to provide comprehensive therapeutic activities consistent with each patient's treatment plan.

12. Nursing services shall be provided by or supervised by a registered nurse.

a. There shall be an adequate number of registered nurses, licensed practical nurses, and other staff, to provide the nursing care necessary under each patient's treatment plan.

b. The PRTF shall ensure the on-site availability of a registered nurse 24 hours per day, seven days per week.

c. All drugs and biologicals shall be administered in accordance with the orders of the practitioner(s) responsible for the resident's care and accepted standards of practice.

13. A physician shall assume 24-hour on-call medical responsibility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:65 (January 2004).

#### **§9049. Personnel Records**

A. The facility shall maintain on file a written personnel record for each employee working at the facility, which shall be kept for at least one year following an employee's separation from employment. The personnel record shall include:

1. an application, résumé, or staff information sheet that documents qualifications for the position;
2. any health records required by the facility;
3. annual performance evaluations and any reports and notes relating to the individual's employment with the facility;
4. date of employment; and
5. date and reason for leaving employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004).

#### **§9051. Volunteers**

A. If a facility uses volunteers, the facility shall have a current, written volunteer policy.

B. Volunteers shall receive orientation before having contact with residents.

C. Volunteers shall work under the direct supervision of a paid staff member. They shall never be left alone or in charge of a resident or group of residents without a paid staff member present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004).

### **Subchapter E. Physical Environment**

#### **§9061. General Provisions**

A. The PRTF shall be constructed, arranged and maintained to ensure the safety and well being of the resident.

##### **B. Buildings**

1. The buildings shall reflect good housekeeping and shall by means of an effective pest control program, be free of insects and rodents.

2. The PRTF shall maintain PRTF-wide ventilation, lighting and temperature controls.

3. There shall be a policy regarding the provision of services during any period in which the supply of electricity, natural gas, water and fuel is temporarily disrupted.

4. Doors leading into a facility or unit may be locked only in the direction of ingress.

5. Doors in the line of egress shall not be locked. Any deviation to allow the outermost doors in the line of egress to be locked may only be made after approval has been given by the Office of the State Fire Marshal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004).

#### **§9063. Interior Space**

A. The arrangement, appearance and furnishing of all interior areas of the facility shall be similar to those of a normal family home within the community.

B. The provider shall ensure that there is evidence of routine maintenance and cleaning programs in all areas of the facility.

C. Each living unit of a facility shall contain a space for the free and informal use of the residents. This space shall be constructed and equipped in a manner in keeping with the programmatic goals of the facility.

D. A facility shall have a minimum of 60 square feet of floor area per resident in living areas accessible to the residents and excluding halls, closets, bathrooms, bedrooms, staff or staff's family quarters, laundry areas, storage areas and office areas.

##### **E. Resident Bed Rooms**

1. Single rooms must contain at least 120 square feet and multi-bed rooms shall contain at least 100 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment. Any resident room shall not contain more than two beds. Rooms shall have at least a 7 1/2 foot ceiling height over the required area. In a room with varying ceiling height, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space.

a. Any PRFT applying for licensure and constructed after the effective date of the licensing regulations must comply with the requirement that each resident room shall not contain more than two beds.

2. There shall be at least 3 feet between beds.

3. There shall be sufficient and satisfactory separate storage space for clothing, toilet articles and other personal belongings of residents.

4. There shall be at least one toilet bowl with accessories, lavatory basin and bathing facility reserved for

resident use on each resident floor and additional toilets, lavatories, and bathing facilities to adequately meet the needs of employees, professional personnel and residents on each unit.

5. Doors to individual bedrooms shall not be equipped with locks or any other device that would prohibit the door from being opened from either side.

6. The provider shall not use any room that does not have a window as a bedroom space.

7. The provider shall ensure that sheets, pillow, bedspread and blankets are provided for each resident.

8. Each resident shall have his/her own dresser or other adequate storage space for private use and designated space for hanging clothing in proximity to the bedroom occupied by the resident.

9. There shall be separate sleeping quarters for males and females.

#### F. Dining Areas

1. The facility shall have dining areas that permit residents, staff and guests to eat together in small groups.

2. A facility shall have dining areas that are clean, well lit, ventilated and attractively furnished.

#### G. Bathrooms

1. A facility shall have wash basins with hot and cold water, flush toilets, and bath or shower facilities with hot and cold water according to resident care needs.

a. Bathrooms shall be so placed as to allow access without disturbing other residents during sleeping hours.

b. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene unless residents are individually given such items. Residents shall be provided individual items such as hair brushes and toothbrushes.

c. Tubs and showers shall have slip proof surfaces.

