PROPOSED RULEMAKING

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 5230]

Psychiatric Rehabilitation Services

The Department of Public Welfare (Department), under the authority of Articles IX and X of the Public Welfare Code (62 P. S. §§ 901—922 and 1001—1059), proposes to add Chapter 5230 (relating to psychiatric rehabilitation services) to read as set forth in Annex A.

Purpose of Proposed Rulemaking

The purpose of this proposed rulemaking is to adopt the minimum standards for the issuance of licenses for psychiatric rehabilitation services (PRS) in facilities operated in this Commonwealth.

Background

Psychiatric rehabilitation is a therapeutic rehabilitative service for individuals with mental illness. PRS may decrease the need for or shorten the length of stay in inpatient, partial hospitalization and day treatment settings. PRS helps individuals to achieve valued roles in the community in living, learning and social environments. This proposed rulemaking for the licensing of PRS facilities provides a unified set of standards in accordance with Nationally-recognized practices consistent with the principles established by the United States Psychiatric Rehabilitation Association (USPRA). PRS emphasizes values such as consumer involvement, consumer choice, consumer strengths and individual growth potential, shared decision making as well as outcome accountability.

In 2006, the Office of Mental Health and Substance Abuse Services (OMHSAS) issued correspondence and directives to Commonwealth mental health/mental retardation administrators endorsing the benefits of PRS and encouraging the development and expansion of an array of PRS in each county mental health system. In 2007, the OMHSAS conducted a Statewide survey which identified over 90 PRS programs across this Commonwealth. To further encourage service expansion a Medicaid State Plan Amendment was submitted to the Centers for Medicare and Medicaid Services in May 2010 requesting the inclusion of PRS in the state plan.

To guide the development of regulatory language for the licensing of PRS facilities, the Department convened a broad-based stakeholder group. This stakeholder group consisted of individuals representing county government, behavioral health managed care organizations, provider organizations, consumers of services and their families. The workgroup met several times between May 2009 and February 2010 to assist in drafting the PRS regulatory language.

Requirements

The proposed rulemaking provides licensing standards which include the values and practices of the USPRA. The USPRA practices utilize evidence based practices, which are service delivery practices identified, recognized and verified by research and empirical data to be effective in producing positive outcomes and supporting recovery from mental illness. Standards for the service were developed in 2001 to implement the service within managed care.

Under the current standards, clubhouse programs, which are one of the Nationally-recognized models of PRS, must be certified by the International Committee for Clubhouse Certification (ICCD) within 2 years of licensing by the Department. The Pennsylvania Clubhouse Coalition and other stakeholders offered feedback to the Department indicating the frequent difficulties and unrealistic time frame of obtaining certification within 2 years of licensure due to the typical challenges associated with new program startup. Therefore, under this proposed rulemaking, a certification time frame of 3 years will be required for ICCD certification.

The proposed rulemaking also provides the requirement that individuals receive a statement of rights that ensures that individuals are treated with dignity and respect and receive services in a setting that fosters recovery from mental illness.

The proposed rulemaking provides staffing requirements which allow for minimum staff qualifications, minimum staff to individual ratios and provision of individual and group service, and for delivery of services within a facility or in the community. The proposed rulemaking also allows PRS assistant staff to work independently in the community if that staff person holds a certified psychiatric rehabilitation practitioner (CPRP) credential. The proposed rulemaking also requires the PRS director and a PRS specialist to be CPRP certified, as well as at least 25% of staff to be CPRP certified.

The proposed rulemaking requires a PRS director or delegated supervisor to meet with a staff member face-to-face on an individual basis no less than two times per month. This proposed requirement makes the employee supervision process timely and cost effective. This proposed requirement adds four methods for providing supervision. The Department proposes language that requires staff to complete a 12-hour orientation course and 18 hours of annual training. Under the proposed rulemaking, new staff are required to receive 6 hours of face-to-face mentoring during the orientation period and will receive 8 hours of training on the specific PRS model or approach prior to working independently.

The proposed rulemaking provides requirements for facilities concerning the development and completion of the individual rehabilitation plan (IRP). The proposed rulemaking also standardizes the time frame for completing this process by day 20 of attendance and not more than 60 calendar days after the individual begins service.

Affected Individuals and Organizations

The proposed rulemaking affects facilities that provide PRS and the individuals receiving PRS.

Accomplishments and Benefits

The proposed rulemaking establishes the minimum standards for licensure of PRS facilities. These requirements will contribute to the development of a professionally-qualified and credentialed PRS workforce and will protect consumer health and safety while receiving PRS.

Fiscal Impact

It is anticipated that the implementation of PRS will not have fiscal impact on the Commonwealth, as the reduction in more costly traditional mental health treatments and improved clinical and social outcomes will offset the cost of PRS.

The clinical and social benefits as well as the cost effectiveness of PRS can broadly be categorized as development of skills and supports related to the role functioning that promote recovery from mental illness. A review of PRS literature suggests that PRS results in improved functioning, increased employment and job retention, improved social and community adjustment, and increased independent living. Further studies documented cost offsets in community resources, hospital admissions and days spent in the hospital. Some studies reported lower costs on a per user basis and documented lower overall system costs. There is evidence of cost offsets for PRS compared to use of more intensive and high cost services such as day treatment, partial hospital and psychiatric hospitalization.

PRS is clinically effective and results in improved consumer outcomes. In studies that analyzed cost per user, PRS resulted in lower costs per user. Most cost analysis studies suggest there are cost offsets due to reduced utilization of inpatient admissions and days spent in the hospital setting. Thus, there is evidence to suggest PRS offered in this Commonwealth will contribute to cost savings or cost neutrality, particularly when modeled on evidence-based practices.

Paperwork Requirements

The proposed rulemaking contains the paperwork requirements for facilities that apply for licensure as PRS facilities. Required documents include the following: a facility service description; provider policies, procedures and daily schedules; contracts and letters of agreement; quality improvement documents; and individual rehabilitation plans.

The proposed rulemaking also requires time frames for the completion of paperwork requirements.

Effective Date

The proposed rulemaking will be effective upon final-form publication in the *Pennsylvania Bulletin*.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed rulemaking to Lisa McMullen, Department of Public Welfare, OMHSAS, BPPD, P. O. Box 2675, DGS Complex, Harrisburg, PA 17105-2675, fax (717) 772-7964, PsychRehab@state.pa.us within 30 calendar days after the date of publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Reference Regulation No. 14-521 when submitting comments.

Persons with a disability who require an auxiliary aid or service may submit comments by using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on October 7, 2010, the Department submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior to final publication of the rulemaking, by the Department, the General Assembly and the Governor of comments, recommendations or objections raised.

HARRIET DICHTER,
Secretary

Fiscal Note: 14-521. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART VII. MENTAL HEALTH MANUAL

Subpart D. NONRESIDENTIAL AGENCIES/FACILITIES/SERVICES

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GENERAL PROVISIONS

§ 5230.1. Purpose.

The purpose of this chapter is to establish requirements for the licensing of facilities providing PRSs.

§ 5230.2. Scope.

This chapter applies to PRS facilities as defined in this chapter and contains the minimum requirements that shall be met to obtain a license to operate a PRS facility.

§ 5230.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Best practice—Service delivery practice based directly on principles and standards that are generally recognized by a profession and are documented in the professional literature.

CPRP—Certified Psychiatric Rehabilitation Practitioner—A person who has completed the required education, experience and testing, and who is currently certified as a Certified Psychiatric Rehabilitation Practitioner by the USPRA.

CPS—Certified peer specialist—A person who has successfully completed the Department-approved training in peer support service and is currently certified as a CPS.

Clubhouse—A psychiatric rehabilitation program that is accredited by the ICCD.

Community support principles—The set of accepted principles for delivery of community mental health services developed by the Department and recognized by the Community Support Program of Pennsylvania.

Coordination of care—Direct contact by a PRS facility with other behavioral health, physical health or human service formal and natural supports, to assure continuity in service planning between service facilities.

County MH/MR administrator—The Mental Health/Mental Retardation administrator who has authority in the geographic area.

Culturally competent—The ability to provide service in a manner that shows awareness of and is responsive to the beliefs, interpersonal styles, attitudes, language and behavior of an individual and family who are referred for or receiving service.

Department—The Department of Public Welfare of the Commonwealth.

Discharge—Discontinuation of service to an individual that is based upon established requirements.

EBP—Evidence based practice—Service delivery practice identified, recognized, and verified by research and empirical data to be effective in producing a positive outcome and supporting recovery.

FTE—Full-time equivalent—37.5 hours per calendar week of staff time.

Face-to-face—Contact between two or more people that occurs at the same location, in person.

Fidelity—The degree to which a system accurately adheres to the specified principles of evidenced based or best practice.

Formal support—An agency, organization or person who provides assistance or resources to others within the context of an official role.

Functional impairment—The loss or abnormality of the ability to perform necessary tasks and roles.

GED—Graduate Equivalency Diploma.

Human services—Programs or facilities designed to meet basic health, welfare and other needs of a society or group.

ICCD—International Center for Clubhouse Development.

IRP—Individual rehabilitation plan—A document that describes the current service needs based on the assessment of the individual, and identifies the individual's goals, interventions to be provided, the location, intensity and duration of services, and staff who will provide the service.

Individual—A person, 18 years or older who has a functional impairment resulting from mental illness, who uses PRS.

Licensed practitioner of the healing arts—Those professional staff currently recognized by the Department as qualified to recommend an individual for service.

MA—Medical Assistance.

Mental health direct service—Working directly with an individual to provide mental health service.

Natural support—A person or organization selected by an individual to provide validation, assistance or resources in the context of a personal or nonofficial role.

Outcome—The observable and measurable result of rehabilitation service.

PRS—Psychiatric rehabilitation service—A recovery-oriented service offered individually or in groups which is predicated upon the principles, values and practice standards of the ICCD, USPRA or other Nationally recognized professional PRS association.

PRS facility—An agency or organization licensed by the Department to deliver PRS.

Psychiatric rehabilitation principles—A list of core values inherent in psychiatric rehabilitation as defined by Nationally-recognized professional associations.

QI—Quality improvement plan—A document outlining the ongoing formal process to assure optimal care and maximize service benefit as part of the licensing process.

USPRA—The United States Psychiatric Rehabilitation Association.

§ 5230.4. Psychiatric rehabilitation processes and practices.

(a) A PRS facility shall assist an individual to develop, enhance, and retain skills and competencies in living, learning, working and socializing so that an individual can live in the environment of choice and participate in the community.

(b) A PRS facility shall use the PRS process in delivering PRS. The PRS process consists of three phases:

(1) *Assessing phase.*

(i) Developing a relationship and trust.

(ii) Determining readiness.

(iii) Mutual assessment of needs.

(iv) Goal setting.

(2) *Planning phase.*

(i) Prioritizing needed and preferred skills and supports.

(ii) Planning for resource development.

(3) *Intervening phase.*

(i) Developing new skills.

(ii) Supporting existing skills.

(iii) Overcoming barriers to using skills.

(iv) Creating or modifying resources.

(c) A PRS facility shall ensure that staff training, provider and individual records include the following practices:

(1) Creating a culturally competent, recovery oriented PRS environment consistent with Nationally-recognized values and practice standards.

(2) Engaging an individual in PRS.

(3) Assessing individual strengths, interests and preferences for rehabilitation service with an individual.

(4) Developing strategies to assist an individual in identifying, achieving and maintaining valued roles.

(5) Developing rehabilitation plans with an individual.

(6) Helping an individual increase awareness of community resources and identify preferred options for the rehabilitation process.

(7) Educating an individual about mental illness, wellness and living in recovery.

(8) Providing direct or indirect skills development.

(9) Assisting an individual in identifying, developing and utilizing natural supports.

(10) Reaching out and reengaging an individual.

(d) A facility may provide PRS concurrently with clinical treatment.

(1) A PRS shall begin as soon as clinically possible following diagnosis.

(2) A PRS facility shall collaborate and coordinate with other services with the consent of the individual.

(e) A PRS facility shall follow EBP or best practices.

(f) A PRS facility shall demonstrate fidelity to the specific PRS approach identified in the service description.

(g) A PRS facility may offer PRS in premises or in the community, or in a combination of the two, consistent with an approved service description.

§ 5230.5. Access to facility and records.

(a) A PRS facility shall provide access to the premises and records during inspection and, upon request, by the Department.

(b) A PRS facility shall grant access to private interviews with individuals upon request by the Department and with individual consent.

GENERAL REQUIREMENTS

§ 5230.11. Organizational structure.

A PRS facility shall:

(1) Develop a PRS advisory board that includes participation by individuals and families who utilize mental health services.

(2) Document that the members of the PRS advisory board have been provided with an overview of PRS processes and practices.

(3) Name a director and staff.

§ 5230.12. Inspections and licenses.

(a) A PRS facility shall meet the requirements under Chapter 20 (relating to licensure or approval of facilities and agencies).

(b) A PRS facility may appeal licensure or approval of PRS facilities in accordance with 1 Pa. Code Part II (relating to the General Rules of Administrative Practice and Procedure).

§ 5230.13. Facility records.

A PRS facility shall maintain records that contain copies of the following:

(1) Inspection reports, certifications or licenses issued by state and local agencies.

(2) The PRS statement of rights under § 5230.41 (relating to PRS statement of rights).

(3) Documentation of civil rights compliance.

(4) A detailed service description under § 5230.15 (relating to service description).

(5) PRS facility policies and procedures that address the following:

(i) The implementation of the PRS based upon the service description.

(ii) Nondiscrimination statement.

(iii) Compliance with other applicable State and Federal regulations, including the Americans with Disabilities Act of 1990 (ADA) (42 U.S.C.A. §§ 12101—12213) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the act of August 21, 1996 (Pub. L. No. 104-191, 110 Stat. 1936).

(iv) Engagement and outreach to an individual to maintain participation in the IRP.

(v) Complaint, grievance and appeal notices.

(vi) Crisis response.

(vii) Disaster preparedness.

(6) Human resources policies and procedures that address the following:

(i) Job descriptions for positions.

(ii) Criminal history background check requirements and protocol.

(iii) Policies regarding transportation of individuals.

(iv) Evidence of staff credentials or qualifications.

(v) Records of orientation and training, including an annual training plan for staff.

(vi) Staff work schedules and time sheets.

(7) PRS daily schedules.

(8) A copy of contracts or letters of agreement with external funding sources including MCOs or County MH/MR Administrators.

(9) Letters of agreement with mental health services and community agencies.

(10) Quality improvement documents.

(i) Quality improvement plan.

(ii) Data gathering tools.

(iii) Evaluation reports and summaries.

§ 5230.14. Physical site requirements.

A PRS facility shall provide:

(1) A physical location within the facility for record keeping and other administrative functions of the PRS regardless of where service is provided.

(2) Space for the PRS distinct from other services offered simultaneously.

(3) A site that is accessible to the service population.

(4) Space, equipment and supplies that are well-maintained and sufficient to deliver the services as provided in the service description.

(5) Private interview space.

(6) Infection control procedures that document compliance with Occupational Safety and Health Administration.

(7) Protocols that meet applicable Federal, State and local requirements for fire, safety and health, including protocols for the following:

(i) Sanitation.

(ii) Fire drills.

§ 5230.15. Service description.

(a) Prior to the initial licensing visit, and when changes occur, a PRS facility shall submit to the Department a service description that includes the following:

(1) The governing body, advisory structure and an agency table of organization.

(2) The philosophy of the PRS facility, incorporating psychiatric rehabilitation and community support program principles.

(3) The population to be served, including the following:

(i) Anticipated daily attendance.

(ii) Age range.

(iii) Diagnostic groups.

(iv) Plans to identify and accommodate special populations.

(v) Plans to identify and accommodate culturally diverse populations.

(4) The approach of PRS offered including EBPs and best practices utilized.

(i) A PRS facility identified as a clubhouse must be accredited by the International Committee for Clubhouse Certification (ICCD) within 3 years of licensing.

(ii) A PRS facility shall demonstrate fidelity to the specific approach identified in the service description.

(5) The location of service, whether in a facility or in the community, or a combination of both.

(6) Expected service outcomes for individuals.

(7) Staffing.

(i) Staffing patterns.

(ii) Staff to individual ratios.

(iii) Staff qualifications.

(iv) Staff supervision plans.

(v) Staff training protocols.

(8) Service delivery patterns, including frequency, intensity and duration of service.

(9) The days and hours of PRS operation.

(10) The geographic limits of PRS operation.

(11) The physical site, including copies of applicable licenses and certificates.

(12) A process for development of an IRP with an individual.

(13) A referral process.

(14) The methods by which PRS staff and an individual will collaborate to identify community resources and establish linkages.

(15) A process for developing and implementing a QI plan.

(16) A procedure for resolving complaints and grievances.

(b) The Department reserves the right to deny service descriptions and approaches that do not meet EBP or best practices standards.

§ 5230.16. Coordination of care.

A PRS facility shall have written agreements to coordinate care with other service providers, including the following:

(1) Psychiatric inpatient facilities.

(2) Partial hospitalization programs.

(3) Psychiatric outpatient clinics.

(4) Crisis intervention programs.

(5) Case management programs.

(6) Housing and residential programs.

(7) Drug and alcohol programs.

(8) Vocational, educational and social programs.

§ 5230.17. Confidentiality.

A PRS facility shall protect information about an individual in compliance with the Mental Health Procedures Act (50 P. S. §§ 7101—7503), §§ 5100.31—5100.39 (relating to confidentiality of mental health records), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the act of August 21, 1996 (Pub. L. No. 104-191, 110 Stat. 1936), and the drug and alcohol confidentiality regulations in 4 Pa. Code § 255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information).

INDIVIDUAL RECORD

§ 5230.21. Content of individual record.

A PRS facility shall develop and maintain a unique record for an individual served containing the following:

(1) Information that identifies the individual.

(2) Eligibility for PRS, including diagnosis.

(3) Referral source, reason for referral, and recommendation by a physician or licensed practitioner of the healing arts.

(4) A signed:

(i) Consent to receive services.

(ii) Set of individual consents to release information to other providers.

(iii) Statement that the individual has received and had an opportunity to discuss the oral and written versions of the PRS statement of rights under § 5230.41 (relating to PRS statement of rights).