2. A facility shall have toilets and baths or showers that allow for individual privacy unless the residents in care require assistance.

3. Toilets, wash basins and other plumbing or sanitary facilities in a facility shall, at all times, be maintained in good operating condition and shall be kept free of any materials that might clog or otherwise impair their operation.

#### H. Kitchens

1. Kitchens used for meal preparations shall have the equipment necessary for the preparation, serving, storage and clean up of all meals regularly served to all of the residents and staff. All equipment shall be maintained in proper working order.

2. The provider shall ensure that all dishes, cups and glasses used by residents are free from chips, cracks or other defects and are in sufficient number to accommodate all residents.

#### I. Administrative and Counseling Area

1. The provider shall provide a space that is distinct from resident's living areas to serve as an administrative office for records, secretarial work and bookkeeping.

2. The provider shall have a designated space to allow private discussions and counseling sessions between individual residents and staff, excluding, bedrooms and common living areas.

#### J. Furnishings

1. The provider shall have comfortable customary furniture as appropriate for all living areas. Furniture for the

use of residents shall be appropriately designed to suit the size and capabilities of the residents.

2. The provider shall promptly replace or repair broken, run-down or defective furnishings and equipment.

#### K. Doors and Windows

1. The provider shall provide insect screens for all windows that can be opened. The screens shall be in good repair and readily removable in emergencies.

2. The provider shall ensure that all closets, bedrooms and bathrooms are equipped with doors that can be readily opened from both sides.

#### L. Storage

1. The provider shall ensure that there are sufficient and appropriate storage facilities.

2. The provider shall have securely locked storage space for all potentially harmful materials. Keys to such storage spaces shall only be available to authorized staff members.

#### M. Electrical Systems

1. The provider shall ensure that all electrical equipment, wiring, switches, sockets and outlets are maintained in good order and in safe condition.

2. The provider shall ensure that any room, corridor or stairway within a facility shall be well lit.

#### N. Heat

1. The provider shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of all residents.

2. The provider shall not use open flame heating equipment or portable electrical heaters.

#### O. Smoking

1. Smoking shall be prohibited in all areas of the PRTF that are heated and air-conditioned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:66 (January 2004).

### **§9065. Facility Exterior**

A. The provider shall maintain all areas of the facility that are accessible to the residents in good repair and free from any reasonably foreseeable hazard to health or safety. All structures on the grounds of the facility shall be maintained in good repair.

1. Garbage and rubbish stored outside shall be secured in noncombustible, covered containers and shall be removed on a regular basis.

2. Trash collection receptacles and incinerators shall be separate from recreation/play areas.

3. Fences shall be in good repair.

4. Areas determined unsafe, including steep grades, open pits, swimming pools, high voltage boosters or high speed roads shall be fenced or have natural barriers to protect residents.

5. Recreation/playground equipment shall be so located, installed and maintained as to ensure the safety of the residents.

6. Residents shall have access to safe, suitable outdoor recreational space and age appropriate equipment.

7. The provider shall ensure that exterior areas are well lit at night.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:67 (January 2004).

#### **§9067. Equipment**

A. Equipment shall be clean and in good repair for the safety and well-being of the residents.

B. Therapeutic, diagnostic and other resident care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. Methods for cleaning, sanitizing, handling and storing of all supplies and equipment shall be such as to prevent the transmission of infection.

D. After discharge of a resident, the bed, mattress, cover, bedside furniture and equipment shall be properly cleaned. Mattresses, blankets and pillows assigned to residents shall be in a sanitary condition. The mattress, blankets and pillows used for a resident with an infection shall be sanitized in an acceptable manner before they are assigned to another resident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:68 (January 2004).

#### **Subchapter F. Facility Operations**

##### **§9077. Safety and Emergency Preparedness**

A. The PRTF shall have an emergency preparedness plan designed to manage the consequences of natural disasters or other emergencies that could disrupt the PRTF's ability to provide care and treatment or threatens the lives or safety of the PRTF residents and/or the community it serves. The emergency preparedness plan shall be made available, upon request or if mandated to do so, to local, parish, regional and/or state emergency planning organizations, DHH and the Office of the State Fire Marshal.

B. As a minimum, the plan shall include:

1. identification of potential hazards that could necessitate an evacuation, including internal and external disasters such as a natural disaster, acts of bio-terrorism, weapons of mass destruction, labor work stoppage, or industrial or nuclear accidents;

2. emergency procedures for evacuation of the PRTF;

3. procedures in the case of interruption of utility services in a way that affects the health and safety of residents;

4. identification of the facility and an alternate facility to which evacuated residents would be relocated;

5. the estimated number of residents and staff that would require relocation in the event of an evacuation;

6. the system or procedure to ensure that medical charts accompany residents in the event of a resident evacuation and that supplies, equipment, records and medications would be transported as part of an evacuation; and

7. the roles and responsibilities of staff members in implementing the disaster plan.

C. The PRTF shall assure that residents receive nursing care throughout the period of evacuation and while being returned to the original PRTF.

D. The provider shall conduct and document fire drills once per month, one drill per shift every 90 days, at varying times of the day.

E. Notification of Emergencies. The provider shall immediately notify the HSS and other appropriate agencies of any fire, disaster or other emergency that may present a danger to residents or require their evacuation from the facility.

F. Access to Emergency Services

1. The provider shall have access to 24-hour telephone service.

2. The provider shall either post telephone numbers of emergency services, including the fire department, police department, medical services, poison control and ambulance services or show evidence of an alternate means of immediate access to these services.

G. General Safety Practices

1. The provider shall not maintain any firearm or chemical weapon in the living units of the facility.

2. The provider shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers labeled as to contents. Such materials shall be maintained only as necessary and shall be used in a manner that ensures the safety of residents, staff and visitors.

3. The provider shall ensure that an appropriately equipped first aid kit is available in the living units and in all vehicles used to transport residents.

4. The provider shall prohibit the use of candles in resident sleeping areas.

5. Power-driven equipment used by the provider shall be safe and properly maintained. Such equipment shall be used by residents only under the direct supervision of a staff member and according to state law.

6. The provider shall have procedures to prevent insect and rodent infestation.

7. The provider shall allow residents to swim only in areas determined to be safe and under the supervision of a person certified/trained in American Red Cross Community Water Safety or equivalent.

H. Transportation

1. The provider shall ensure that each resident is provided with the transportation necessary for implementation of the resident's treatment plan.

2. The provider shall have the means of transporting residents in cases of emergency.

3. The provider shall ensure and document that vehicles used in transporting residents, whether such vehicle is operated by a staff member or any other person acting on behalf of the provider, is inspected and licensed in accordance with state law and carries current liability insurance.

4. Any staff member of the facility or other person acting on behalf of the provider, operating a vehicle for the purpose of transporting residents shall be currently and appropriately licensed.

5. The provider shall not allow the number of persons in any vehicle used to transport residents to exceed the number of available seats in the vehicle. The provider shall not transport residents in the back or the bed of a truck.

6. The provider shall ensure that residents being transported in the vehicle are properly supervised while in the vehicle and during the trip.

7. All vehicles used for the transportation of residents shall be maintained in a safe condition and in conformity with all applicable motor vehicle laws.

8. Vehicles used to transport residents shall not be identified in a manner that may embarrass or in any way produce notoriety for residents.

9. The provider shall ascertain the nature of any need or problem of a resident that might cause difficulties during transportation, such as seizures, a tendency toward motion sickness or a disability. The provider shall communicate such information to the operator of any vehicle transporting residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:68 (January 2004).

#### **§9079. Food and Diet**

A. The provider shall ensure that a resident is, on a daily basis, provided with food of such quality and in such quantity as to meet the recommended daily dietary allowances adjusted for age, gender and activity of the Food Nutrition Board of the National Research Council.

1. Menus shall be written and approved annually in writing by a registered dietician.

2. The provider shall develop written menus at least one week in advance.

3. Written menus and records of foods purchased shall be maintained on file for 30 days. Menus shall provide for a sufficient variety of foods, vary from week to week and reflect all substitutions.