(iv) Statement that the individual has received verbal and written notification of freedom of choice of providers.

(5) An assessment and updates.

(6) The IRP.

(7) Staff documentation of IRP outcomes.

(8) Staff documentation of coordination with other services and supports.

(9) Discharge summary.

§ 5230.22. Record security, retention and disposal.

A PRS facility shall ensure that an individual record meets the following standards:

(1) The record must be legible throughout.

(2) The record must identify the individual on each page.

(3) Entries shall be signed and dated by the responsible licensed provider.

(4) The record must indicate progress at each day of service, changes in service and response to services.

(5) Alterations of the record shall be signed and dated.

(6) The record is kept in a permanent, secure and protected location.

(7) The record shall be maintained for a minimum of 4 years.

(8) Records shall be destroyed in a manner that protects confidentiality.

§ 5230.23. Access to individual record.

An individual may review, provide written comments and sign daily entries in the individual record.

ADMISSION, CONTINUED STAY AND DISCHARGE REQUIREMENTS

§ 5230.31. Admission requirements.

(a) To be eligible for PRS, an individual shall meet the following:

(1) Have a written recommendation for PRS by a physician or licensed practitioner of the healing arts acting within the scope of professional practice.

(2) Have the presence or history of a serious mental illness, based upon medical records, which includes one of the following diagnoses by a psychiatrist:

(i) Schizophrenia.

(ii) Major mood disorder.

(iii) Psychotic disorder (not otherwise specified).

(iv) Schizoaffective disorder.

(v) Borderline personality disorder.

(3) As a result of the mental illness, have a moderate to severe functional impairment that interferes with or limits performance in at least one of the following domains:

(i) Living.

(ii) Learning.

(iii) Working.

(iv) Socializing.

(4) Choose to participate in the PRS program.

(b) A PRS facility shall document the functional impairment in an assessment.

§ 5230.32. Continued stay requirement.

A PRS facility shall determine eligibility for continued stay by an assessment that indicates the following:

(1) An individual chooses additional participation in the PRS.

(2) A continued need for service based upon one or both of the following:

(i) As a result of a mental illness, there is a functional impairment or skill deficit that is addressed in the IRP.

(ii) The withdrawal of service could result in loss of rehabilitation gain or goal attained by an individual.

§ 5230.33. Discharge requirements.

When a PRS facility documents one of the following criteria, discharge may occur. An individual:

(1) Has achieved a rehabilitation goal and sustained progress as designated in the IRP.

(2) Has gained maximum rehabilitative benefit.

(3) Will not lose rehabilitation gain or goal as a result of withdrawal of service.

(4) Has voluntarily terminated.

RIGHTS

§ 5230.41. PRS statement of rights.

(a) An individual has the right to be treated with dignity and respect and to be free from physical and mental harm.

(b) An individual has the right to receive PRS in a culturally respectful and nondiscriminatory environment.

(c) An individual has the right to receive PRS in the least restrictive setting that fosters recovery and promotes growth.

(d) An individual has the right to access competent, timely and quality service to assist with fulfillment of a personal goal.

(e) An individual has the right to express a goal which is individualized and reflects informed choice concerning selection, direction or termination of service and service plan.

(f) An individual has the right to choose a service based on individual need, choice and acceptance and not dependent on compliance or participation with another treatment or rehabilitation service.

(g) An individual has the right to keep and use personal possessions in a manner that is reasonable to the service and location. Any necessary limitations shall be clearly communicated and defined, universally applied, and documented.

(h) An individual has the right to offer an opinion and belief, to express a complaint related to service and to the IRP and to have the complaint heard in a fair manner.

(i) An individual has the right to appeal an individual service decision.

(j) An individual has the right to have the assistance of a personally chosen representative or advocate in expressing a complaint or grievance.

(k) An individual has the right to be able to contribute to, have access to, and control release of the individual record.

(l) An individual has the right to have information and records concerning service treated in a confidential manner, as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the act of August 21, 1996 (Pub. L. No. 104-191, 110 Stat. 1936).

(m) A PRS facility shall:

(1) Assure compliance with the PRS statement of rights.

(2) Develop and implement a written procedure for assuring compliance with the PRS statement of rights.

(3) Post the PRS statement of rights within the facility.

(4) Notify an individual verbally and in writing and include a signed acknowledgement of rights in the individual record.

(5) Make service decisions in compliance with individual rights.

§ 5230.42. Nondiscrimination.

A PRS facility may not discriminate against an individual or staff on the basis of age, race, sex, religion, ethnic origin, economic status, sexual orientation or gender identity or expression, or disability.

§ 5230.43. Complaint, grievance and appeal procedures.

(a) The PRS facility shall have written policies and procedures for requesting, responding, and resolving complaints and grievances.

(b) A PRS facility shall give verbal and written notice to an individual upon admission to the service, explaining complaint, grievance and appeal procedures.

(c) A PRS facility shall offer assistance to an individual as needed to file a complaint, grievance or appeal.

STAFFING

§ 5230.51. Staff qualifications.

(a) A PRS director shall have one of the following:

(1) A bachelor's degree and CPRP certification.

(2) A bachelor's degree and at least 3 years work experience in mental health direct service, 2 years of which must be work experience in PRS. CPRP certification must be attained within 2 years of hire.

(b) A psychiatric rehabilitation specialist shall have one of the following:

(1) A bachelor's degree and 2 years work experience in mental health direct service, 1 year of which must be work experience in PRS. CPRP certification must be attained within 2 years from the date of hire as a psychiatric rehabilitation specialist.

(2) CPRP certification.

(c) A psychiatric rehabilitation worker shall have one of the following:

(1) A bachelor's degree.

(2) An associate's degree and 1 year work experience in mental health direct service.

(3) A CPS certificate and 1 additional year paid or volunteer work experience in mental health direct service.

(4) A high school diploma or GED and 2 years work experience in human services which must include 1 year of mental health direct service.

(d) A psychiatric rehabilitation assistant shall have a high school diploma or GED and 6 months experience in human services.

§ 5230.52. General staffing patterns.

(a) A PRS facility shall staff the service according to the following:

(1) The location of services is consistent with the service description.

(2) The service may range from individual service to group service.

(3) The service and the choice of service locations must be determined by the IRP of the individual.

(b) A PRS facility shall employ a director and a specialist for the PRS.

(c) When a service is delivered in a facility, a PRS facility shall have an overall complement of one FTE staff for every ten individuals (1:10), based upon average daily attendance.

(d) When a service is delivered, a PRS facility shall schedule a specialist or worker to be present.

(e) A PRS facility shall develop a schedule that includes a plan to maintain staffing requirements during:

(1) Staff absence.

(2) Deployment of staff for community service.

(f) A PRS facility shall document staffing by maintaining work schedules, time records and daily utilization data.

(g) When a PRS operates at more than one facility address, the PRS director shall be present at each licensed PRS facility address an average of 7.5 hours per week in a calendar month.

(h) A minimum of 25% of the FTE staff complement shall meet specialist criteria within 1 year of initial licensing.

(i) A minimum of 25% of the FTE staff complement shall have CPRP credential within 2 years of initial licensing.

(j) Trained staff shall be available, or other accommodations made, to address the language needs of an individual, including American Sign Language and Braille.

§ 5230.53. Individual services.

A PRS facility shall provide individual PRS in a facility or in the community on a one staff to one individual (1:1) ratio.

§ 5230.54. Group services.

(a) A PRS facility shall provide group PRS in a facility or in the community.

(1) When a group service is provided in a facility, group size may vary as long as the one staff to ten individuals (1:10) ratio for the overall service is met.

(2) When a service is delivered in the community, one staff may serve a group of two to five (2:5) ratio individuals.

(b) Individuals participating in a group service shall be working on similar goals, as identified in the individual's IRP.

(c) A PRS facility shall consider personal preferences of an individual and shall inform an individual of the following:

(1) The location where the group is to meet.

(2) Purpose of providing service in a community setting.

(3) The roles of individuals and PRS staff.

(d) A PRS facility shall obtain individual consent to participate in the group activity in a community location.

(e) A PRS facility may not require community group participation and individual preference for one to one (1:1) ratio service shall be honored, per freedom of choice requirements.

(f) A PRS facility shall design group community service as experiential rather than verbal, to protect confidentiality in a public location.

(g) A PRS facility shall arrange for group discussion of the experience, before and after the service in a community setting, to occur in the privacy of the facility.

§ 5230.55. Supervision.

(a) A PRS director shall supervise staff.

(b) A PRS specialist may perform supervisory functions as delegated by the director, consistent with approved job descriptions for the two positions.

(c) A PRS director or PRS specialist shall meet with staff individually, face-to-face, no less than two times per calendar month.

(d) A PRS director shall provide additional supervision utilizing the following methods:

(1) Monitoring active PRS delivery.

(2) Individual case discussions.

(3) Staff meetings.

(e) A PRS director shall annually evaluate staff.

§ 5230.56. Staff training requirements.

A PRS facility shall implement a staff training plan that ensures initial and ongoing training in PRS practices.

(1) Staff that provides services in a PRS shall complete a 12-hour psychiatric rehabilitation orientation course approved by the Department no later than 1 year after hire. This course shall be credited to the annual training requirement listed under paragraph (2) for the calendar year in which it is completed.

(2) Staff providing services in a PRS shall complete 18 hours of training per year with 12 hours specifically focused on psychiatric rehabilitation or recovery practices, or both.

(3) A PRS facility shall assure competency of new staff by providing an additional PRS service specific orientation that includes the following:

(i) Eight hours of training in the specific PRS model or approach outlined in the service description prior to new staff working independently.

(ii) Six hours of face-to-face mentoring of service delivery by a supervisor for new staff before services are delivered independently.

(4) A PRS facility shall assure that training has learning objectives.

(5) A PRS facility shall maintain documentation of training hours in the PRS facility records under § 5230.13(5)(v) (relating to facility records).

§ 5230.57. Criminal history background check.

(a) A PRS facility shall complete a criminal history background check for staff that will have direct contact with an individual.

(b) A PRS facility shall develop and consistently implement written policies and procedures regarding personnel decisions based on the outcome of the criminal history background check.

SERVICE PLANNING AND DELIVERY

§ 5230.61. Assessment.

(a) A PRS facility shall complete an assessment of an individual.

(b) The assessment shall be completed in collaboration with the individual and must:

(1) Include the functioning of the individual in the living, learning, working and socializing domains.

(2) Include strengths and needs of the individual.

(3) Identify existing and needed natural and formal supports, including other health care facilities and social service agencies.

(4) Identify the specific skills, supports and resources the individual needs and prefers to accomplish stated goals.

(5) Identify cultural needs and preferences of the individual.

(6) Be signed by the individual and staff.

(7) Be updated annually and when one of the following occurs:

(i) The individual requests an update.

(ii) The individual completes a goal or objective.

(iii) The individual is not progressing on stated goals.

§ 5230.62. Individual rehabilitation plan.

(a) A PRS staff and an individual shall jointly develop an IRP, that is consistent with the assessment and includes the following:

(1) A rehabilitation goal and objective designed to achieve a measurable outcome.

(2) The method of service provision, including skill development and resource acquisition.

(3) The responsibilities of the individual and the staff.

(4) Action steps and time frame.

(5) The expected frequency and duration of participation in the PRS.

(6) The intended service location.

(7) Dated signatures of the individual, the staff working with the individual and the PRS director.

(b) A PRS facility shall complete an IRP by day 20 of attendance, but no more than 60 calendar days after initial contact.

(c) A PRS facility and an individual shall review and revise the IRP at least every 90 days, and when:

(1) The overall rehabilitation goal is completed.

(2) An objective is completed.

(3) No significant progress is made.

(4) An individual requests a change.

(d) The IRP review must include a comprehensive summary of the individual's progress that includes the following:

(1) A description of the service in the context of the goal identified in the IRP.

(2) Documentation of individual participation and response to service.

(3) A summary of progress or lack of progress toward the goal in the IRP.

(4) A summary of changes made to the IRP.

(5) The dated signature of the individual.

(6) Documentation of the reason if the individual does not sign.

(7) The dated signature of PRS staff.

§ 5230.63. Daily entry.

A PRS facility shall include an entry for the day service was provided in the record of an individual as follows:

(1) Indicates the date, time, duration, location, and type of interaction.

(2) Documents service provided in the context of the goal.

(3) Documents the individual response to service.

(4) Includes the signature of the individual, or if the individual does not sign, document the reason.

(5) Is signed and dated by staff providing the service.

DISCHARGE

§ 5230.71. Discharge.

(a) A PRS facility shall discuss discharge with an individual.

(b) A decision to discharge should be a joint decision between the individual and the PRS.

(c) When a decision to discharge is not a joint decision, the PRS facility shall document the reason for discharge.

(d) When a decision to discharge is reached, a PRS facility shall offer the individual the opportunity to participate in future service.

(e) When an individual voluntarily terminates from the PRS, a PRS facility shall plan and document next steps with the individual, including recommended service and referral.

(f) When it is necessary to discharge an individual from PRS due to the individual's disengagement, prior to discharge the PRS facility shall document:

(1) Attempts to reengage the individual.

(2) The circumstances and rationale for discharge.

(g) When an individual has a recurring or new need for PRS and meets admission criteria, the PRS facility shall reconsider the individual for readmission without regard to previous participation.

§ 5230.72. Discharge summary.

(a) Upon discharge, a PRS facility shall complete a dated and signed discharge summary that must include a description of the following:

(1) Service provided.

(2) Progress.

(3) Reason for discharge.

(4) Referral or recommendation for future service.

(b) A PRS facility shall assure that the discharge summary is:

(1) Completed no more than 30 days after the date of discharge.

(2) Reviewed and signed by the PRS director.

(3) Offered to the individual for review, signature and the opportunity to comment.

QUALITY IMPROVEMENT

§ 5230.81. Quality improvement requirements.

A PRS facility shall establish and implement a written quality improvement plan that meets the following requirements:

(1) Provides for an annual review of the quality, timeliness and appropriateness of services, including the following:

(i) Outcomes for PRS.

(ii) Individual record audits.

(iii) Individual satisfaction.

(iv) Use of exceptions to admission and continued stay requirements.

(v) Evaluation of fidelity to the service description.

(2) Identifies reviewers, frequency and types of audits and methodology for establishing sample size.

(3) Documents that individuals served participate in QI plan development and follow up.

(4) Results in an annual comprehensive summary that:

(i) Reports on actions to address QI findings.

(ii) Is available to the public.

WAIVER OF STANDARDS

§ 5230.91. Request for waiver.

(a) A PRS facility may submit a written request to the Department for a waiver of a specific requirement contained in this chapter.

(b) The Department reserves the right to grant or deny waiver of a specific requirement contained in this chapter.

(c) A waiver request will be considered only in exceptional circumstances.

(d) A waiver will be granted only when the health and safety of an individual and the quality of service are not adversely affected.

(e) The Department reserves the right to revoke a waiver if the conditions required by the waiver are not met.

[Pa.B. Doc. No. 10-2001. Filed for public inspection October 22, 2010, 9:00 a.m.]

[55 PA. CODE CHS. 23, 3800 AND 5310]

Residential Treatment Facilities

The Department of Public Welfare (Department), under the authority of sections 201(2) and 403(b) and Articles IX and X of the Public Welfare Code (code) (62 P. S. §§ 201(2), 403(b), 901—922 and 1001—1080) and section 1905(r)(5) of the Social Security Act (42 U.S.C.A. § 1396 d(r)(5)), proposes to add Chapter 23 (relating to residential treatment facilities) and amend Chapters 3800 and 5310 (relating to child residential and day treatment facilities; and community residential rehabilitation services for the mentally ill) to read as set forth in Annex A.

Purpose of Proposed Rulemaking

The purpose of this proposed rulemaking is to codify minimum licensing and program standards, requirements for participation in the Medical Assistance (MA) Program

and MA payment conditions for residential treatment facilities (RTFs), which provide behavior health services in a 24-hour setting to children under 21 years of age with a diagnosed mental illness or serious emotional or behavioral disorder, or a drug and alcohol diagnosis in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder. The proposed rulemaking will codify the requirements that apply to RTFs in one chapter, replace the requirements for RTFs currently in Chapter 3800 and Notices of Rule Change. It also proposes to require RTFs to be accredited by the Council on Accreditation (COA), the Commission on Accreditation of Residential Facilities (CARF), the Joint Commission (JCAHO) or other accrediting entity approved by the Department. Finally, this proposed rulemaking also proposes to amend § 3800.3 (relating to exemptions) to exempt RTFs and community residential rehabilitation group homes from Chapter 3800. Exempting community residential rehabilitation group homes from Chapter 3800 will give eight bed nonaccredited RTFs that are not located on a larger campus the option to meet the requirements under Chapter 5310 to become licensed as a community residential rehabilitation group home.

The proposed health and safety, treatment, program and payment requirements for comprehensive, culturally competent, medically necessary behavioral health treatment in an RTF were developed after obtaining input through numerous stakeholder meetings and comments to draft proposals prior to publication. By codifying the requirements for RTFs in one chapter, the Department intends to eliminate multiple licensing and monitoring visits to each RTF, thereby enhancing the efficiency of Departmental operations while minimizing interruptions in RTF programs. By requiring accreditation and the concomitant adherence to the standards established by the accrediting entities, in addition to compliance with this proposed rulemaking, the Department intends to enhance the quality of care provided in RTFs.

Requirements

The following is a summary of the specific provisions in the proposed rulemaking:

Sections 23.11—23.22 (relating to general requirements) address the general licensing and approval requirements for an RTF, including maximum capacity, fire safety, reportable and recordable incidents, consent to treatment and confidentiality of records. Section 23.14 (relating to maximum capacity) specifically provides for a maximum number of beds per unit and a maximum number of units per facility. RTFs that currently exceed the proposed maximums will have the opportunity to develop and implement a transition plan to reduce the number of beds. Section 23.17 (relating to reportable incidents) expands the definition of "reportable incident" in Chapter 3800 to include the use of drugs as a restraint.

Sections 23.31—23.34 (relating to child rights) address child rights and include several additional child rights beyond those in Chapter 3800. For example, one additional right is the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. Other additional rights in § 23.32 (relating to specific rights) include the right of the child to advocate for the child's own needs without retaliation or removal from the RTF, as well as the right to a clean, healthy and comfortable living environment.