B. A person designated by the administrator/director shall be responsible for the total food service of the facility. This person shall be responsible for:

1. initiating food orders or requisitions;

2. establishing specifications for food purchases and insuring that such specifications are met;

3. storing and handling of food;

4. food preparation;

5. food serving;

6. orientation, training and supervision of food service personnel;

7. maintaining a current list of residents with special nutritional needs;

8. having an effective method of recording and transmitting diet orders and changes;

9. recording information in the resident's record relating to special nutritional needs;

10. providing information on the resident's diets to the staff.

C. The provider shall ensure that any modified diet for a resident shall be:

1. prescribed by the resident's physician and treatment plan with a record of the prescription kept on file;

2. planned, prepared and served by persons who have received instruction from the registered dietician who has approved the menu for the modified diet.

D. The provider shall ensure that a resident is provided at least three meals or their equivalent daily at regular times with not more than 14 hours between the evening meal and breakfast on the following day.

E. The provider shall ensure that the food provided to a resident in care of the provider is in accord with his/her religious beliefs.

F. No resident shall be denied food or force-fed for any reason except as medically required pursuant to a physician's written order. A copy of the order shall be maintained in the resident's file.

G. When meals are provided to staff, the provider shall ensure that staff members eat the same food served to residents in care, unless special dietary requirements dictate differences in diet.

H. The provider shall purchase and provide to the residents only food and drink of safe quality. The storage, preparation and serving techniques shall ensure that nutrients are retained and spoilage is prevented. Milk and milk products shall be Grade A and pasteurized.

I. The provider shall ensure that food served to a resident and not consumed is discarded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:69 (January 2004).

#### **§9081. Health Care and Nursing Services**

##### **A. Health Care**

1. The provider shall have a written plan for providing preventive, routine and emergency medical and dental care for residents and shall show evidence of access to the resources outlined in the plan. This plan shall include:

a. ongoing appraisal of the general health of each resident;

b. provision of health education, as appropriate; and

c. provisions for keeping resident's immunizations current.

2. The provider shall ensure that a resident receives timely, competent medical care when he/she is ill or injured. The provider shall notify the resident's parent or legal guardian, verbally/in writing, within 24 hours of a resident's illness or injury that requires treatment from a physician or hospital.

3. Records of all medical examinations, follow-ups and treatment together with copies of all notices to parent(s) or guardian(s) shall be kept in the resident's file.

4. Immunizations. Within 30 days of admission, the provider shall obtain documentation of a resident's immunization history, insuring that the resident has received all appropriate immunizations and booster shots that are required by the Office of Public Health.

##### **B. Nursing Services**

1. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction and supervision of a registered nurse licensed to practice in Louisiana, employed full time, 40 hours per week.

2. Written nursing policies and procedures shall define and describe the resident care provided. There shall be a

written procedure to ensure that all licensed nurses providing care in the PRTF have a valid and current Louisiana license to practice, prior to providing any care.

3. Nursing services are either furnished or supervised and evaluated by a registered nurse.

4. There shall be at least one registered nurse on duty on site at all times.

#### C. Medications

1. All PRTFs that house or use scheduled narcotics shall have a site-specific Louisiana dangerous substance license and a United States Drug Enforcement Administration controlled substance registration for the facility in accordance with the Louisiana Uniform Controlled Dangerous Substance Act and Title 21 of the *United States Code*.

2. The provider shall have written policies and procedures that govern the safe administration and handling of all drugs as appropriate to the facility.

3. The provider shall have a written policy governing the self-administration of both prescription and nonprescription drugs.

4. The provider shall ensure that medications are either self-administered or administered by qualified persons according to state law.

5. The provider shall have a written policy for handling medication taken from the facility by residents on pass.

6. The provider shall ensure that any medication given to a resident for therapeutic and medical purposes is in accordance with the written order of a physician.

a. There shall be no standing orders for prescription medications.

b. There shall be standing orders, signed by the physician, for nonprescription drugs with directions from the physician indicating when he/she is to be contacted. Standing orders shall be updated annually by the physician.

c. Copies of all written orders shall be kept in the resident's file.

7. Proper disposal procedures shall be followed for all discontinued and outdated drugs and containers with worn, illegible or missing labels.

8. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

a. Drugs used externally and drugs taken internally shall be stored on separate shelves or in separate cabinets.

b. All drugs, including refrigerated drugs, shall be kept under lock and key.