Sections 23.41—23.44 (relating to family participation) address family participation and require an RTF to make efforts to include a child's family in the planning and delivery of the child's treatment. The proposed requirements include providing information about the treatment process, the expected length of stay, the type of treatment, the formal process to resolve disagreements and the contact information for advocacy organizations and consumer satisfaction teams. Another proposed requirement is for an RTF to provide opportunities for families to have regular contact with the child and staff, as well as to collaboratively develop a family participation plan that identifies specific goals for the family's participation in the child's ongoing treatment. Other proposed requirements include the following: assisting with scheduling visits and travel arrangements; providing treatment services in conjunction with family visits at the RTF in the child's home and in the community; arranging for family participation in medical appointments; and providing adequate comfortable space for visiting.

Sections 23.51—23.62 (relating to staffing) address staff qualifications, including education and experience, staffing ratios and staff training. These proposed sections require enhanced credentials, increased staffing ratios and more clinically oriented training topics than current requirements, in addition to health and safety training requirements. Section 23.60 (relating to family advocacy) also proposes the requirement that an RTF have a family advocate.

Sections 23.81—23.106, 23.121—23.133, 23.141—23.149, 23.151, 23.161—23.164 and 23.171 address the health and safety issues that are currently in Chapter 3800. Because Chapter 3800 will no longer apply to RTFs, the requirements from that chapter that will continue to apply to RTFs are repeated in this proposed rulemaking. They include the physical site, fire safety, child and staff health, nutrition and safe transportation.

Sections 23.181—23.190 (relating to medications) address the storage, use and administration of medications. Section 23.183 (relating to use of prescription medications) requires that information be provided to a child and the child's family regarding the effects and side effects of medication. Section 23.187 (relating to administration) limits the ability to administer prescription medications and injections to licensed personnel, except as specified in §§ 23.188 and 23.189 (relating to self-administration; and special circumstances). In addition, § 23.190 (relating to medication performance monitoring) requires that an RTF report to the Department every 6 months the number and percentage of children who are taking multiple psychotropic or antipsychotic medications.

Sections 23.201—23.206 (relating to restrictive procedures) address restrictive procedures and focus on the requirements that an RTF use de-escalation approaches and other alternatives to coercive techniques to reduce or eliminate the need to use restrictive procedures. Section 23.205 (relating to emergency safety intervention) specifically prohibits the use of prone restraint. Section 23.203 (relating to written plan to create a restraint-free environment) requires an RTF to create a written plan with goals and objectives and time frames to develop a trauma-informed approach which establishes a restraint-free environment within the RTF.

Sections 23.221—23.230 (relating to services) address the services that an RTF provides as part of its program. Section 23.221 (relating to description of services) requires an RTF to have a service description with both detailed information about the scope of the program and general information about the services the RTF will provide. The service description must include the number,

ages and special characteristics of the children the RTF proposes to serve. Section 23.224 (relating to content of the ISP) requires an RTF to develop a treatment plan that addresses the behavioral health needs of each child, with specified goals, objectives and interventions, as part of the individual service plan that addresses the broader health, safety and education goals for the child.

Sections 23.241—23.244 and 23.251—23.257 address the requirements regarding the content, storage and retention of child records. Additional requirements for facilities serving nine or more children as well as additional requirements for facilities providing secure care are also included in these sections.

Sections 23.281, 23.282 and 23.291—23.295 address the participation requirements for an RTF licensed under this chapter to become and remain an MA provider. Section 23.291 (relating to general participation requirements for an RTF) includes a new requirement that each RTF shall receive and maintain accreditation by COA, CARF, JACHO or other accrediting body approved by the Department. Participation requirements for an out-of-State RTF and an RTF serving children with a drug and alcohol diagnosis in conjunction with a diagnosed mental illness or serious emotional behavioral disorder are also specified in these sections.

Sections 23.301—23.319, 23.321—23.323, 23.331, 23.332, 23.341, 23.342 and 23.351 address payment provisions, including rate-setting policy, cost reporting, allowable costs, bed occupancy, readmissions, therapeutic and hospital leave, payment conditions and third-party liability. In addition, §§ 23.341 and 23.342 (relating to provider abuse; and administrative sanctions) address administrative sanctions. Section 23.351 (relating to provider right of appeal) addresses an RTF's appeal rights.

Affected Individuals and Organizations

Stakeholders, including children, families, advocates, providers, county and State government representatives, and medical directors of behavioral health managed care organizations have, for the past decade, been providing input to the Department in developing the clinical guidelines and program standards for RTFs in workgroups, through draft documents, at forums and in meetings. The Department has adopted many of the recommendations of these stakeholders in developing this proposed rulemaking.

The incorporation of the requirements for licensure, covering health and safety as well as treatment, participation in the MA program and MA payment conditions into one chapter will result in greater convenience to an RTF, since the RTF will not have to refer to multiple documents to determine the requirements that apply to it. One coordinated annual licensing and monitoring visit from the Department, rather than multiple visits, will also be more convenient for an RTF. Some RTFs that currently participate in the MA program may incur greater costs as a result of the proposed accreditation requirements, number of units per facility, staffing ratios, higher staff qualifications and increased training requirements, but the rate-setting policies address the additional costs associated with these requirements.

Accomplishments and Benefits

The proposed rulemaking benefits children under 21 years of age who need behavioral health services in the more intensive level of care provided in an RTF. The proposed rulemaking promotes quality treatment in meeting a child's needs and assisting in making the transition to a less-restrictive setting. Children and their families will benefit from the enhanced standards for behavioral health services proposed in this chapter.

Fiscal Impact

The increased costs incurred by an RTF to meet the enhanced staffing and training requirements may result in higher per diem rates for some RTFs, but the expected aggregate reduction in lengths of stay due to high quality behavioral health treatment is expected to offset the fiscal impact of the higher rates. In addition, RTFs that are currently not accredited and choose to remain MA providers will incur the costs associated with accreditation. The Department will be able to build the cost of accreditation into the rates.

Paperwork Requirements

Since the Department is proposing that accreditation be a requirement for participation in the MA program, an RTF that is not accredited will have to complete additional paperwork to become accredited. For those RTFs, it is estimated that the accreditation requirement will also entail several staff hours per week for paperwork in addition to the initial paperwork needed to become accredited. Requirements for accreditation vary by accrediting organization.

Effective Date

This proposed rulemaking will be effective 12 months from the date the final-form rulemaking is published in the *Pennsylvania Bulletin*, with the exception of the accreditation requirement, which will be effective 24 months from the date the final-form rulemaking is published in the *Pennsylvania Bulletin*.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed rulemaking to Shaye Erhard, Office of Mental Health and Substance Abuse Services, 233 Beechmont Building, DGS Complex, P. O. Box 2675, Harrisburg, PA 17105-2675, ra-rtfcomments@state.pa.us within 30 calendar days after the date of publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Reference regulation No. 14-522 when submitting comments.

Persons with a disability who require an auxiliary aid or service may submit comments by using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on October 7, 2010, the Department submitted a copy of this proposed rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. A copy of this material is available to the public upon request.

Under section 5(g) of the Regulatory Review Act, IRRC may convey any comments, recommendations or objections to the proposed rulemaking within 30 days of the close of the public comment period. The comments, recommendations or objections must specify the regulatory review criteria which have not been met. The Regulatory Review Act specifies detailed procedures for review, prior

to final publication of the rulemaking, by the Department, the General Assembly and the Governor of comments, recommendations or objections raised.

HARRIET DICHTER,
Secretary

Fiscal Note: 14-522. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 55. PUBLIC WELFARE

PART I. DEPARTMENT OF PUBLIC WELFARE

Subpart C. LICENSING/APPROVAL

CHAPTER 23. RESIDENTIAL TREATMENT FACILITIES

Subchap.
A. GENERAL PROVISIONS
B. LICENSURE/APPROVAL REQUIREMENTS
C. PARTICIPATION REQUIREMENTS
D. PAYMENT PROVISIONS

Subchapter A. GENERAL PROVISIONS

Sec.
23.1. Purpose.
23.2. Applicability.
23.3. Definitions.
23.4. Waivers.

§ 23.1. Purpose.

The purpose of this chapter is to establish minimum licensing and treatment standards, MA participation requirements and MA payment conditions for RTFs.

§ 23.2. Applicability.

This chapter applies to RTFs that operate in this Commonwealth to serve children under 21 years of age with a diagnosed mental illness, or serious emotional or behavioral disorder, or a drug and alcohol diagnosis in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder.

§ 23.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Active treatment—The implementation and supervision of interventions and services outlined in a treatment plan.

Antipsychotic medication—A powerful tranquilizer, such as the phenothiazines or butyrophenones, used especially to treat psychosis and believed to act by blocking dopamine nervous receptors.

ASD—Autism Spectrum Disorder

BMI—Body Mass Index.

CAO—County Assistance Office.

CASSP (Child and Adolescent Service System Program)—A philosophy of collaborative service delivery in which services that are rendered to children and their families are least restrictive and least intrusive, child centered, family focused, community based, multisystem and culturally competent.

CCYA—The County Children and Youth Agency.

CMS—Centers for Medicare and Medicaid Services—The agency of the United States Department of Health and Human Services that is responsible for administering the Medical Assistance Program.

CRNP—Certified Registered Nurse Practitioner.

Certified day—A day of care approved by the Department under this chapter.

Child—An individual under 21 years of age.

Contracting agency—A public or private entity that has an agreement with an RTF to pay for services provided by the RTF.

Cost center—A group of services or employees, or both, or another unit or type of activity into which functions of a facility are divided for purposes of expense assignment and allocations.

Day of care—Room, board and professional behavioral health services calculated on a 24-hour day basis using a midnight census hour.

Department—The Department of Public Welfare of the Commonwealth.

Drug used as a restraint—A drug that has the following characteristics:

(i) Is administered to manage a child's behavior in a way that reduces the risk to the safety of the child or others.

(ii) Has the temporary effect of restricting the child's freedom of movement.

(iii) Is not standard treatment for the child's medical or psychiatric condition.

(iv) A drug ordered by a licensed physician as part of ongoing medical treatment, or as pretreatment prior to a medical or dental examination or treatment, is not a drug used as a restraint.

Eligible recipient—An individual who has been determined eligible for MA benefits.

Emergency safety intervention—The use of an intervention, such as a restraint or seclusion, as an immediate response to an emergency safety situation.

Emergency safety situation—Unanticipated child behavior that places the child or others at serious risk of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Family—Birth, adoptive or foster parents; grandparents; other relatives; nonrelatives identified by the child; and guardians or custodians, except child welfare agencies.

Family advocate—A family member of a child who is currently receiving services or has received services from a child-serving system including mental health, intellectual disabilities, child welfare, juvenile justice, drug and alcohol or special education.

Fire safety expert—A local fire department, fire protection engineer, Commonwealth-certified fire protection instructor, college instructor in fire science, county of Commonwealth fire school, volunteer trained and certified by a county or Commonwealth fire school, or an insurance company loss control representative.

Fiscal year—The period of time beginning July 1 and ending June 30 of the following year.

High Fidelity Wraparound—A team-based, collaborative process for developing and implementing individualized care plans for children with mental health challenges and their families. The therapeutic goals of High Fidelity Wraparound are to meet the needs prioritized by youth and family, improve their ability and confidence to manage their own services and supports, develop or

strengthen their natural social support system over time, and integrate the work of all child serving systems and natural supports into one streamlined plan.

Hospital-reserved bed day—A day when the child is approved for and admitted to an acute care general hospital, a psychiatric or rehabilitation unit of an acute care general hospital, or a psychiatric or rehabilitation hospital and the child is expected to return to the RTF.

ISP—Individual Service Plan.

ISPT—Interagency Service Planning Team.

Intimate sexual contact—An act of an erotic nature involving unclothed physical contact.

JPO—Juvenile probation office.

LEA—Local Education Agency.

MA—Medical Assistance.

MH/MR—Mental Health/Mental Retardation.

Manual restraint—The application of a physical hands-on technique without the use of a device, for the purposes of restraining the free movement of a child's body or portion of a child's body.

Mechanical restraint—A device attached or adjacent to a child's body that the child cannot easily remove that restricts the child's freedom of movement of the child's normal access to the child's body, which include handcuffs, anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets and similar devices.

Minor—A child under 18 years of age.

Natural supports—A nonpaid assistance, relationship or interaction that allows a child to advance in the community in ways that correspond to the typical routines and social actions of other people and that enhance the child's relationships.

PA—Physician's Assistant.

PRN—Pro Re Nata.

Psychotropic medication—A medication, as defined by active ingredient, in one of the following drug classes:

(i) Attention deficit hyperactivity disorder agents.

(ii) Antidepressants.

(iii) Antidyskinetic agents.

(iv) Antipsychotic agents.

(v) Anxiolytic and sedative or hypnotic agents.

(vi) Mood stabilizers.

(vii) Substance abuse agents.

RN—Registered Nurse.

RTF—Residential treatment facility—A nonhospital living setting in which behavioral health treatment is provided to one or more children with a diagnosed mental illness, or serious emotional behavioral disorders or a diagnosed substance abuse condition in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder.

Restraint—A manual restraint, mechanical restraint or drug used as a restraint as defined in this section, which does not include briefly holding, without restricting free movement.

Seclusion—Placing a child in a locked room, which includes a room with any type of door-locking device, such as a key lock, spring lock, bolt lock, food pressure lock or physically holding the door shut.

Serious injury—A significant impairment of the physical condition of a child as determined by qualified medical personnel, including, but not limited to, burns, lacerations, bone fractures, substantial hematoma and injuries to internal organs.

Serious occurrence—A child's death, a serious injury or a child's suicide attempt.

Staff—Individuals employed directly or on a contract basis by an RTF.

Trauma-informed care—A philosophy with related intervention practices that recognizes the prevalence and consequences of maltreatment or childhood trauma, is committed to avoiding retraumatization during treatment and care, and promotes resilience to enable the child to overcome the negative consequences of trauma and move forward in the child's development.

§ 23.4. Waivers.

(a) An RTF may submit a written request for a waiver of any provision of this chapter, except as specified in subsection (b), on a form prescribed by the Department, and the Department may grant a waiver of one or more provisions of this chapter if the RTF demonstrates the following:

(1) A waiver will not jeopardize the health or safety of a child.

(2) The RTF has an alternative for providing an equivalent level of health, safety and emotional protection of the children.

(3) The children will benefit from the waiver of the requirement.

(b) The scope, definitions and applicability of this chapter may not be waived.

(c) The Department may grant a waiver unconditionally or subject to conditions that the RTF shall meet, and a decision to grant a waiver will identify the time period for which the waiver will be in effect, subject to the review specified in subsection (e).

(d) An RTF shall notify affected children and their families of the Department's decision to grant or deny a request for a waiver and post both the waiver request and the Department's decision in a conspicuous and public place in the RTF.

(e) The Department will review its decision to grant a waiver annually and may revoke the waiver if the conditions of the waiver are not met.

Subchapter B. LICENSURE/APPROVAL REQUIREMENTS

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GENERAL REQUIREMENTS

§ 23.11. Licensure or approval of facilities.

The requirements under Chapter 20 (relating to licensure or approval of facilities and agencies) shall be met.

§ 23.12. Inspections and certificates of compliance.

(a) An RTF will be individually inspected at least once a year, including at least one onsite unannounced inspection, unless otherwise specified by statute.

(b) A separate certificate of compliance will be issued for each physical structure that qualifies for a certificate.

(c) The RTF shall post in a conspicuous and public place the current certificate of compliance and a copy of this chapter.

§ 23.13. Appeals.

(a) An RTF may appeal the Department's licensure or approval action under 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law) and 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure), except that the appeal shall be made by filing a petition within 30 days after service of notice of the action.

(b) Subsection (a) supersedes the appeal period of 1 Pa. Code § 35.20 (relating to appeals from actions of the staff).

§ 23.14. Maximum capacity.

(a) An RTF may not exceed 4 units of 12 beds each for a total of 48 beds.

(b) The maximum capacity specified on the certificate of compliance will be based on available bedroom square footage, the number of toilets and sinks, the needs of the population of children residing in the RTF, the RTF's staffing levels, the RTF's program components and the treatment intensity of the RTF.

(c) The maximum capacity specified on the certificate of compliance may not be exceeded and may be temporarily or permanently reduced if the Department determines that the physical plant, clinical programming or needs of the population of children residing in the RTF requires that maximum capacity be reduced.

§ 23.15. Fire safety approval.

(a) If a fire safety approval is required by State statute or regulations, a valid fire safety approval from the appropriate authority, listing the type of occupancy, is required prior to receiving a certificate of compliance under this chapter.

(b) If the fire safety approval is withdrawn or restricted, the RTF shall notify the appropriate Departmental regional office orally within 24 hours and in writing within 48 hours of the withdrawal or restriction with a plan for remedy or a plan for child relocation.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the RTF shall submit to the appropriate Departmental regional office within 2 weeks of the completed renovation, the new fire safety approval, or written certification that a new fire safety approval is not required, from a fire safety authority.

§ 23.16. Child abuse.

(a) An RTF shall immediately report suspected abuse of a child in accordance with 23 Pa.C.S. §§ 6301—6385 (relating to the Child Protective Services Law) and Chapter 3490 (relating to child protective services).

(b) If an allegation of child abuse involves staff, the RTF shall submit and implement a plan of supervision in accordance with 23 Pa.C.S. § 6368 (relating to investigation of reports) and § 3490.56 (relating to county agency investigation of suspected child abuse perpetrated by persons employed or supervised by child care services and residential facilities).

§ 23.17. Reportable incidents.

(a) A reportable incident is one of the following:

(1) A death of a child.

(2) A physical act by a child to attempt suicide.

(3) An injury, trauma or illness of a child requiring inpatient treatment at a hospital.

(4) An injury, trauma or illness of a child requiring outpatient treatment at a hospital, not to include minor injuries, such as sprains or cuts.

(5) A violation of a child's rights specified in § 23.32 (relating to specific rights).

(6) Intimate sexual contact or attempted sexual contact between children, consensual or otherwise.

(7) Sexual assault of a child.

(8) A child absence from the premises for 2 hours or more without the approval of staff, or for 30 minutes or more without the approval of staff, if the child may be in immediate jeopardy.

(9) Use of a drug as a restraint.

(10) Abuse or misuse of a child's funds.

(11) An outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions).

(12) An incident requiring the services of the fire, police or emergency management departments, except for false alarms.

(13) A condition which results in closure of the RTF.

(14) Emergency relocation of a child.

(15) Food poisoning of a child.

(16) Bankruptcy filed by the RTF.

(17) A prescription medication error.

(18) A criminal conviction against the RTF, administrator or staff that occurs after the reporting on the criminal history checks under § 23.51 (relating to child abuse and criminal history checks).

(b) An RTF shall develop, and submit for Department approval, written policies and procedures, on the prevention, reporting, investigation and management of reportable incidents.

(c) An RTF shall complete an initial written reportable incident report, in a format prescribed by the Department, and send it to the appropriate Departmental regional office, the contracting agency, the Department of Health, the RTF's Family Advocate and the Disability Rights Network no later than close of business the next business day. Staff shall document in the child's record that the incident was reported and a copy of the report must be maintained in the child's record.

(d) An RTF shall orally report to the appropriate Departmental regional office and the contracting agency within 12 hours of the following:

(1) A fire requiring the relocation of children.

(2) An unexpected death of a child.

(3) A child's unauthorized absence from the premises, if police have been notified.

(e) An RTF shall initiate an investigation of a reportable incident immediately following the identification of the incident.

(f) An RTF shall submit a final written reportable incident report to the agencies specified in subsection (c) by no later than close of business the next business day following the conclusion of the investigation.

(g) If the final reportable incident report validates the occurrence of the alleged incident, the RTF shall notify, unless restricted by applicable confidentiality statutes, regulations or a court order, the affected child and other children who could be potentially harmed, and their family.

(h) A copy of a reportable incident report shall be maintained for 6 years in the business office of the RTF.

(i) An RTF shall notify the child's parent and, when applicable, the child's guardian or custodian, as soon as possible, and in no case later than 24 hours after a reportable incident relating to a specific child, unless restricted by applicable confidentiality statutes, regula-

tions or a court order. An RTF shall document in the child's record that the parent and, when applicable, the guardian or custodian, has been notified. The documentation must include the date and time of notification, the name of the staff providing notification, and actions taken subsequent to the event until the time of contact with the parent, guardian or custodian.

(j) A report of death must comply with the following:

(1) In addition to the reporting requirements contained in this section, an RTF shall report the death of a child to the CMS regional office by no later than close of business the next business day after a child's death.

(2) An RTF shall document in the child's record that the death was reported to the CMS regional office.

(k) An RTF shall notify the child's parent and, when applicable, the child's guardian or custodian of a child who has been restrained as soon as possible after the initiation of each emergency safety intervention.

(l) A report of a serious occurrence must comply with the following:

(1) An RTF shall report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated protection and advocacy system.

(2) Serious occurrences that must be reported include the following:

(i) The death of a child.

(ii) A serious injury as defined in this chapter.

(iii) An attempted suicide by a child.

(3) Staff shall report a serious occurrence involving a resident to both the Department 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 following:

(i) The name of the child.

(ii) A description of the occurrence.

(iii) The name, street address and telephone number of the RTF.

(4) In the case of a minor, an RTF shall notify the child's parent and, when applicable, legal guardian or custodian as soon as possible, and in no case later than 24 hours after the serious occurrence.

(5) An RTF shall document in a child's record that the serious occurrence was reported to both the Department 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 shall be maintained in a child's record, as well as in the incident and accident report logs kept by the facility.

§ 23.18. Recordable incidents.

An RTF shall maintain for 6 years in the business office of the RTF, a record of the following:

(1) Seizures.

(2) Suicidal gestures.

(3) Incidents of staff or residents of the RTF intentionally striking or physically injuring a child.

(4) Property damage of more than $500.

(5) Child absences from the premises without the approval of staff, that do not meet the definition of reportable incident in § 23.17(a) (relating to reportable incidents).

(6) Injuries, traumas and illnesses of children that do not meet the definition of reportable incident in § 23.17(a), which occur at the RTF or offsite.

(7) Emergency safety situations, the emergency safety interventions used and their outcomes.

§ 23.19. Child funds.

(a) Money earned or received by a child is the child's personal property.

(b) Commingling of child and RTF funds is prohibited.

(c) An RTF may place reasonable limits on the amount of money to which a child has access. The RTF shall develop a policy on access to a child's funds, which must be approved by the Department.

(d) An RTF shall maintain a separate accounting system for child funds, which includes the dates and amounts of deposits and withdrawals.

(e) Except for a child expected to be in the RTF for fewer than 30 days, an RTF shall maintain an interest-bearing account for child funds, with interest earned tracked and applied for the child.

(f) An RTF shall return money left in a child's account to the child upon discharge or transfer.

§ 23.20. Consent to treatment.

(a) An RTF shall comply with the following statutes and regulations relating to consent to treatment, to the extent applicable:

(1) 42 Pa.C.S. §§ 6301—6365 (relating to the Juvenile Act).

(2) The Mental Health Procedures Act (50 P. S. §§ 7101—7503).

(3) Sections 1—5 of the act of February 13, 1970 (P. L. 19, No. 10) (35 P. S. §§ 10101—10105).

(4) Chapter 5100 (relating to mental health procedures).

(5) The Pennsylvania Drug and Alcohol Abuse Control Act (71 P. S. §§ 1690.101—1690.115).

(6) Sections 1.1 and 1.2 of the act of February 13, 1970 (35 P. S. §§ 10101.1 and 10101.2), regarding mental health treatment and release of medical records.

(b) The following consent requirements apply, unless in conflict with the requirements of the statutes and regulations specified in subsection (a):

(1) An RTF shall obtain written consent upon admission, whenever possible, from a child's parent and, when applicable, a child's guardian or custodian, for the provision of routine health care such as child health examinations, dental care, vision care, hearing care and treatment for injuries and illnesses.

(2) An RTF shall obtain separate written consent prior to treatment, from a child's parent and, when applicable, a child's guardian or custodian, for each incidence of nonroutine treatment, such as elective surgery or experimental procedures. If the parent or, when applicable, the guardian or custodian, cannot be located, an RTF shall obtain separate written consent prior to treatment by court order, for each incidence of nonroutine treatment,

such as elective surgery or experimental procedures. A CCYA that has legal custody of a child may not consent to nonroutine treatment.

(3) Consent for emergency care or treatment is not required.

§ 23.21. Confidentiality of records.

(a) An RTF shall comply with the following statutes and regulations relating to confidentiality of records, to the extent applicable.

(1) 23 Pa.C.S. §§ 6301—6386 (relating to the Child Protective Services Law).

(2) 23 Pa.C.S. §§ 2101—2910 (relating to Adoption Act).

(3) The Mental Health Procedures Act (50 P. S. §§ 7101—7503).

(4) Section 602(d) of the Mental Health and Mental Retardation Act (50 P. S. § 4602(d)).

(5) The Confidentiality of HIV-Related Information Act (35 P. S. §§ 7601—7612).

(6) Sections 5100.31—5100.39 (relating to confidentiality of mental health records).

(7) Sections 3490.91—3490.95 (relating to confidentiality).

(8) Sections 1.1 and 1.2 of the act of February 13, 1970 (35 P. S. §§ 10101.1 and 10101.2), regarding mental health treatment and release of medical records.

(9) The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule (45 CFR Parts 160 and 164, Subparts A and E).

(10) 42 CFR Part 2 (relating to confidentiality of alcohol and drug abuse patient records).

(b) The following confidentiality requirements apply unless in conflict with the requirements of the statutes and regulations specified in subsection (a):

(1) A child's record, information concerning a child or family, and information that may identify a child or family by name or address, is confidential and may not be disclosed or used other than in the course of official RTF duties.

(2) Information specified in paragraph (1) shall be released upon request only to the following:

(i) A child's parent.

(ii) A child's guardian or custodian.

(iii) The child's and parent's attorneys.

(iv) Court and court services, including probation staff.

(v) County government agencies.

(vi) Authorized agents of the Department.

(vii) A child, if the child is 14 years of age or older, unless the information may be harmful to the child. Documentation of the harm to be prevented by withholding information shall be kept in the child's record.

(3) Information specified in paragraph (1) may be released to other providers of service to the child if the information is necessary for the provider to carry out its responsibilities. Documentation of the need for release of the information shall be kept in the child's record.

(4) Information specified in paragraph (1) may not be used for teaching or research purposes unless the information released does not contain information which would identify the child or family.

(5) Information specified in paragraph (1) may not be released to anyone specified in paragraphs (2)—(4), without written authorization from the court, if applicable, or the child's parent or, when applicable, the child's guardian or custodian, or the child.

(6) Release of information specified in paragraph (1) may not violate the confidentiality of another child.

§ 23.22. Applicable health and safety laws.

An RTF shall have a valid certificate or approval document from the appropriate State or Federal agency relating to health and safety protections for child required by another applicable law.

CHILD RIGHTS

§ 23.31. Notification of rights, grievance procedures and consent to treatment protections.

(a) The RTF shall develop and implement written grievance procedures for a child, a child's family and staff to ensure the investigation and resolution of grievances regarding an alleged violation of a child's rights.

(b) A copy of a child's rights, the grievance procedures and a list of organizations that can assist in lodging grievances, and applicable consent to treatment protections shall be posted in a conspicuous and public place at the RTF.

(c) A child, a child's parents, unless court-ordered otherwise; and, when applicable, a child's guardian or custodian, shall be informed of the child rights and grievance procedures in an easily understood manner and in the primary language or mode of communication of the child and child's parent or, when applicable, guardian or custodian.

(d) A child shall be informed of these rights and grievance procedures upon admission. The child's parent and, when applicable, a child's guardian or custodian, shall be informed of the child rights and grievance procedures within 7 days of the child's admission, if not present when the child is admitted.

(1) A child, parent and, when applicable, the guardian or custodian, shall be given a copy of this information in writing in the primary language of the child and the child's parent or, when applicable, guardian or custodian. The RTF shall obtain a signed statement acknowledging receipt of this information to be retained in the child's file.

(2) If the RTF is unable to obtain an acknowledgement of receipt, the efforts made to obtain the signature shall be documented in the child's file.

(e) A child and the child's family have the right to lodge a grievance with the RTF for an alleged violation of the rights specified in § 23.32 (relating to specific rights) without fear of retaliation.

§ 23.32. Specific rights.

(a) A child may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age or sex.

(b) A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

(c) A child shall be treated with fairness, dignity and respect.

(d) A child shall be informed of the rules of the RTF.

(e) A child has the right to communicate with others by telephone subject to RTF policy approved by the Department, and written instructions from the CCYA, JPO or court regarding circumstances, frequency, time, payment and privacy of telephone calls.

(f) A child has the right to visit with family at least once a week, at a time and location convenient for the family, the child and the RTF, as outlined in the family participation plan specified in § 23.42 (relating to documentation of efforts for family contacts), unless visits are restricted by court order. This subsection does not restrict more frequent family visits.

(g) A child has the right to receive and send mail.

(1) Outgoing mail may not be opened or read by staff.

(2) Incoming mail from Federal, State or county officials, or from the child's attorney, may not be opened or read by staff.

(3) Incoming mail from persons other than those specified in paragraph (2), may not be opened or read by staff, unless the RTF has reasonable suspicion that contraband, or other information that may jeopardize the child's health, safety, or well-being, may be enclosed. If the RTF has reasonable suspicion that contraband, or other information that may jeopardize the child's health, safety, or well-being may be enclosed, mail may be opened by the child in the presence of staff.

(h) A child has the right to communicate and visit privately with the child's attorney and clergy.

(i) A child has the right to be protected from unnecessary search and seizure. An RTF shall conduct search and seizure procedures, subject to RTF policy approved by the Department.

(j) A child has the right to practice the religion or faith of the child's choice, or not to practice a religion or faith.

(k) A child shall have appropriate medical, behavioral health and dental treatment.

(l) A child shall have appropriate rehabilitation services.

(m) A child shall be free from excessive medication.

(n) A child may not be subjected to unusual or extreme methods of discipline which may cause psychological or physical harm to the child.

(o) A child shall have clean, seasonal clothing that is age and gender appropriate.

(p) A child has the right to the following:

(1) To ask staff questions related to the child's treatment.

(2) To advocate for himself.

(3) To disagree respectfully.

(4) To submit a formal grievance without jeopardizing the child's standing or privileges within the RTF or the right to continued services.

(q) A child shall be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

(r) A child shall have a clean, healthy and comfortable living environment.

§ 23.33. Prohibition against deprivation of rights.

(a) A child may not be deprived of the specific rights specified in § 23.32 (relating to specific rights) or civil rights.

(b) A child's rights may not be used as a reward or sanction.

(c) A child's visits with family may not be used as a reward or sanction.

§ 23.34. Notification of RTF restraint policy.

At admission, an RTF shall:

(1) Inform both the child, the child's parent and, when applicable, the guardian or custodian, of the RTF's policy regarding the use of restraint during an emergency safety situation that may occur while the child is at the RTF.

(2) Communicate its restraint policy in a language that the child, the child's family, guardian or custodian, understands, including American Sign Language. When necessary, the RTF shall provide interpreters or translators.

(3) Obtain an acknowledgement, in writing, from the child, or in the case of a minor, from the parent or, when applicable, the guardian or custodian that he has been informed of the RTF's policy on the use of restraint during an emergency safety situation. Staff shall file this acknowledgement in the child's record.

(4) Provide a copy of the RTF restraint to the child and, in the case of a minor, to the child's parent or, when applicable, guardian or custodian in a language that the child, the child's family, guardian or custodian understands.

(5) Provide contact information, including the phone number and mailing address, for the Disabilities Rights Network.

FAMILY PARTICIPATION

§ 23.41. Family participation in the treatment process.

An RTF shall ensure that a child's family is given the opportunity to participate fully in the planning for delivery of services to the child as evidenced by the following:

(1) Meetings being held at times convenient to the family with at least 2 weeks notice to maximize the possibility of family participation.

(2) ISPT meetings and other formal meetings with the family as active members of the team.

(3) Demonstrated opportunities for frequent and regular family contact including daily telephone calls and at least weekly visits at the family home or at the RTF, as well as community activities with the family within and outside the RTF to be determined as part of the treatment planning.

(4) Family therapy for the benefit of the child, as well as parent support and education groups involving parents and, when applicable, guardians or custodians, as appropriate, shall be provided to a child as part of the overall treatment offered in the RTF and documented in the child's record.

(5) Efforts to link the child and family with community resources, both formal human service systems and informal community supports. An RTF shall base the choice of community linkages outside the RTF on the planned expectation that the child will be returning to the community and will need support to assist a child in making a smooth transition.

(6) Participation of the family in making appropriate medical and medication decisions including arranging for family participation in the medical appointments when desired by the family.

(7) Participation of the family in making appropriate decisions about the child's activities and schedule.

(8) Having a formal process for families to resolve disagreements about the treatment plan or the delivery of service.

(9) An RTF shall ensure that an onsite meeting with the parents and, when applicable, the guardians or custodians, is arranged within the first 7 days of the child's admission including day of admission, unless the family is present on the day of admission. The following information shall be discussed with the family at the time of the onsite visit:

(i) Family expectations regarding the child's treatment.

(ii) The need to jointly develop a written family participation plan that identifies specific goals for family participation in the child's ongoing treatment, to be reviewed and updated at least monthly.

(iii) Expected length of stay and type of treatment that will be offered.

(iv) Opportunities for family-focused therapy targeted to benefit the child, using evidence-based approaches, when possible, with discussions about potential frequencies and possible locations when distance is an issue.

(v) Information about advocacy organizations and consumer satisfaction teams that are available to assist in the lodging of grievances.

§ 23.42. Documentation of efforts for family contacts.

An RTF shall document in the child's record efforts to involve a child's family in service planning and delivery.

§ 23.43. Space onsite for family visits.

An RTF shall have at least one designated area onsite for family visits that offers privacy for the child and family.

§ 23.44. Assistance with coordination of transportation for family contacts.

An RTF shall assist with the coordination of available transportation for the family's onsite participation and visits when the family needs assistance with transportation.

STAFFING

§ 23.51. Child abuse and criminal history checks.

Child abuse and criminal history checks shall be completed for all staff in accordance with 23 Pa.C.S. §§ 6301—6386 (relating to the Child Protective Services Law) and Chapter 3490 (relating to child protective services).

§ 23.52. Staff hiring, retention and utilization.

(a) Staff hiring, retention and utilization shall be in accordance with 23 Pa.C.S. §§ 6301—6386 (relating to the Child Protective Services Law) and Chapter 3490 (relating to child protective services).

(b) Prospective staff responsible for providing direct care to a child shall have a preemployment physical and drug screening.

§ 23.53. RTF director.

(a) There shall be one director responsible for the RTF

(b) The director shall be responsible for the administration and management of the RTF, including the safety and protection of the children, implementation of policies and procedures and compliance with this chapter.

(c) The director shall have one of the following:

(1) A master's degree from an accredited college or university and 2 years work experience in administration or human services.

(2) A bachelor's degree from an accredited college or university and 4 years work experience in administration or human services.

§ 23.54. Medical director.

(a) There shall be one medical director who is responsible for overseeing the delivery of services and programs to children.

(b) The medical director shall be a board-certified or board-eligible psychiatrist with at least 2 years experience in the delivery of behavioral health services to children.

(c) The medical director shall be responsible for the following duties:

(1) Regular and ongoing contact with children and more frequent contact for a child on medication, ensuring at least 2 hours per week of psychiatric time for every 5 children.

(2) Ensuring a psychiatric face-to-face visit with a child on psychotropic medication as deemed clinically appropriate, but not less frequently than every 30 days by the medical director or a psychiatrist working under the direction of the medical director.

(3) Regular and ongoing contact with treatment staff to formulate and monitor the implementation of the child's treatment plans.

(4) Regular and ongoing face-to-face or phone contact with a child's family.

(5) Regular and ongoing contact, as appropriate, with external, community agencies and natural supports important to a child's life, including informal networking and face-to-face participation in ISPT and treatment team meetings.

(6) Preparation of formal, written psychiatric evaluations as required.

(7) Coordination and supervision of RTF staff on clinical and medical matters, including the prescription and monitoring of psychotropic and other medication.