9. The provider using psychotropic medications on a regular basis shall have a written description of the use of psychotropic medications including:

a. a description of procedures to ensure that medications are used as ordered by the physician for therapeutic purposes and in accordance with accepted clinical practice;

b. a description of procedures to ensure that medications are used only when there are demonstrable benefits to the resident unobtainable through less restrictive measures;

c. a description of procedures to ensure continual physician review of medications and discontinuation of

medications when there are no demonstrable benefits to the resident;

d. a description of an ongoing program to inform residents, staff, and where appropriate, resident's parent(s) or legal guardian(s) on the potential benefits and negative side-effects of medications and to involve residents and, where appropriate, their parent(s) or legal guardian(s) in decisions concerning medication.

10. All compounding, packaging, and dispensing of drugs, biologicals, legend and controlled substances shall be accomplished in accordance with Louisiana law and Board of Pharmacy regulations and be performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

11. Dispensing of prescription legend or controlled substance drugs direct to the public or resident by vending machines is prohibited.

12. Current and accurate records shall be maintained on the receipt and disposition of all scheduled drugs. An annual inventory, at the same time each year, shall be conducted for all Schedule I, II, III, IV and V drugs.

13. Medications are to be dispensed only upon written orders, electromechanical facsimile, or oral orders from a physician or other legally authorized prescriber, and be taken by a qualified professional.

14. All drug containers shall be labeled to show at least the resident's full name, the chemical or generic drug's name, strength, quantity and date dispensed unless a unit dose system is utilized. Appropriate accessory and cautionary statements as well as the expiration date shall be included.

15. Drugs and biologicals that require refrigeration shall be stored separately from food, beverages, blood, and laboratory specimens.

16. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician. An entry shall be made in the resident's record.

17. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the administrator, the Louisiana Board of Pharmacy, DHH Controlled Dangerous Substances Program and to the Regional Drug Enforcement Administration (DEA) office, as appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:69 (January 2004).

#### **§9083. Delivery of Services**

A. The PRTF shall have an on-going plan, consistent with available community and PRTF resources, to provide or make available social work, psychological and educational services to meet the medically related needs of its residents.

##### B. Arrangement of Residents into Groups

1. The provider shall arrange residents into groups that effectively address the needs of the residents.

2. All residents shall have an opportunity to build relationships within small groups.

3. Residents shall be involved in decision making regarding the roles and routines of their living group to the degree possible considering their level of functioning.

4. No more than 15 residents shall be in a group or unit.

5. The PRTF shall have a distinct unit for minors.

6. Groups shall be separated by gender.

C. Individual Plan of Care Developed by a Team of Professionals. The team shall be composed of physicians and other personnel who are employed by, or who provide services to patients in the facility. The team must be capable of assessing the recipient's immediate and long-range therapeutic needs, personal strengths and liabilities, potential resources of the recipient's family, capable of setting treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives.

1. The team must include, as a minimum, either:

a. a board-certified or board-eligible psychiatrist; or

b. a licensed clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

c. a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology.

2. The team must also include one of the following:

i. a psychiatric social worker;

ii. a registered nurse with specialized training or one year of experience in treating mentally ill individuals;

iii. a licensed occupational therapist with specialized training, or one year of experience in treating mentally ill individuals; or

iv. a psychologist who has a master's degree in clinical psychology.

3. The plan shall be developed in consultation with the recipient and parents, legal guardians, or others in whose care he/she will be released after discharge.

4. Content. The individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan must:

a. be based on a diagnostic evaluation that includes examination of the medical, psychosocial, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for PFTF services, including:

i. diagnoses, symptoms, complaints, and complications indicating the need for admission;

ii. a description of the functional level of the individual;

iii. any orders for medication and diet;

iv. restorative, social and rehabilitation services;

v. treatment objectives;

vi. an integrated program of therapies, activities, and experiences designed to meet the objectives;

vii. plans for continued care, as appropriate; and

viii. post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

5. The plan of care must be reviewed every 30 days or as often as necessary by the team of professionals.

D. The provider shall ensure that any provider of professional or special services (internal or external to the agency) meets the following:

1. are adequately qualified and, where appropriate, currently licensed or certified according to state or federal law;

2. have adequate space, facilities and privacy;

3. have appropriate equipment;

4. have adequate supplies;

5. have appropriate resources.