§ 23.55. Clinical director.

(a) There shall be one clinical director who ensures that staff receives training and clinical supervision.

(b) The clinical director shall be a licensed psychologist, a licensed clinical social worker, or a licensed marriage and family therapist, with at least 2 years of experience providing therapeutic interventions to children with serious emotional or behavioral disorders.

(c) The medical director may serve as the clinical director provided that the medical director has at least 2 years of experience providing therapeutic interventions to children with serious emotional or behavioral disorders.

§ 23.56. Mental health professional.

(a) The mental health professional shall have the following duties:

(1) Participating on the treatment team.

(2) Ensuring the implementation of the treatment interventions, therapeutic activities and schedule for the children.

(3) Supervising of mental health workers.

(b) The mental health professional shall have the following:

(1) A graduate degree in a generally recognized clinical, mental health discipline such as psychiatry, social work, psychology, counseling, nursing, rehabilitation or activities therapies.

(2) At least 1 year of clinical experience working with children in a behavioral health program whose operating principles were in accordance with CASSP principles.

§ 23.57. Mental health worker and mental health aide.

(a) The mental health worker shall be responsible for implementing therapeutic interventions.

(b) The mental health worker shall meet one of the following requirements:

(1) Have at least 1 year of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles and a bachelor's degree, with at least 12 credit hours of education in psychology, sociology, social work, counseling, nursing, education or theology.

(2) Be a licensed RN and have at least 1 year of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles.

(3) Have a high school diploma or equivalent and at least 4 years of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles.

(c) A mental health aid shall have a high school diploma or general education development certificate.

§ 23.58. Staff ratios.

(a) The staff to child ratio during awake hours must reflect the needs of the population being served. The minimum staff ratios in this chapter apply unless the Department's clinical consultants determine these minimum staff ratios are inadequate to meet the needs of the population being served as described in the RTF service description.

(b) Staff to child ratios are as follows:

(1) There shall be at least one mental health professional available either onsite or by telephone when a child is at the RTF.

(2) During awake hours, one mental health worker shall be present with every four children.

(3) A mental health worker or mental health aide who is counted in the worker to child ratio must be 21 years of age or older.

(4) For RTFs serving six or more children, whenever six or more children are present at the RTF, there shall be at least one mental health professional for every six children present at the RTF during awake hours.

(5) During sleep hours, one mental health worker or mental health aide shall be present with every six children.

(6) Staff may not sleep while being counted in the staff to child ratios.

§ 23.59. Primary contact.

(a) At the time of a child's admission, an RTF shall designate either a mental health professional or a mental health worker to be the child's primary contact during the child's stay at the RTF, to have primary responsibility for coordination of the child's care. The assignment of a primary contact will, at no time, preclude a parent, or when applicable, a guardian or custodian from communicating directly with the treating physician or other staff about the child.

(b) The primary contact's responsibilities include the following:

(1) Liaison activities for coordination and collaboration with other individuals and systems involved with the child, including the following:

(i) The family.

(ii) The behavioral health care manager at the appropriate behavioral health managed care organization.

(iii) The county intensive case manager.

(iv) The education system.

(v) The child welfare system, if applicable.

(vi) The juvenile justice system, if applicable.

(2) Participation in the High Fidelity Wraparound, if the child and family have a High Fidelity Wraparound team.

(3) Promoting resiliency through risk reduction and asset-building strategies.

(4) Coordinating the child's aftercare plan with the community agencies that will provide services after discharge, the education system, natural supports and the family prior to the child's return home by doing the following:

(i) Providing an aftercare agency with a comprehensive written discharge summary that includes information on the child's discharge diagnosis, treatment rendered during the RTF stay, treatment plans and the extent to which the child attained identified goals, and treatment team recommendations for the next level of care, following discharge. In addition, the written discharge summary must identify each psychotropic medication and dose, and describe the clinical rationale for each medication.

(ii) Ensuring that medications that the child will need until an appointment with the community based psychiatrist are prepared for discharge.

(iii) Assisting the family in determining whether the prescribed medications are covered by MA. If a medication is not covered, the primary contact shall assist so that an appropriate substitute, which is covered, can be prescribed.

(c) The primary contact shall arrange for an onsite meeting with the parents and, when applicable, the guardians or custodians, within the first 7 days of the child's admission including day of admission and assist in developing the family participation plan as specified in § 23.42 (relating to documentation of efforts for family contacts).

§ 23.60. Family advocacy.

(a) For every 48 children, an RTF shall have on staff, or contract for the services of, a full-time equivalent family advocate. If an RTF serves fewer than 48 children, the RTF shall have on staff, or contract for the services of, a family advocate whose work hours are prorated according to the number of children in the RTF.

(b) The responsibilities of the family advocate include the following:

(1) Participating in quality improvement activities.

(2) Ensuring restraint reduction activities.

(3) Promoting the observance of children's rights.

(4) Reviewing of grievances.

(5) Ensuring availability to families and children as requested.

(6) Monitoring of general conditions.

(7) Facilitating family involvement plans.

(8) Participating in ISPT meetings at family request.

(9) Meeting with children regularly.

§ 23.61. Supervision.

(a) An RTF shall ensure that a child is supervised during awake and sleeping hours by conducting observational checks of each child at least every 15 minutes.

(b) Observational checks of a child specified in subsection (a) must include actual viewing of each child.

(c) Observational checks shall be documented.

§ 23.62. Staff training.

(a) *Orientation*. Prior to working with a child, staff, including temporary staff and volunteers, shall have an orientation to their specific duties and responsibilities; policies and procedures of the RTF, including reportable incident reporting; discipline, care and management of children; and use of restrictive procedures.

(b) *Training*. Prior to working alone with a child and within 120 calendar days after the date of hire, staff, including temporary staff, shall have at least 30 hours of training in the areas specified in this subsection. If staff has completed comparable training within 12 months prior to the date of hire, the requirement for training in this subsection does not apply. Training must include at least the following areas:

(1) The requirements of this chapter.

(2) The requirements of 23 Pa.C.S. §§ 6301—6386 (relating to the Child Protective Services Law) and Chapter 3490 (relating to child protective services).

(3) Fire safety.

(4) First aid, Heimlich techniques, cardiopulmonary resuscitation and blood-borne pathogen training taught by an individual certified as a trainer by a hospital or other recognized health care organization.

(5) Crisis intervention, including use of relationships and de-escalation approaches, positive behavior support, suicide prevention and proper, safe use of restraint when it is necessary as an emergency measure to maintain the safety of the child and others, using the least restrictive restraint intervention needed to address the crisis.

(6) Health and other special issues affecting the population.

(7) Use of assessment, evaluation and treatment plans as guides to understanding a child's strengths and needed supports in the milieu.

(8) Principles of milieu treatment and the specific roles of staff in maintaining the therapeutic milieu.

(c) *Ongoing annual training.*

(1) After initial training, staff, including temporary staff, shall have at least 40 hours per year of training relating to the care and management of children. This requirement does not apply to the initial year of employment unless the person to be trained was exempt from subsection (b).

(2) Staff shall complete training in first aid, Heimlich techniques and cardiopulmonary resuscitation taught by an individual certified as a trainer by a hospital or other recognized health care organization. Staff shall demonstrate their competency on an annual basis even if the certification is for longer than 1 year.

(3) In an RTF serving more than 20 children, staff shall complete training in fire safety taught by a fire safety expert.

(4) In an RTF serving 20 or fewer children, staff shall complete training in fire safety taught by a staff trained by a fire safety expert. Video tapes prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff trained by a fire safety expert.

(5) A total of 20 hours of training in the following:

(i) Professional ethics and conduct and legal issues including professional boundaries with children and their families; child and general protective services; mandated child abuse reporting; and confidentiality.

(ii) CASSP principles and implementing and supporting those principles in clinical practice.

(iii) Cultural competency as described in the Cultural Competence Clinical/Rehabilitation Standards of Practice published by the Department and available at www.parecovery.org.

(iv) The Department's Special Transmittal on Strategies and Practices to Eliminate the Unnecessary Use of Restraint issued on January 30, 2006, or subsequent updates.

(v) RTF policy, including the ability to effectively transfer the application of policy and procedure to the direct care work with a child and a child's family.

(vi) Trauma-informed care, including its provision as part of ongoing care, and attachment issues.

(vii) Signs and symptoms of abuse and neglect.

(viii) Serious emotional or behavioral disorders and other behavioral health needs in children as they relate to the biopsychosocial needs of the children being served.

(ix) Applicable State laws related to the scope of practice for medication administration.

(x) Psychotropic medications, including types, appropriate uses and possible side effects.

(xi) The discharge process.

(xii) Cross-system training appropriate to the population the RTF serves.

(xiii) Current clinical practice and methodologies, including evidence-based practices to address the unique characteristics of the children served and the role of staff in maintaining a therapeutic milieu.

(xiv) Documentation skills and requirements.

(xvi) Recovery and resiliency in children and their families, including how to integrate these philosophies and concepts into treatment approaches for a child and the child's family during the child's RTF stay.

(xvii) Principles of participation on a high fidelity wraparound team.

(xviii) Principles of child development appropriate for the age of the children served.

(xv) Other topics appropriate to the age, characteristics, diagnosis and developmental needs of the children served.

(d) *Restrictive procedure training.*

(1) In addition to the ongoing annual training listed in subsection (c), staff who are responsible for administering restrictive procedures shall demonstrate competency on a semiannual basis in the use of interventions they are permitted to use, and knowledge of the specific circumstances and limited indications for their use.

(2) Only staff trained in the application of the type of restraint to be used may restrain a child during an emergency safety situation.

(3) Training in restraint techniques must include the following:

(i) Techniques to identify staff and child behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint.

(ii) De-escalation techniques and alternative nonrestrictive strategies.

(iii) Knowledge of normal behavior reactions to stress at various ages.

(iv) Nonphysical intervention skills.

(v) The least restrictive intervention based on an individualized assessment of a child's medical or behavioral status or condition.

(vi) Techniques and procedures appropriate for the age and weight of the children served.

(vii) The safe application and use of restraints used, including how to recognize and respond to signs of physical and psychological distress, for example, positional asphyxia.

(viii) Health risks for a child associated with use of specific procedures.

(ix) Monitoring of the physical and psychological well-being of a child who is restrained, including respiratory and circulatory status, skin integrity, vital signs and any special requirements specified by policy associated with the 1-hour face-to-face evaluation.

(x) First-aid techniques and certification in the use of cardiopulmonary resuscitation, including required annual recertification.

(xi) Response to the child's emotional and mental state after use of a restrictive procedure.

(xii) First-hand experience of the specific techniques taught after demonstration by a qualified trainer.

(xiii) A testing process to demonstrate understanding of and ability to apply specific procedures. Staff may only apply procedures in which they have been trained and shown mastery.

(e) *Serving children with ASD.*

(1) Staff of an RTF that proposes to treat children with ASD shall have training specific to the needs of children with ASD.

(2) The trainings under paragraph (1) must be in protocols that yield success with children diagnosed with ASD, such as applied behavior analysis, relationship-based interventions, targeted social skills instruction, strategies to support sensory needs and functional behavioral assessment.

(f) *Record of training.* A record of training including the name of the trained individual, along with the date, source, content, length of each course and copies of any certificates and documentation of competencies received, shall be kept in each staff training file.

PHYSICAL SITE

§ 23.81. Physical accommodations and equipment.

An RTF shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a child with a disability.

§ 23.82. Poisons.

(a) Poisonous materials shall be kept locked and inaccessible to a child.

(b) Poisonous materials shall be stored in their original, labeled containers.

(c) Poisonous materials shall be kept separate from food, food preparation surfaces and dining surfaces.

§ 23.83. Heat sources.

Heat sources, such as hot water pipes, fixed space heaters, hot water heaters and radiators, exceeding 120° F that are accessible to a child, shall be equipped with protective guards or insulation to prevent a child from coming in contact with the heat source.

§ 23.84. Sanitation.

(a) Sanitary conditions shall be maintained.

(b) There may be no evidence of infestation of insects or rodents in an RTF.

(c) Trash shall be removed from the premises at least once a week.

(d) Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

(e) Trash outside the RTF shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

§ 23.85. Ventilation.

Living areas, recreation areas, dining areas, bathrooms, bedrooms and kitchens shall be ventilated by at least one operable window or mechanical ventilation.

§ 23.86. Lighting.

Rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps and fire escapes shall be lighted to avoid accidents.

§ 23.87. Surfaces.

(a) Floors, walls, ceilings, windows, doors and other surfaces shall be free of hazards.

(b) An RTF may not use asbestos products for renovations or new construction.

§ 23.88. Water.

(a) An RTF shall have hot and cold water under pressure.

(b) Hot water temperature in areas accessible to a child may not exceed 120° F.

(c) An RTF that is not connected to a public water system shall have a coliform water test at least every 3 months, by a Department of Environmental Protection-certified laboratory, stating that the water is safe for drinking. Documentation of the certification shall be kept.

§ 23.89. Air temperature.

(a) Indoor temperature shall be at least 65° F during awake hours when a child is present in the RTF.

(b) Indoor temperature may not be less than 62° F during sleeping hours.

(c) When indoor temperature exceeds 90° F, mechanical ventilation such as fans or air conditioning shall be used.

§ 23.90. Communication system.

(a) An RTF shall have a working, non-coin-operated, telephone with an outside line that is accessible to staff in emergencies.

(b) An RTF shall have a communication system to allow staff to contact other staff in the RTF for assistance in an emergency.

§ 23.91. Emergency telephone numbers.

Telephone numbers for the nearest hospital, police department, fire department, ambulance and poison control center shall be posted on or by a telephone with an outside line.

§ 23.92. Screens.

Windows, including windows in doors, must be securely screened when doors or windows are open.

§ 23.93. Handrails and railings.

(a) A ramp, interior stairway and outside steps exceeding two steps must have a well-secured handrail.

(b) A porch that has over an 18-inch drop must have a well-secured railing.

§ 23.94. Landings and stairs.

(a) There must be a landing which is at least as wide as the doorway, beyond each interior and exterior door which opens directly into a stairway.

(b) Interior stairs must have nonskid surfaces.

§ 23.95. Furniture and equipment.

(a) Furniture and equipment must be free of hazards.

(b) There shall be enough seating furniture to accommodate the largest group of children that may routinely congregate in a room so that no child is required to sit on the floor.

(c) Power equipment shall be kept in safe condition.

(d) Power equipment, excluding normal household appliances, shall be stored in a place that is inaccessible to children.

(e) Power equipment, excluding normal household applications, may not be used by children except under supervision of staff.

§ 23.96. First aid supplies.

An RTF shall have a first aid manual, nonporous disposable gloves, antiseptic, assorted band-aids, adhesive bandages, gauze pads, thermometer, tape, tweezers and scissors that are stored together.

§ 23.97. Elevators.

An elevator must have a valid certificate of operation from the Department of Labor and Industry in accordance with 34 Pa. Code § 7.15 (relating to inspection).

§ 23.98. Indoor activity space.

An RTF shall have separate indoor activity space for activities such as studying, recreation and group activities.

§ 23.99. Recreation space.

An RTF shall have regular access to outdoor, or large indoor, recreation space and equipment.

§ 23.100. Exterior conditions.

(a) The exterior of the building and the building grounds or yard must be free of hazards.

(b) Outside walkways must be free of ice, snow and obstruction.

§ 23.101. Firearms and weapons.

Firearms, weapons and ammunition are not permitted in an RTF or on the RTF grounds, except for those carried by law enforcement personnel.

§ 23.102. Child bedrooms.

(a) A single bedroom must have at least 70 square feet of floor space per child measured wall to wall, including space occupied by furniture.

(b) A shared bedroom must have at least 60 square feet of floor space per child measured wall to wall, including space occupied by furniture.

(c) No more than two children may share a bedroom.

(d) Children of the opposite sex may not share a bedroom.

(e) Ceiling height in each bedroom must be at least an average of 7 1/2 feet.

(f) A bedroom must have a window with a source of natural light.

(g) A child shall have the following in the bedroom:

(1) A bed with solid foundation and fire-retardant mattress in good repair.

(2) A pillow and bedding appropriate for the temperature in the RTF.

(3) A storage area for clothing.

(h) Cots or portable beds are not permitted.

(i) Bunk beds must allow enough space between each bed and the ceiling to allow a child to sit up in bed.

(j) Bunk beds must be equipped with securely attached ladders capable of supporting at least 250 pounds.

(k) The top bunk of bunk beds must be equipped with a secure safety rail on each open side and open end of the bunk.

(l) A bedroom may not be used as a means of egress from or access to another part of the RTF.

§ 23.103. Bathrooms.

(a) There shall be at least one flush toilet for every six children.

(b) There shall be at least one sink for every six children.

(c) There shall be at least one bathtub or shower for every six children.

(d) There shall be slip-resistant surfaces in bathtubs and showers.

(e) Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

(f) There shall be at least one wall mirror for every six children.

(g) An individual towel, washcloth, comb, hairbrush and toothbrush shall be provided for a child.

(h) Toiletry items including toothpaste, shampoo, deodorant and soap shall be provided.

(i) Bar soap is not permitted unless there is a separate bar clearly labeled for each child.

§ 23.104. Kitchen areas.

(a) An RTF shall have a kitchen area with a refrigerator, sink, cooking equipment and cabinets for storage.

(b) Utensils for eating, drinking and food serving and preparation shall be washed and rinsed after each use.

(c) Food shall be protected from contamination while being stored, prepared, transported and served.

(d) Uneaten food from a person's dish may not be served again or used in the preparation of other dishes.

(e) Cold food shall be kept at or below 40° F. Hot food shall be kept at or above 140° F. Frozen food shall be kept at or below 0° F.

§ 23.105. Laundry.

Bed linens, towels, washcloths and clothing shall be laundered at least weekly.

§ 23.106. Swimming.

(a) Above-ground and in-ground outdoor pools must be fenced with a gate that is locked when the pool is not in use.

(b) Indoor pools shall be made inaccessible to children when not in use.

(c) A certified lifeguard shall be present with the children at all times while children are swimming.

(d) The certified lifeguard specified in subsection (c) may not be counted in the staff to child ratios specified in §§ 23.56 and 23.58 (relating to mental health professional; and staff ratios).

FIRE SAFETY

§ 23.121. Unobstructed egress.

(a) Stairways, hallways, doorways, passageways and egress routes from rooms and from buildings must be unlocked and unobstructed, unless the fire safety approval specified in § 23.15 (relating to fire safety approval) permits locking of certain means of egress under the following circumstances:

(1) A locked facility is medically necessary for the safety of a child through:

(i) Internal locks within the building or external locks.

(ii) Secure fencing around the premises of the building.

(2) A child needs immediate admission to locked facility for treatment of behavioral health needs and has associated child-safety or protection needs as determined by CCYA or the juvenile court.

(3) An RTF service description has been approved by the Department and contains information regarding the security of the RTF in addition to information that demonstrates a level of clinical treatment that is beyond the standard level of service expected within a nontreatment focused locked residential facility.

(b) Doors used for egress routes from rooms and from buildings may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of a child from the building.

§ 23.122. Exits.

If more than four children sleep above the ground floor, there must be a minimum of two interior or exterior exits from each floor. If a fire escape is used as a means of egress, it shall be permanently installed.

§ 23.123. Evacuation procedures.

There shall be written emergency evacuation procedures that include staff responsibilities, means of transportation and emergency location.

§ 23.124. Notification of local fire officials.

An RTF shall notify local fire officials in writing of the address of the RTF, location of bedrooms and assistance needed to evacuate in an emergency. The notification shall be kept current.

§ 23.125. Flammable and combustible materials.

(a) Combustible materials may not be located near heat sources.

(b) Flammable materials shall be used safely, stored away from heat sources and inaccessible to children.

§ 23.126. Furnaces.

(a) Furnaces shall be inspected and cleaned at least annually by a professional furnace cleaning company or trained maintenance staff.

(b) Documentation of the inspection and cleaning shall be maintained in the business of the RTF.

§ 23.127. Portable space heaters.

The use of portable space heaters, defined as heaters that are not permanently mounted or installed, is not permitted.

§ 23.128. Wood and coal burning stoves.

The use of wood and coal burning stoves is not permitted.

§ 23.129. Fireplaces.

(a) Fireplaces must be securely screened or equipped with protective guards while in use.

(b) Staff shall be present with a child while a fireplace is in use.

(c) A fireplace chimney and flue shall be cleaned when there is an accumulation of creosote. Written documentation of the cleaning shall be kept.

§ 23.130. Smoke detectors and fire alarms.

(a) An RTF shall have a minimum of one operable automatic smoke detector on each floor, including the basement and attic.

(b) There shall be an operable automatic smoke detector located within 15 feet of a bedroom door.

(c) The smoke detectors specified in subsections (a) and (b) shall be located in common areas or hallways.

(d) Smoke detectors and fire alarms must be of a type approved by the Department of Labor and Industry or listed by Underwriters Laboratories.

(e) If the RTF serves four or more children or if the RTF has three or more stories including the basement and attic, there shall be at least one smoke detector on each floor interconnected and audible throughout the RTF or an automatic fire alarm system that is audible throughout the RTF.

(f) If one or more children or staff are not able to hear the smoke detector or fire alarm system, all smoke

detectors and fire alarms must be equipped so that a person with a hearing impairment will be alerted in the event of a fire.

(g) If a smoke detector or fire alarm becomes inoperative, repair or replacement shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

(h) There shall be a written procedure for fire safety monitoring if the smoke detector or fire alarm becomes inoperative.

§ 23.131. Fire extinguishers.

(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

(b) If the indoor floor area on a floor including the basement or attic is more than 3,000 square feet, there shall be an additional fire extinguisher with a minimum 2-A rating for each additional 3,000 square feet of indoor floor space.

(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in a kitchen. The kitchen fire extinguisher will meet the requirement for one operable fire extinguisher for each floor as required in subsection (a).

(d) Fire extinguishers must be listed by Underwriters Laboratories or approved by Factory Mutual Systems.

(e) Fire extinguishers must be accessible to staff. A fire extinguisher may be kept locked if access to the extinguisher by a child may cause a safety risk to the child. If fire extinguishers are kept locked, staff shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

(f) Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection must be on the extinguisher.

§ 23.132. Fire drills.

(a) An unannounced fire drill shall be held at least once a month.

(b) Fire drills shall be held during normal staffing conditions and not when additional staff are present.

(c) A written fire drill record shall be kept of the following:

(1) Date.

(2) Time.

(3) Amount of time for evacuation.

(4) Exit route used.

(5) Number of children in the RTF at the time of the drill.

(6) Problems encountered.

(7) Whether the fire alarm or smoke detector was operative.

(d) The evacuation route must allow children to evacuate the entire building into a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within 2 1/2 minutes or within the period of time specified in writing within the past year by a fire safety expert. The fire safety expert may not be an employee of the RTF.

(e) A fire drill shall be held during sleeping hours at least every 6 months.

(f) Alternate exit routes shall be used during fire drills at least every 3 months.

(g) Fire drills shall be held on different days of the week, at different times of the day and night and on different staffing shifts.

(h) Children shall evacuate to a designated meeting place outside the building or within the fire-safe area during a fire drill.

(i) A fire alarm or smoke detector shall be set off during each fire drill.

(j) An elevator may not be used during a fire drill or a fire.

§ 23.133. False alarms.

An RTF shall document false alarms internally and make the documentation available for review by the Department. The frequency of false alarms should be considered as part of the overall quality assurance plan.

CHILD HEALTH

§ 23.141. Child health and safety.

(a) A child shall have a written health and safety assessment within 24 hours of admission.

(b) The assessment shall be completed or coordinated, signed and dated by medical personnel or staff trained by medical personnel as specified in an RTF training policy approved by the Department.

(c) The assessment must include the following:

(1) Identification of strengths of the child and family.

(2) Known or suspected suicide or self-injury attempts or gestures and emotional history which may indicate a predisposition for self-injury or suicide.

(3) Known incidents of aggressive or violent behavior.

(4) Substance abuse history.

(5) Sexual history or behavior patterns that may place the child or other children at a health or safety risk.

(6) Medical information and health concerns such as allergies; medications; immunization history; hospitalizations; medical diagnoses; family history of medical problems; issues experienced by the child's mother during pregnancy; special dietary needs; illnesses; injuries; dental, mental or emotional problems; body positioning and movement stimulation for children with disabilities; and ongoing medical care needs.

(7) Trauma history.

(8) Potential medical or psychological contraindications to the use of manual restraint.

(d) A copy of the health and safety assessment shall be kept in the child's record.

(e) An RTF shall develop a policy for revising and updating the health and safety assessment, which must be approved by the Department.

§ 23.142. Health and safety plan.

If the health and safety assessment in § 23.141 (relating to child health and safety) identifies a health or safety risk, a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed.

§ 23.143. Child health examination.

(a) A child shall have a health examination within 3 days after admission and annually thereafter or more

frequently, as specified at specific ages in the periodicity schedule recommended by the American Academy of Pediatrics in the most current version of *Recommendations for Preventive Pediatric Health Care* (RE9939) available at http://practice.aap.org/content.aspx?aid=1599.

(b) If a child had a health examination prior to admission that meets the requirements of subsection (e) within the periodicity schedule specified in subsection (a), and there is written documentation of the examination, an initial examination within 3 days is not required. The next examination must occur within the periodicity schedule specified in subsection (a).

(c) If a child will participate in a program that requires physical exertion; a health examination shall be completed before the child is scheduled to participate in the physical exertion portion of the program.

(d) The health examination shall be completed, signed and dated by a licensed physician, CRNP or licensed PA. Written verification of completion of each health examination shall be kept in the child's medical record specifying the following:

(1) Date of the examination.

(2) Results of the examination.

(3) Name and address of the examining practitioner.

(4) Follow-up recommendations.

(e) The health examination must include the following:

(1) A comprehensive health and developmental history, which includes both physical and behavioral health development and the following:

(i) The following information about the child's mother's pregnancy, if available:

(A) Use of alcohol, drugs, cigarettes and prescribed medications during the child's mother's pregnancy and signs of fetal alcohol spectrum disorder.

(B) Complications during the child's mother's pregnancy.

(C) Child's weight at birth.

(D) Whether child's birth was early, late or term.

(E) Type and nature of delivery and complications, if applicable.

(F) Child's mother's postpartum complications.

(G) Domestic violence victimization of the child's mother during or after pregnancy.

(ii) Developmental milestones.

(iii) Emotional complications.

(iv) Medical illnesses, injuries, surgeries and hospitalizations.

(v) Drug allergies.

(vi) History of abuse or neglect.

(vii) Out-of-home placements.

(viii) Use of psychotropic medications and responses.

(ix) Regular or special education placement in school.

(x) Nature of special education settings, if applicable.

(xi) Psychological or educational testing and results.

(2) A comprehensive, unclothed physical examination.

(3) Immunizations, screening tests and laboratory tests as recommended by the American Academy of Pediatrics in the most current version of *Recommendations for Preventative Pediatric Health Care* (RE9939) available at http://practice.aap.org/content.aspx?aid=1599 including the following laboratory tests:

(i) CBS, differential and platelets.

(ii) Electrolytes.

(iii) Liver function studies.

(iv) BUN and creatinine (renal).

(v) Fasting blood glucose.

(vi) Lipid profile.

(vii) Blood level if one or more of the following medications are being taken:

(A) Lithium.

(B) Depakote.

(C) Tegretol.

(D) Wellbutrin.

(viii) Blood level assessments for a child under 5 years of age, unless the examining practitioner determines that the testing is unnecessary, after reviewing the results of previously conducted blood lead testing, which review and conclusion is documented in the child's medical record.

(ix) Sickle cell screening for a child who is African-American unless the examining practitioner determines that the testing is unnecessary, after reviewing the results of previously conducted sickle cell testing, which review and conclusion is documented in the child's medical record.

(4) A gynecological examination including a breast examination and a Pap test as recommended by medical personnel.

(5) Urine screen for drugs.

(6) Calculation of BMI.

(7) Communicable disease detection, if recommended by medical personnel based on a child's health status and with required written consent in accordance with applicable laws.

(8) Specific precautions to be taken if the child has a communicable disease, to prevent spread of the disease to other children.

(9) An assessment of the child's health maintenance needs, medication regimen and the need for blood work at recommended intervals.

(10) Special health or dietary needs of the child, including consideration of the child's BMI.

(11) Allergies or contraindicated medications.

(12) Medical information pertinent to diagnosis and treatment in case of an emergency.

(13) Physical or mental disabilities of the child, if any.

(14) Health education, including anticipatory guidance.

(15) Recommendations for follow-up physical and behavioral health services, examinations and treatment.

(f) Immunization records, screening tests and laboratory tests may be completed, signed and dated by an RN or licensed practical nurse instead of a licensed physician, CRNP or licensed PA.

§ 23.144. Dental care.

(a) A child shall receive dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

(b) A child who is 3 years of age or older shall have a dental examination performed by a licensed dentist and teeth cleaning performed by a licensed dentist or dental technician at least semiannually. If a child has not had a documented dental examination and teeth cleaning within 6 months prior to admission, a dental examination and teeth cleaning shall be performed within 30 days after admission.

(c) Follow-up dental work indicated by the examination, such as treatment of cavities and application of protective sealants, shall be provided in accordance with recommendations by the licensed dentist.

(d) A written record of completion of each dental examination, including the preadmission examination permitted in subsection (b), shall be kept in the child's record, specifying the following:

(1) Date of the examination.

(2) Dentist's name and address.

(3) Procedures completed.

(4) Follow-up treatment recommended.

(5) Dates follow-up treatment was provided.

§ 23.145. Vision care.

(a) A child shall receive vision screening and services to include diagnosis and treatment, including eyeglasses, for defects in vision.

(b) A child who is 3 years of age or older shall receive vision screening within 30 days after admission in accordance with the periodicity schedule recommended by the American Academy of Pediatrics in the most current versions of "Guidelines for Health Supervision," and "Eye examination and Vision Screening in Infants, Children and Young Adults (RE9625)."

(c) If a child had a documented vision screening prior to admission that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b) an initial examination within 30 days after admission is not required. The next screening must occur within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment and services, such as provision of eyeglasses, shall be provided as recommended by the treating practitioner.

(e) A written record of completion of a vision screening, including the preadmission screening permitted in subsection (c), shall be kept in the child's record, and include the following:

(1) Date of the screening.

(2) Treating practitioner's name and address.

(3) Results of the screening.

(4) Follow-up recommendations.

(5) Dates follow-up services and treatment were provided.

§ 23.146. Hearing care.

(a) A child shall receive a hearing screening and services to include diagnosis and treatment, including hearing aids, for defects in hearing.

(b) A child who is 3 years of age or older shall receive a hearing screening within 30 days after admission in accordance with the periodicity schedule recommended by the American Academy of Pediatrics in the most current version of "Guidelines for Health Supervision."

(c) If a child had a documented hearing screening prior to admission that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b) an initial examination within 30 days after admission is not required. The next screening must occur within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment and services, such as provision of hearing aids, shall be provided as recommended by the treating practitioner.

(e) A written record of completion of each hearing screening, including the preadmission screening permitted in subsection (c), shall be kept in the child's record, specifying the following:

(1) Date of the screening.

(2) Treating practitioner's name and address.

(3) Results of the screening.

(4) Follow-up recommendations.

(5) Dates follow-up services and treatment were provided.

§ 23.147. Use of tobacco.

(a) Use or possession of tobacco products by a child is prohibited.

(b) Use or possession of tobacco products by staff is prohibited in the RTF and during transportation provided by the RTF.

(c) If staff use tobacco products outside but on the premises of the RTF, the following apply:

(1) An RTF shall have written fire safety procedures. Procedures must include extinguishing procedures and requirements that smoking shall occur at least 100 yards from the RTF and at least 100 yards from flammable or combustible materials or structures.

(2) Written safety procedures shall be followed.

(3) Use of tobacco products shall be out of the sight of the children.

§ 23.148. Health and behavioral health services.

(a) An RTF shall identify acute and chronic conditions of a child and arrange for or provide appropriate medical treatment.

(b) Medically necessary physical and behavioral health services, diagnostic services, follow-up examinations and treatment, such as medical, nursing, pharmaceutical, dental, dietary, hearing, vision, blood lead level, psychiatric and psychological services that are planned or prescribed for the child, shall be arranged for or provided.

§ 23.149. Emergency medical plan.

(a) An RTF shall have a written emergency medical plan listing the following:

(1) The hospital or source of health care that will be used in an emergency.

(2) The method of transportation to be used.

(3) An emergency staffing plan for an emergency situation where staff counted in staff ratio are required to leave the RTF.

(4) Medical and behavioral health conditions or situations under which emergency medical care and treatment are warranted.

(b) A child's parent and, when applicable, a child's guardian or custodian, shall be given a copy of the emergency medical plan upon admission.

(c) A child's parent and, when applicable, a child's guardian or custodian, shall be notified immediately if the emergency plan is implemented for the child.

STAFF HEALTH

§ 23.151. Staff health statement.

(a) Staff or volunteers who come into direct contact with a child or who prepare or serve food, shall submit a staff health statement that the staff or volunteer is free of serious communicable disease that may be spread through casual contact or that the staff or volunteer has a serious communicable disease that may be spread through casual contact, but is able to work in the RTF if specific precautions are taken that will prevent the spread of the disease to children.

(b) The staff health statement shall be signed and dated by a licensed physician, CRNP or licensed PA within 12 months prior to working with a child or food service and every 2 years thereafter.

(c) The RTF shall follow the written instructions and precautions specified in subsection (a).

NUTRITION

§ 23.161. Three meals a day.

An RTF shall provide at least three meals and one snack a day to the children.

§ 23.162. Quantity of food.

(a) The quantity of food served shall meet minimum daily requirements as recommended by the United States Department of Agriculture, unless otherwise recommended in writing by a licensed physician, CRNP or licensed PA for a specific child.

(b) Additional portions of meals shall be available for a child.

§ 23.163. Food groups and alternative diets.

(a) A meal must contain at least one item from the dairy, protein, fruits and vegetables and grain food groups, unless otherwise recommended in writing by a licensed physician, CRNP or licensed PA for a specific child.

(b) Dietary alternatives shall be available for a child who has special health needs, including a need to lower BMI, religious beliefs regarding dietary restrictions or vegetarian preferences.

§ 23.164. Withholding or forcing of food prohibited.

(a) An RTF may not withhold meals or drink as punishment.

(b) A child may not be forced to eat food or drink.

TRANSPORTATION

§ 23.171. Safe transportation.

The following requirements apply whenever an RTF, staff or volunteer provides transportation for a child. These requirements do not apply if transportation is provided by a source other than the RTF.

(1) The mental health worker-to-child ratios specified in § 23.58 (relating to staff ratios) apply.

(2) A child shall be in an individual, age and size appropriate, safety device at all times when the vehicle is in motion.

(3) Restraints may not be used routinely for transport and may only be used in the event of an emergency safety situation as specified in §§ 23.201 and 23.206 (relating to general information; and restrictive procedure records).

(4) A driver of a vehicle shall be 21 years of age or older.

(5) Vehicles utilized for transportation of a child must comply with local, State and Federal laws.

MEDICATIONS

§ 23.181. Storage of medications.

(a) Prescription and over-the-counter medications shall be kept in their original containers.

(b) Prescription and potentially poisonous over-the-counter medications shall be kept in an area or container that is locked.

(c) Prescription and potentially poisonous over-the-counter medications stored in a refrigerator shall be kept in a separate locked container.

(d) Prescription and over-the-counter medications shall be stored separately.

(e) Prescription and over-the-counter medications shall be stored under proper conditions of sanitation, temperature, moisture and light.

(f) Discontinued and expired medications, and prescription medications for a child who is no longer served at the RTF, shall be disposed of in a safe manner.

§ 23.182. Labeling of medications.

(a) The original container for prescription medications must be labeled with a pharmacy label that includes the child's name, the name of the medication, the date the prescription was issued, the prescribed dosage and the name of the prescribing physician.

(b) Over-the-counter medications must be labeled with the original label.

§ 23.183. Use of prescription medications.

(a) The clinical rationale for a prescribed medication shall be clearly documented in a child's medical record.

(b) A change in medication shall be documented in a child's medical record.