E. Discharge Planning. The PRTF shall also have an effective, on-going discharge planning program that facilitates the provision of follow-up care. Each resident's record shall be annotated with a note regarding the nature of post PRTF care arrangements. Discharge planning shall be initiated in a timely manner. Residents, along with necessary medical information (e.g., the resident's functional capacity, nursing and other care requirements, discharge summary, referral forms) shall be transferred or referred to appropriate facilities, agencies or services, as needed, for follow-up or ancillary care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:70 (January 2004).

### **§9085. Resident Rights and Grievance Procedure**

A. Every resident shall have the following rights, none of which shall be abridged by the PRTF or any of its staff. The PRTF administrator shall be responsible for developing and implementing policies to protect resident rights and to respond to questions and grievances pertaining to resident rights. These rights shall include at least the following:

1. every resident, or his/her designated representative, shall whenever possible, be informed of the resident's rights and responsibilities in advance of furnishing or discontinuing resident care;

2. the right to have a family member, chosen representative and/or his or her own physician notified promptly of admission to the PRTF;

3. the right to receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or source of payment;

4. the right to be treated with consideration, respect and recognition of their individuality, including the need for privacy in treatment;

5. the right to receive, as soon as possible, the services of a translator or interpreter, if needed, to facilitate communication between the resident and the PRTF's health care personnel;

6. the right to participate in the development and implementation of his/her plan of care;

7. every resident or his/her representative (as allowed by state law) has the right to make informed decisions regarding his/her care;

8. the resident's rights include being informed of his/her health status, and being involved in care planning and treatment;

9. the right to be included in experimental research only when he/she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent resident in accordance with appropriate laws and regulations. The resident may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

10. the right to be informed if the PRTF has authorized other health care and/or educational institutions to participate in the resident's treatment. The resident shall also have a right to know the identity and function of these institutions;

11. the right to be informed by the attending physician and other providers of health care services about any continuing health care requirements after the resident's discharge from the PRTF. The resident shall also have the right to receive assistance from the physician and appropriate PRTF staff in arranging for required follow-up care after discharge;

12. the right to consult freely and privately with his/her parent(s) or legal guardian(s);

13. the right to consult freely and privately with legal counsel, as well as the right to employ legal counsel of his/her choosing;

14. the right to make complaints without fear of reprisal;

15. the opportunity for telephone communication;

16. the right to send and receive mail;

17. the right to possess and use personal money and belongings, including personal clothing;

18. the right to visit or be visited by family and friends subject only to reasonable Rules and to any specific restrictions in the resident's treatment plan. Special restrictions shall be imposed only to prevent serious harm to the resident. The reasons for any special restrictions shall be recorded in the resident's treatment plan;

19. the right to have the individual resident's medical records, including all computerized medical information, kept confidential;

20. the right to access information contained in his/her medical records within a reasonable time frame;

21. the right to be free from all forms of abuse and harassment;

22. the right to receive care in a safe setting;

23. the right to be informed in writing about the PRTF's policies and procedures for initiation, review and resolution of resident complaints;

24. the provider shall ensure that each resident has access to appropriate educational services consistent with the resident's abilities and needs, taking into account his/her age and level of functioning;

25. the provider shall have a written description regarding the involvement of the resident in work including:

a. description of any unpaid tasks required of the resident;

b. description of any paid work assignments including the pay scales for such assignments;

c. description of the provider's approach to supervising work assignments;

d. assurance that the conditions and compensation of such work are in compliance with applicable state and federal laws;

e. all work assignments shall be in accordance with the resident's treatment plan;

f. the provider shall assign as unpaid work for the resident only housekeeping tasks similar to those performed in a normal family home. Any other work assigned shall be compensated, at such rate and under such conditions as the

resident might reasonably be expected to receive for similar work in outside employment;

26. the provider shall have a written plan for insuring that a range of indoor and outdoor recreational and leisure opportunities are provided for residents. Such opportunities shall be based on both the individual interests and needs of the resident and the composition of the living group;

a. the provider shall be adequately staffed and have appropriate recreation spaces and facilities accessible to residents;

b. any restrictions of recreational and leisure opportunities shall be specifically described in the treatment plan, together with the reasons such restrictions are necessary and the extent and duration of such restrictions;

27. every resident shall be permitted to attend religious services in accordance with his/her faith. Residents shall not be forced to attend religious services;

28. the provider shall have a program to ensure that residents receive training in independent living skills appropriate to their age and functioning level. This program shall include instruction in:

a. hygiene and grooming;

b. laundry and maintenance of clothing;

c. appropriate social skills;

d. housekeeping;

e. budgeting and shopping;

f. cooking; and

g. punctuality, attendance and other employment related matters;

29. the provider shall ensure services in the following areas to meet the specialized needs of the resident:

a. physical/occupational therapy;

b. speech pathology and audiology;

c. psychological and psychiatric services; and

d. social work services;

30. in addition to the rights listed herein, residents have the rights provided in the Louisiana Mental Health Law.