(c) The prescribing physician shall obtain and document consent from the responsible party for medication prescribed, explaining the medication's expected effects, expected side effects and the expected effects of withholding the medication. The responsible party is the individual who initially consented for child's treatment, including the child 14 years of age and older, the child's parent or, when applicable, the child's guardian or custodian.

(d) Psychotropic medication orders shall be written by a physician.

(e) A psychiatrist shall see a child on psychotropic medications at least every 30 days, and more frequently until the child's condition is stable, and document in the child's medical record the child's progress and clinical status.

(f) Dosage changes do not require additional consent; however, an RTF shall notify, by phone or in writing, the child's parents and, when applicable, the child's guardian or custodian, whenever dosage changes are made.

(g) The clinical rationale for a prescribed medication shall be clearly documented on a child's discharge summary or final evaluation.

(h) A prescription medication shall be used only by the child for whom the medication was prescribed.

(i) A child and the child's family may not be threatened or incur negative consequences, including discharge, when they disagree with or refuse a clinical recommendation for medication.

(j) An RTF shall put in place strategies that promote choice in medication decisions including the following:

(1) Full access to information for a child and the child's family about medications, including side effects.

(2) Staff who are willing and able to help a child and the child's family explore and understand the positive and negative possible consequences of taking or not taking a medication.

(3) Processes which are immediately responsive to concerns or side effects which the family or child suspect are related to the medication, including a consult with the prescribing physician within 24 hours, or sooner if necessary.

(4) Staff who are able to identify alternative or complementary strategies which address the areas of concern that the medication seeks to address, including relaxation and coping processes which match a child's interests, temperament, culture and developmental levels.

(k) Prescribed medications shall be included on the ISP.

§ 23.184. Medication log.

(a) A medication log shall be kept for each child. The medication log shall be made available to members of the treatment team.

(b) A child's medication log must include the following:

(1) A list of prescription medications.

(2) The prescribed dosage.

(3) Possible side effects.

(4) Contraindicated medications.

(5) Specific administration instructions, if applicable.

(6) The name of the prescribing physician.

(7) A list of over-the-counter medications.

(c) For prescription and over-the-counter medication, including insulin administered or self-administered, documentation in the medication log must include the medication that was administered, route of administration, dosage, date, time and the name of the person who administered or self-administered the medication.

(d) The information in subsection (c) shall be logged at the same time a dosage of medication is administered or self-administered.

§ 23.185. Medication errors.

(a) Documentation of a medication error shall be kept in the child's medication log. A medication error includes the failure to administer medication, administering the incorrect medication, administering the correct medication in an incorrect dosage or administering the correct medication at the incorrect time.

(b) After a medication error, follow-up action to prevent a future medication error shall be taken and documented.

§ 23.186. Adverse reaction.

If a child has a suspected adverse reaction to a medication, an RTF shall notify the prescribing physician, the child's parent and, when applicable, the child's guardian or custodian, no later than 24 hours after the suspected adverse reaction occurs. Documentation of adverse reactions and the physician's response shall be kept in a child's medical record.

§ 23.187. Administration.

(a) Prescription medications, including injections, shall be administered by one of the following:

(1) A licensed physician, licensed dentist, PA, RN, CRNP, licensed practical nurse or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of an RN who is present in the RTF.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the RTF.

(4) A child, if the child meets the requirements in § 23.188 (relating to self-administration).

(5) Staff who have completed a medication training approved by the Department under certain circumstances listed in § 23.189 (relating to special circumstances).

(b) A prescription medication and an injection shall be administered according to the directions specified by a licensed physician, CRNP or licensed PA.

§ 23.188. Self-administration.

A child is permitted to self-administer medications, insulin injections and epinephrine injections for insect bites, food and latex allergies, if the following requirements are met:

(1) A person who meets the qualifications of § 23.187(a)(1)—(3) and (5) (relating to administration) is physically present observing the administration and immediately records the administration in accordance with § 23.184 (relating to medication log).

(2) A child recognizes and distinguishes the medication and knows the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken.

§ 23.189. Special circumstances.

Staff who have completed a medication training approved by the Department are permitted to administer medications in the following circumstances:

(1) The staff who have completed the medication administration training are accompanying one or more children away from the RTF and the person who meets the qualifications in § 23.187(a)(1)—(3) (relating to administration) is not with the group.

(2) Staff who meet the qualifications in § 23.187(a)(1)—(3) are not present at the RTF during sleep hours, and the medication is prescribed to be administered during sleep hours.

(3) A person who meets the qualifications in § 23.187(a)(1)—(3) is unavailable do to an emergency situation caused by a natural disaster, weather related condition, or unexpected illness.

§ 23.190. Medication performance monitoring.

To assist in measuring the quality of care provided and outcomes achieved for a child in an RTF, an RTF shall provide a report to the Department on the following every 6 months:

(1) The number and percentage of children under 21 years of age who are receiving 3 or more psychotropic medications.

(2) The number and percentage of children under 21 years of age who are receiving 1 or more antipsychotic medications.

RESTRICTIVE PROCEDURES

§ 23.201. General information.

(a) If a restrictive procedure is used, the staff who administers the procedure shall have completed training specified in § 23.62(d) (relating to staff training).

(b) Restrictive procedures include time-out, restraint and seclusion.

(c) The only restrictive procedures permitted in an RTF are drugs used as a restraint and manual restraint and those may be used only in an emergency safety situation in accordance with the provisions of this chapter. If the child objects to the administration of a drug used as a restraint, which a physician has determined is needed as a result of an emergency safety situation, an RTF shall have the child evaluated for inpatient psychiatric hospitalization.

(d) A restrictive procedure may not be used in a punitive manner, as a means of coercion, discipline, retaliation or retribution, or for the convenience of staff, or as compensation for lack of staff presence or competency, or as a program substitution.

(e) A restrictive procedure shall be discontinued when a child demonstrates the child has regained self-control. Staff involved in implementing a restrictive procedure shall inform the child during the procedure, in easily understandable language, of the criteria for discontinuation of the restrictive procedure.

(f) A restrictive procedure may not result in harm or injury to a child.

§ 23.202. Restrictive procedure policy.

(a) An RTF shall establish a policy for the use of restrictive procedures and specifically address the use of restraint as an emergency safety intervention in the policy.

(b) The policy must address the requirements set forth in this chapter and applicable Federal laws.

§ 23.203. Written plan to create a restraint-free environment.

(a) An RTF shall submit to the Department a written plan that includes goals and time frames for establishing a trauma-informed care approach to move toward a restraint-free environment within the RTF.

(b) The written plan must include:

(1) Alternative approaches to the use of restraint consistent with a trauma-informed approach and ongoing staff training on alternative approaches and trauma-informed care as specified in § 23.62(d) (relating to staff training).

(2) The data that the RTF will collect and the manner in which the RTF will collect the data based on the requirements of the Department.

(3) Additional data the RTF has chosen to collect.

(4) The RTF's internal performance improvement process to monitor and reduce the use of restraint.

(c) The RTF shall annually review the plan to measure progress toward establishing an environment that is free from the use of restraints and restrictive procedures, modify the plan as needed, and submit any modifications for Department approval.

§ 23.204. Time out.

(a) Time out is used as intervention to provide a child with a period of time in a designated quiet area, such as the child's room or a place away from the area of activity or other child, for the purpose of providing the child an opportunity to learn how to gain self-control.

(b) A child may request time out, or staff who notices a change in a child's behavior that the child has not identified but appears to be escalating, or has escalated, to loss of self-control may ask a child to take time out to retain or regain self-control and function in a more positive manner.

(c) Time out may not be used in a punitive manner or for the purpose of excluding a child from general activities.

(d) Staff shall monitor a child while the child is in time out and record in the child's record the following:

(1) The date and start and end times of the time out.

(2) The reason for the time out, including whether it was requested by the child.

(3) The name of the staff that monitored the time out.

(4) The resolution of the time out, including whether it was or was not successful and the reason for the success or lack of success.

(5) The signature of the monitoring staff.

(c) A child in time out may never be physically prevented from leaving the area where the time out is taking place.

(d) If a child is not permitted to leave the time out area, the intervention ceases to be a time out and is considered seclusion.

§ 23.205. Emergency safety intervention.

(a) *Mechanical restraints.*

(1) Mechanical restraints are prohibited.

(2) The following devices are not considered mechanical restraints:

(i) A device used to provide support for functional body position or proper balance.

(ii) A device used for medical treatment, such as sand bags to limit movement after medical treatment.

(iii) A wheelchair belt that is used for body positioning and support.

(iv) A helmet used for prevention of injury during seizure activity.

(v) A seatbelt used during transportation.

(b) *Seclusion.*

(1) Seclusion is prohibited.

(2) Seclusion does not include the use of a time out room as defined in this chapter.

(3) Locking a child in a bedroom during sleeping hours is considered seclusion.

(c) *Permissible restraint.* A permissible restraint may only be used:

(1) To ensure the safety of a child or others during an emergency safety situation.

(2) After every attempt has been made to anticipate and de-escalate the behavior using methods of intervention less than restraint.

(d) *Maintaining restraints.* Efforts to calm and de-escalate a child should continue even after a restraint is implemented, with the goal of shortening the time needed to maintain the restraint.

(e) *Prohibited interventions.* The following interventions are prohibited:

(1) A restraint that applies pressure or weight on a child's respiratory system.

(2) Prone position restraints.

(3) Drugs used as restraint to control acute, episodic behavior that restricts the movement or function of a child, except for the administration of drugs ordered by a licensed physician and administered by licensed/certified/registered medical personnel on an emergency basis.

(4) The application of startling, painful or noxious stimuli, also referred to as adverse conditioning.

(5) The application of pain for the purpose of achieving compliance, except pressure at a child's jaw point for the purpose of bite release, also referred to as pressure point techniques.

(f) *Emergency safety intervention.* Orders for the use of restraint as an emergency safety intervention.

(1) Prior to ordering and applying a manual restraint, information and history shall be obtained about potential medical or psychological contraindications to the use of manual restraint for a child. This information shall be documented in a child's record and accessible to staff working with the child, including an individual who might order a restraint as an emergency safety intervention.

(2) Manual restraint shall be ordered only by one of the following:

(i) The child's treatment team physician, if available.

(ii) If the child's treatment team physician is not available, one of the following, if permitted by the RTF:

(A) Another physician.

(B) If another physician is not available, a CRNP or PA. Documentation that a physician was not available shall be entered in the restraint log and the child's medical record.

(C) If the individuals specified in clauses (A) and (B) are not available, a licensed psychologist, licensed social worker or licensed clinical social worker. Documentation that individuals specified in clauses (A) and (B) were not available shall be entered in the restraint log and the child's medical record.

(3) If neither the treatment team physician nor one of the alternative individuals specified in paragraph (2) (ii) is available in the RTF at the time of the emergency safety situation, a verbal order for restraint may be obtained from an individual specified in paragraph (2) by an RN or licensed practical nurse (LPN). If an RN or LPN is not in the RTF, a licensed occupational therapist or physical therapist may accept a verbal order for restraint from an individual specified in paragraph (2).

(i) The individual who ordered the restraint must be available to staff for consultation, at least by telephone, throughout the period of restraint.

(ii) A verbal order shall be verified by the individual who ordered the restraint in the child's record.

(4) When a restraint is ordered by someone other than the child's treatment team physician, the treatment team physician shall be contacted and informed about the use of restraint by the individual who ordered the restraint no later than 24 hours after the restraint was ordered.

(5) An order for a restraint shall be entered into a child's record by the ordering individual.

(6) An order for restraint must include the following:

(i) The name of the ordering physician or other individual specified in paragraph (2)(ii).

(ii) The date and time the order was obtained.

(iii) The specific type of restraint ordered, including length of time for which the order authorized the restraint.

(iv) The reason the restraint was ordered.

(v) The frequency and duration that staff shall monitor the child's vital signs.

(7) The physician or other individual specified in paragraph (2)(ii) shall order the least restrictive restraint likely to be effective in resolving the emergency safety situation taking into account onsite-staff recommendations.

(8) An order to administer a drug used as a restraint must meet the following requirements:

(i) The drug is ordered by a licensed physician.

(ii) The drug is administered by a licensed, certified or registered medical professional.

(iii) The child is examined by a licensed physician immediately prior to each incidence of administering a drug and the licensed physician has given a written order to administer the drug immediately prior to each incidence of administering a drug.

(9) An order for restraint must:

(i) Be limited to no longer than the duration of the emergency safety situation. A standing or PRN order for restraint is prohibited.

(ii) Under no circumstances exceed 2 hours for a child between 18 and 21 years of age, 1 hour for a child between 9 and 18 years of age, and 30 minutes for a child under 9 years of age.

(10) If the restraint is discontinued before the original order expires, a new order shall be obtained prior to reapplying the restraint.

(g) *Application of restraint.*

(1) Only staff trained in the use of emergency safety interventions as specified in § 23.62 (relating to staff training) shall be permitted to apply a restraint.

(2) During a restraint, the trained staff shall:

(i) Continually access and monitor the physical and psychological well-being of the child.

(ii) Release the hold by changing the position of the physical restraint or the staff applying the restraint at least once every 10 consecutive minutes during the restraint.

(iii) Ensure the safe use of restraint throughout the duration of the restraint and assess both physical and psychological factors of the child.

(iv) Clearly identify for the child the criteria for discontinuation of the restraint.

(v) Discontinue a restraint when a child demonstrates the child has regained self-control.

(3) During a restraint, staff trained in the use of restraint, but who are not applying the restraint, shall continuously observe, monitor and document the physical and emotional condition of the child. Staff shall document the condition of the child at least every 10 minutes after the restraint begins in the child's record.

(4) The use of the restraint must be limited to the duration of the emergency safety situation and until the child's safety and the safety of others can be ensured, even if the order for restraint has not expired.

(5) If the emergency safety situation continues beyond the time specified in the order authorizing the restraint, an RN or other licensed staff, shall contact the individual specified in subsection (f)(2)(ii) to receive further instructions.

(6) During a restraint, a child's physical needs shall be met.

(7) During the use of a drug as a restraint, staff shall monitor the child's vital signs at least once an hour and in accordance with the frequency and duration recommended and documented by the prescribing physician, in addition to the requirements in paragraph (2).

(8) Within 1 hour of the initiation of the restraint, a physician, CRNP, RN or PA trained in the use of emergency safety interventions and permitted by the RTF to assess the physical and psychological well-being of children shall conduct a face-to-face assessment of the physical and psychological well-being of the child including:

(i) The child's physical and psychological status.

(ii) The child's behavior.

(iii) The appropriateness of the intervention measures.

(iv) Complications resulting from the intervention.

(h) *Medical treatment for injuries.* Medical treatment for injuries resulting from the use of restraint is as follows:

(1) Staff shall assess a child to determine the extent of any injuries and shall obtain medical treatment from qualified medical personnel for a child injured as a result of a restraint immediately after discovery of an injury. Staff that is medically trained to provide emergency first-aid care and cardiopulmonary resuscitation should be available during and after a restraint to provide emergency medical interventions until further follow-up care can be provided.

(2) Staff that applied or participated in a restraint that results in an injury to a child shall meet with supervisory staff and evaluate the circumstances that caused the injury, and the RTF shall develop a plan to prevent further injuries.

(i) *Notification.* Notification of parent and, when applicable, the guardian or custodian shall be as follows:

(1) An RTF shall notify a parent and, when applicable, the guardian or custodian, of a child who has been restrained as soon as possible, but no later than 5 hours after the initiation of the restraint.

(2) An RTF shall document in a child's record that the parent and, when applicable, the guardian or custodian, has been notified of the restraint, including the date and time of notification and the name of the staff providing the notification.

(j) *Documentation of restraint.*

(1) Documentation of a restraint shall be written in a child's medical record and include the following:

(i) A description of the emergency safety situation.

(ii) The order for restraint as specified in subsection (f)(7).

(iii) If an individual specified in subsection (f)(2)(ii) ordered the restraint, an explanation that other staff were unavailable, as specified in subsection (f)(2)(ii).

(iv) For verbal orders, the name and title of the individual ordering the restraint, the time the order was given, the type of restraint ordered and the maximum time for which the restraint was ordered. The licensed staff identified in subsection (f)(3) accepting the verbal order shall sign and date the orders received. The ordering individual shall counter sign the order within 1 business day of the restraint.

(v) The time the restraint actually began and ended.

(vi) The names and job titles of staff involved in the restraint.

(vii) The time and results of the 1 hour assessment, specified in subsection (g)(8).

(viii) The date and time the treatment team physician was contacted and informed about the use of restraint, if the restraint was ordered by someone other than the treatment team physician.

(ix) Other documentation in § 23.206(b) (relating to restrictive procedure records).

(x) The dates, times and methods of attempts to notify a child's parent and, when applicable, the guardian or custodian, and the date and time of successful notification signed by each individual that attempted to contact the parent and, when applicable, the guardian or custodian.

(xi) A summary of each postintervention debriefing.

(xii) A description of all injuries that occur as a result of the restraint, including injuries to staff resulting from restraint.

(2) An RTF shall maintain a record of each emergency safety situation, the restraints used, and their outcomes.

(k) *Postintervention debriefings.*

(1) Shortly after the restraint is discontinued, staff involved in the restraint and supervisory staff shall conduct an informal and brief postrelease debriefment with the child for the purpose of rebuilding trust, helping the child regain composure and briefly discussing how the restraint might have been avoided and can be avoided in the future. If a child requests that the child does not want a particular staff who was involved in the restraint to participate in the postrelease debriefment, that request shall be honored.

(2) Within 24 hours after the restraint is discontinued, staff involved in the restraint, except when the presence of particular staff may jeopardize the well-being of the child, shall meet face-to-face with the child to discuss the circumstances that resulted in the use of restraint and strategies to be used by the staff, the child, or others that could prevent the use of restraint in the future.

(i) Other RTF staff, the RTF Family Advocate, ISPT members, the child's parents and, when applicable, the guardian or custodian, shall be given the opportunity to participate in the meeting.

(ii) If the child's parents and, when applicable, the child's guardian or custodian, attends the meeting, the RTF must conduct the meeting in a language that is understood by the child's parent and, when applicable, the guardian or custodian.