B. Resident rights regarding the use of restraint or seclusion. In addition to the resident rights listed above in this §9085, every resident shall have the following rights regarding the use of restraint or seclusion in the PRTF.

#### I. Protection of Residents

a. Restraint and seclusion policy for the protection of residents.

i. Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

ii. An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

iii. Restraint or seclusion must not result in harm or injury to the resident and must be used only:

(a). to ensure the safety of the resident or others during an emergency safety situation; and

(b). until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired;

iv. Restraint and seclusion must not be used simultaneously.

b. Emergency Safety Intervention. An emergency safety intervention must be performed in a manner that is

safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, and psychiatric condition and personal history (including any history of physical or sexual abuse).

2. Orders for the Use of Restraint or Seclusion

a. Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the state and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under age 21 be provided under the direction of a physician.

b. If the resident's treatment team physician is available, only he/she can order restraint or seclusion. If the resident's treatment team physician is unavailable, the physician covering for the treatment team physician can order restraint or seclusion. The covering physician must meet the same requirements for training and experience described in Subparagraph a. of this Paragraph 2.

c. A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with the staff.

d. If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by the staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to the staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

e. Each order for restraint or seclusion must:

i. be limited to no longer than the duration of the emergency safety situation; and

ii. under no circumstances exceed four hours for residents ages 18 to 21; two hours for residents ages 9 to 17; or one hour for residents under age 9.

f. Within one hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to:

i. the resident's physical and psychological status;

ii. the resident's behavior;

iii. the appropriateness of the intervention measures; and

iv. any complications resulting from the intervention.

g. Each order for restraint or seclusion must include:

i. the name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;

ii. the date and time the order was obtained; and

iii. the emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

h. Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

i. each order for restraint or seclusion as required in Subparagraph g of this Paragraph 2;

ii. the time the emergency safety intervention actually began and ended;

iii. the time and results of the one-hour assessment required in Subparagraph f of this Paragraph 2;

iv. the emergency safety situation that required the resident to be restrained or put in seclusion; and

v. the name of staff involved in the emergency safety intervention.

i. The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

j. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.

3. Consultation with Treatment Team Physician. If a physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion orders the use of restraint or seclusion, that person must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of restraint or seclusion must:

a. consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and

b. document in the resident's record the date and time the team physician was consulted.

4. Monitoring of the Resident in and Immediately after Restraint

a. Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

b. If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

c. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency

safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.

5. Monitoring of the Resident in and Immediately after Seclusion

a. Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

b. A room used for seclusion must:

i. allow staff full view of the resident in all areas of the room; and

ii. be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

c. If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

d. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

6. Notification of Parent(s) or Legal Guardian(s). If the resident is a minor as defined in this Chapter:

a. the facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention;

b. the facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

7. Time Out Application

a. A resident in time out must never be physically prevented from leaving the time out area.

b. Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).

c. Staff must monitor the resident while he/she is in time out.

8. Post Intervention Debriefings

a. Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff,

the resident, or others that could prevent the future use of restraint or seclusion.

b. Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of:

i. the emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;

ii. alternative techniques that might have prevented the use of the restraint or seclusion;

iii. the procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

iv. the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

c. Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that resulted from the debriefings.

9. Medical Treatment for Injuries Resulting from an Emergency Safety Intervention

a. Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

b. The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that:

i. a resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

ii. medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with state medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

iii. services are available to each resident 24 hours a day, seven days a week.

c. Staff shall document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

d. Staff involved in an emergency safety intervention that results in an injury to a resident or staff shall meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

C. Grievance Procedure for Residents

1. The provider shall have a written grievance procedure for residents designed to allow residents to make complaints without fear of retaliation.

2. The provider shall document that the resident and the resident's parent(s) or legal guardian(s) are aware of and understand the grievance procedure.

3. The provider shall document the resolution of the grievance in the resident's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 30:71 (January 2004).

David W. Hood  
Secretary

0401#086

## RULE

### Department of Public Safety and Correction Corrections Services

#### Access to and Release of Active and Inactive Records? Adult (LAC 22:I.101)

The Department of Public Safety and Corrections, Corrections Services, in accordance with R.S. 15:823, and the Administrative Procedure Act, R.S. 49:950 et seq., hereby repeals the current LAC 22:I.101, Records of Adult Offenders and Ex-Offenders, in its entirety and adopts LAC 22:I.101, Access to and Release of Active and Inactive Records.

#### Title 22

### CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

#### Part I. Corrections

#### Chapter 1. Secretary's Office

#### §101. Access to and Release of Active and Inactive Records

A. Purpose. To establish the secretary's policy and procedures for access to and release of active and inactive inmate records.

B. Applicability. This regulation applies to all persons employed by the department and those who are under contract with the department. The assistant secretary/office of adult services, all wardens-adult and the director of probation and parole-adult are responsible for implementing this regulation and conveying its contents to all affected persons.

#### C. Definitions

*Application for Pardon or Parole?* for the purpose of this regulation, an *application for pardon or parole* is defined as any time that an inmate has made an *application for pardon or parole*, (including medical parole) or has been released on diminution of sentence (Good Time Parole Supervision-GTPS).

*Law Enforcement Agencies?* those agencies designed to enforce federal, state or municipal laws and who receive public funds as their primary source for operation, i.e., sheriff's offices, local and state police departments, departments of corrections, U.S. attorneys, district attorneys, and the Federal Bureau of Investigation (FBI).

*Sex Offender, Serial Sexual Offender, Sexually Violent Predator, Child Predator?* inmates committed to the Department for a crime listed in R.S. 15:536 and 15:541. (See Paragraph N.1, List of Sex Offenses.)

#### D. Release of Information and Records

1. The pre-sentence investigation report, the pre-parole report, the clemency report, the information and data gathered by the staffs of the Board of Pardons and Board of Parole, the prison record, and any other information obtained by the Boards or Corrections Services, in the discharge of official duties shall be confidential and shall not be subject to public inspection nor be disclosed directly or indirectly to anyone except as in accordance with this regulation.

2. Following an *application for pardon and parole*, all information pertaining to an individual's misconduct while incarcerated, statistical information, information pertaining to disposition of criminal charges and incarcerations, and information of a general nature including an individual's age, offense, date of conviction, length of sentence, any correspondence by a public official which requests, or may be determined to be in support of, or in opposition to, the pardon or parole of an individual, and discharge date shall be released to the general public at any time upon request.

NOTE: This provision shall not apply to any public official correspondence which requests, or may be determined to be in support of, or in opposition to, the pardon or parole of an individual, which was received prior to August 15, 1997.

3. An inmate's DOC number and assigned location may be released without restriction.

4. Except as noted below, any communication with the Board of Pardons or Board of Parole urging parole, pardon, clemency, or commutation of sentence or otherwise regarding an inmate shall be deemed a public record and subject to public inspection.

a. Exception. Any letter written by, or on behalf of, any victim of a crime committed by an inmate under consideration for parole, pardon, clemency, or commutation of sentence, or any letter written in opposition to pardon, clemency, or commutation of sentence shall be confidential and shall not be deemed a public record and subject to public inspection. This exception shall not apply to any elected or appointed public official.

5. Information on a particular inmate may be released without special authorization, subject to other restrictions that may be imposed by federal law or by other provisions of state law, to the following:

- a. Board of Parole;
- b. Board of Pardons;
- c. governor;
- d. sentencing judge;
- e. district attorneys;
- f. *law enforcement agencies*;

g. Department of Public Safety and Corrections personnel, including legal representatives and student workers;

h. appropriate governmental agencies or public officials, when access to such information is imperative for the discharge of the responsibilities of the requesting agency, official or court officer and the information is not reasonably available through any other means; and

i. court officers with court orders specifying the information requested.

6. Fingerprints, photographs, and information pertaining to arrests and disposition of criminal charges, as well as information regarding escapes may be released to law enforcement agencies without special authorization.