(3) Within 24 hours after the restraint is discontinued, staff involved in the restraint, appropriate supervisory and administrative staff, and the RTF Family Advocate shall conduct a debriefing session that includes, at a minimum, a review and discussion of the following:

(i) The emergency safety situation that required the restraint, including discussion of the participating factors that led up to the restraint.

(ii) Alternative techniques that might have prevented the use of the restraint.

(iii) The procedures, if any that staff are to implement to prevent any recurrence of the use of restraint.

(iv) The outcome of the restraint, including any injuries that may have resulted from the use of restraint.

(4) Staff shall document in the child's record that all three debriefing sessions took place. The documentation must include the following:

(i) The name of staff present for the debriefings.

(ii) The name of staff that were excused from the debriefings.

(iii) Changes to the child's treatment plan that result from the debriefings.

§ 23.206. Restrictive procedure records.

(a) A central record of each use of restrictive procedure shall be kept and include the following:

(1) The specific behavior addressed.

(2) The methods of intervention used to address the behavior, including all less intrusive measures attempted, and the reasons these measures were not effective.

(3) The date and time the procedure was used.

(4) The specific procedure used.

(5) The staff that used the procedure.

(6) The duration of the procedure.

(7) The staff who observed the child during the procedure.

(8) The child's condition upon completion of the procedure.

(9) The order for restraint.

(10) The time and results of the required 1-hour assessment.

(11) The physician or other licensed practitioner who order the restraint shall sign the restraint order in the record as soon as possible.

(b) Documentation of compliance with this section shall be kept in the child's record.

SERVICES

§ 23.221. Description of services.

(a) An RTF shall operate its program and provide services in accordance with a written service description approved by the Department.

(b) The service description must include the following:

(1) The RTF location, legal ownership and administration table of organization.

(2) The vision and mission of the RTF.

(3) A detailed description of how the program will meet the requirements in this chapter and current clinical standards of care.

(4) The scope and a general description of the services provided by the RTF.

(5) The number, ages, needs and any special characteristics of the children the RTF serves.

(6) The specific activities and programs provided by the RTF.

(7) The staff qualifications and staffing ratios with explanations for those that exceed the minimum requirements.

(8) An explanation of the RTF's ability to support and maximize the quality of life and functional abilities of children with emotional and behavioral issues using gender-responsive approaches that include a continuum of out-of-home treatment options for children with behavioral health needs.

(9) A demonstration of the RTF's ability to address special characteristics of the children the RTF intends to serve including neurological disability such as ASD or a co-occurring disorder such as substance abuse or disability such as developmental delay, deafness and blindness.

(10) A written policy regarding staff filing legal charges against a child which includes the following:

(i) The nature of the emotional and behavioral needs of the children residing at the RTF.

(ii) The possibility for injury to staff because of the potential of aggressive behaviors to occur as a result of the clinical conditions of a child.

(iii) A procedure for staff that choose to press charges to inform RTF management and discuss the pros and cons of pressing charges with the RTF director, with documentation of the meeting and meeting outcomes prior to filing charges.

(11) Verification from the LEA of the school district in which the RTF is located stating the following:

(i) The RTF has consulted with the LEA and the LEA has acknowledged its obligation to educate a child who is in an RTF in the most integrated setting and in the public school, whenever appropriate.

(ii) The LEA will meet the education, special education and related service needs of the children in the RTF.

(iii) An RTF shall notify the LEA if the RTF plans to expand or make other changes that will impact the LEA's requirement to provide educational services.

(c) The service description and policies and procedures shall be approved by the Department before the RTF begins operation.

(d) A change to an approved service description, which includes a change in the number of children the RTF plans to serve and to any approved policy or procedure, shall be approved by the Department prior to implementation.

§ 23.222. Admission process.

(a) Prior to admitting a child, an RTF shall interview the child and determine if its services, activities and programs are appropriate for the age, needs and any special characteristics of the child. The RTF shall document its findings. If the RTF determines that its services, activities and programs are not appropriate for the child and the child should not be admitted to the RTF, the RTF shall explain to the referral source in writing the reason the child cannot be admitted to the RTF. The RTF shall

maintain the documentation in the business office of the RTF for periodic review by the Department.

(b) The RTF shall have an admission process that assesses and documents the following for a child, prior to or upon admission:

(1) A child's diagnosis.

(2) The results from a structured screening or assessment.

(3) The service needs of a child.

(4) A child's legal status.

(5) The circumstances that make admission of a child necessary.

(6) The results of a trauma screen administered upon admission or within 7 days of admission with a summary of findings and a discussion of the clinical relevance of the findings to the child's presenting problems. If the RTF has a copy of a trauma screen administered to the child within the prior 4 months, then the RTF does not need to administer another screen, but must include a written discussion of the findings of the earlier trauma screen and the clinical relevance of those findings to the child's presenting problems as required.

(7) A summary of a strengths and culture discovery or assessment completed upon admission or within 7 days of admission.

(8) How the activities and services provided by the RTF will address the biopsychosocial needs of a child.

(c) An RTF shall retain documentation of the prior approval of the administrator of the Interstate Compact on the Placement of Children in the record of a child admitted from outside of this Commonwealth.

(d) If a child is readmitted to the same RTF within 5 days, the readmission will not be considered a new admission for MA program purposes, but rather a continuation of the original admission.

§ 23.223. Development of the ISP.

(a) A preliminary treatment plan addressing a child's behavioral health needs shall be completed within 24 hours of admission.

(b) An ISP shall be developed for a child within 14 calendar days of a child's admission and include the following:

(1) A comprehensive strengths-based treatment plan addressing the behavioral health needs of a child and based on a diagnostic evaluation and the information related to a child's trauma screen and history demonstrating that trauma-related factors are being addressed in clinical treatment.

(2) Medical needs of a child, including medications.

(3) Psychological, social, behavioral and developmental needs of a child that reflect the need for RTF admission.

(c) The ISP shall be developed by an ISPT, an independent team comprised of the following:

(1) The child.

(2) The child's parents and, when applicable, the child's guardian or custodian.

(3) A person invited by the child or the child's parent.

(4) A contracting agency representative.

(5) A representative of the county Mental Health/ Mental Retardation Program.

(6) A prescribing or treating psychiatrist or other clinician who will be working with the child.

(7) A representative of the CCYA or JPO if the child is in the child welfare or juvenile justice system.

(8) A child's Behavioral Health MCO.

(9) A representative of the responsible school district if written parental consent has been obtained.

(10) A physician.

(d) The treatment plan portion of the ISP addressing a child's behavioral health needs shall be developed by the treatment team, which must be an interdisciplinary team of physicians and other personnel who are employed by, or provide services to children in, the RTF.

(1) The treatment team shall:

(i) Assess a child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and limitations.

(ii) Assess the potential resources of a child's family.

(iii) Set treatment objectives.

(iv) Prescribe therapeutic modalities to achieve a plans objective.

(2) The treatment team must include a board-eligible or board-certified psychiatrist and one of the following:

(i) A psychiatric social worker.

(ii) An RN with specialized training or 1 year of experience in treating children with a serious mental illness or emotional or behavioral disorder.

(iii) A licensed occupational therapist who has specialized training or one year of experience in treating children with a serious mental illness or behavioral disorder.

(iv) A psychologist who has a master's degree in clinical psychology or who has been licensed by the Commonwealth.

(e) At least 3 phone or written contacts shall be made at least 2 weeks in advance to invite the child and the child's parent and, when applicable, a guardian or custodian, to participate in the development of the ISP at a time and location convenient for the child and the child's parent, and when applicable, the child's guardian or custodian, and the RTF.

(f) Documentation of a contact made to involve a child's parent and, when applicable, guardian or custodian shall be kept in the child's record.

(g) Persons who participated in the development of the ISP shall sign and date the ISP, with the exception of the child, the child's parent and, when applicable, the child's guardian or custodian, who shall be given the opportunity to, but are not required to, sign the ISP. Disagreement with the ISP or refusal to sign the ISP shall be documented in the child's record.

§ 23.224. Content of the ISP.

An ISP should reflect the needs, strengths, culture and priorities of a child and the child's family, and include the following:

(1) A treatment plan that is written in language understandable to the child and the child's family, and includes the following:

(i) Developmentally appropriate, asset-building treatment goals and objectives, such as building functional competencies.

(ii) Biologic, psychological and social interventions.

(iii) The child's identified priorities.

(iv) The environments in which the child exhibits a behavioral health treatment need.

(v) An explanation of the appropriate settings and time allocations for an intervention.

(vi) A detailed description of changes or updates from previous treatment plans.

(vii) Documentation of the continued clinical need for the service.

(viii) Detailed information to assist the staff with a comprehensive understanding of the specific interventions and objectives with which the staff will be assisting a child in attaining goals.

(2) Evaluation of the child's skill level for a goal.

(3) Monthly documentation of the child's progress on each goal.

(4) Services and training that meet the child's needs, including the child's needs for safety, competency development and permanency.

(5) A component addressing family involvement including, when applicable, the collaborative efforts with a High-Fidelity Wraparound Team.

(6) A plan to teach the child health and safety skills including the following:

(i) Nutrition and food selection.

(ii) Exercise.

(iii) Physical self-care.

(iv) Sleep.

(v) Coping skills.

(vi) Relaxation approaches.

(vii) Personal interests for constructive use of leisure time.

(viii) Substance use and abuse.

(ix) Personal safety.

(x) Healthy interpersonal relationships.

(xi) Services to others.

(xii) Decision-making skills.

(7) A component addressing how a child's education needs will be met in accordance with applicable Federal and State laws and regulations.

(8) The anticipated duration of the stay at the RTF.

(9) Discharge and aftercare plan to be addressed during monthly treatment team meetings and during ISPT meetings to ensure continuity of care with a child's family, school and community upon discharge.

(10) Methods to be used to measure progress on the ISP, including who is to measure progress and the objective criteria to be used.

(11) The name of the person responsible for coordinating the implementation of the ISP.

(12) Medical needs, including medication.

§ 23.225. Review and revision of the ISP.

(a) A review of a child's progress on the ISP, and a revision of the ISP if needed, shall be completed at least every 30 days.

(b) A child's ISP shall be revised if one of the following occur:

(1) There has been no progress on a goal.

(2) A goal is no longer appropriate.

(3) A goal needs to be modified.

(4) A goal needs to be added.

(c) A review and revision of the ISP shall be completed in accordance with § 23.223(b)(1) (relating to development of the ISP.)

(d) An RTF shall notify and invite a child's parents and, when applicable, a guardian or custodian, to participate in the review of the ISP and consider making changes based on a child's clinical course. Parent, and when applicable, guardian or custodian involvement is also to be obtained for a change in type of psychotropic medication.

(e) A child and the child's parent and, when applicable, guardian or custodian, shall contribute to the development, review and revision of a child's ISP.

§ 23.226. Implementation of the ISP.

(a) An RTF shall implement an ISP as written.

(b) An RTF is responsible to assign sufficient staff responsible for the implementation of the ISP, including the treatment plan.

§ 23.227. Copies of the ISP.

(a) A copy of an ISP, revisions to an ISP and monthly documentation of progress shall be provided to the child if the child is over 14 years of age, the parent and, when applicable, the child's guardian or custodian, the contracting agency and a person who participated in the development of or revision to the ISP.

(b) A copy of an ISP, revisions to an ISP and monthly documentation of progress shall be kept in the child's record.

§ 23.228. Behavioral health treatment.

(a) An RTF shall provide behavioral health treatment that is built on the competencies of a child and the child's family, while addressing specific needs of the child including culture, treatment history and family relationships.

(b) Behavioral health treatment must include, at a minimum, the following, which shall be provided as needed:

(1) Individual psychotherapy, group psychotherapy, family therapy and other therapeutic interventions, using evidence-based approaches, when possible, as indicated in the treatment plan, which addresses both the child's presenting behaviors and underlying mental health issues and, when clinically indicated, co-occurring issues to include mental health and substance abuse.

(2) Alternative approaches for a child when individual or group psychotherapy modalities are not considered effective treatment approaches, such as with a child with ASD, alternative approaches must be used.

(3) Both resiliency-promoting therapeutic milieu and trauma-informed care, characterized by supporting dignity, respect and hope, as part of both individual and group programming that includes the following:

(i) Community meetings.

(ii) Prosocial peer groups.

(iii) Psychoeducation groups.

(4) Social skills consistent with a child's successful adaptation to both society norms and a child's individual community.

(5) Age-appropriate training about maintenance of good physical health including, with the permission of a parent and, when applicable, a guardian or custodian, the prevention of sexually transmitted diseases including HIV/AIDS.

(6) Special individualized activities, relevant to a child's medical or physical needs.

(7) Use of psychotropic medication, when indicated.

(8) Training in daily living skills and community access skills.

§ 23.229. Education.

(a) Under 22 Pa. Code Chapters 11, 14 and 15 (relating to student attendance; special education services and programs; and protected handicapped students), a child who is of compulsory school age shall participate in a school program approved by the Department of Education or an educational program under contract with the LEA.

(b) The decision regarding the education portion of a child's day is to be made on an individualized basis utilizing the most integrated setting, with input from members of the ISPT, local public education officials and the child's home school district.

§ 23.230. Discharge and aftercare planning.

(a) A child's discharge and aftercare planning shall occur at a treatment team meeting and must be child centered and incorporate the following:

(1) Short-term goals, such as participation in a sport, community activity or religious organizations.

(2) Long-term life goals, including attainment of independent living and vocational skills and other special skills, such as playing a musical instrument or attending postsecondary education.

(3) A psychiatric discharge summary or final evaluation for a child receiving or who has received psychotropic medication during the child's RTF stay.

(b) Prior to discharge, the RTF shall schedule an appointment with the community behavioral health agency that will provide aftercare and submit documents related to the child's care in the RTF to that behavioral health agency.

(c) Within 14 days prior to discharge, the RTF shall submit the discharge summary to the community behavioral health agency providing aftercare.

(d) For each child receiving or who has received psychotropic medication during the child's RTF stay, the clinical rational for psychotropic medication shall be clearly documented on the child's psychiatric discharge summary or final evaluation.

(e) Prior to the transfer or discharge of a child, the RTF shall inform, and discuss with the child's parent and, when applicable, the child's guardian or custodian, the recommended transfer or discharge. Documentation of the discussion or transmission of the information shall be kept in a child's record.

(f) No later than 10 days after discharge, if a child was placed in the RTF by another state, the RTF shall document in the child's record that the administrator of the Interstate Compact on the Placement of Children was notified of the discharge.

(g) An RTF shall follow up with a child and family by telephone, 15 and 30 days postdischarge to determine if the child is receiving community-based behavioral health services, as identified in the discharge and aftercare plan.

(h) If, as a result of the RTF telephonic contact at 15 or 30 days postdischarge with a child and family, the RTF learns that a child is not receiving community-based behavioral health services, the primary contact or other designated staff, with child and family consent, shall contact the community-based behavioral health provider, the county MH/MR office, or the CASSP Coordinator to facilitate the provision of the community-based behavioral health services. The outcome of this telephonic contact shall be documented in a child's record.

CHILD RECORDS

§ 23.241. Emergency information.

(a) Emergency information shall be easily accessible at an RTF and documented in a child's record.

(b) Emergency information for a child must include the following:

(1) The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.

(2) The name, address and telephone number of the child's physician or other source of health care, health insurance and MA information.

(3) The name, address and telephone number of the person able to give consent for medical treatment, if needed.

(4) A copy of the child's most recent health examination.

§ 23.242. Child records.

(a) A separate record shall be kept for a child.

(b) Entries in a child's record must be legible, dated and signed by the person making the entry. The record shall be maintained in an organized and competent manner.

§ 23.243. Content of child records.

A child's record must include the following:

(1) Personal information including:

(i) Name, sex, admission date, birth date and Social Security number.

(ii) Race, height, weight, color of hair, color of eyes and identifying marks.

(iii) Dated photograph of the child taken within the past year.

(iv) Language spoken or means of communication understood by a child and the primary language used by a child's family, if other than English.

(v) Religious affiliation.

(vi) Emergency information required under § 23.241(b) (relating to emergency information).

(2) Physical health records.

(3) Dental, vision and hearing records.

(4) Health and safety assessments.

(5) Behavioral health evaluations during the course of treatment, including psychiatric evaluations, psychological evaluations and psychological testing results, if obtained.

(6) ISP and ISP revisions and summaries of ISP reviews.

(7) Restrictive procedure records relating to the child as required under § 23.206 (relating to restrictive procedure records).

(8) Reports of reportable incidents, as specified in § 23.17 (relating to reportable incidents).

(9) Consent to treatment, as specified in § 23.20 (relating to consent to treatment).

(10) A court order, if applicable.

(11) Admission information specified in §§ 23.221 and 23.222 (relating to description of services; and admission process).

(12) Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 23.31 (relating to notification of rights, grievance procedures and consent to treatment protections).

(13) Service records of the contracting agency.

(14) Education records.

(15) Current treatment plans.

(16) Past treatment plans.

(17) Special consultations or assessments completed or requested.

(18) Progress notes that document a child's participation in individual therapy, group therapy, family therapy and other therapeutic interventions.

(19) Documentation of a child's progress toward meeting treatment goals.

(20) Documentation of the family's participation in planning and treatment and ongoing efforts of the RTF to accommodate family schedules and encourage participation.

(21) Current psychotropic medication and documentation of regular medication reviews and the clinical rationale for the psychotropic medication including the following:

(i) A change in medication documented in a medication order.

(ii) Documentation of the administration of a prescribed medication, including dosage, route of administration, staff administering and signature of staff administering.

(22) Documentation of goals of therapeutic leave and the outcomes and reviews following therapeutic leave.

§ 23.244. Record retention.

(a) A child's record shall be kept in a locked location when unattended.

(b) Information in a child's record shall be kept for at least 6 years or until an audit is final or litigation is resolved.

(c) A child's record shall be kept for at least 6 years following a child's discharge or until an audit is final or litigation is resolved, whichever is later.

RTFs SERVING NINE OR MORE CHILDREN

§ 23.251. Additional requirements.

In addition to the other provisions of this chapter, this section and §§ 23.252—23.257 apply to an RTF serving nine or more children.

§ 23.252. Sewage system approval.

An RTF that is not connected to a public sewer system shall have a written sanitation approval for its sewage system by the sewage enforcement official of the municipality in which the RTF is located.

§ 23.253. Evacuation procedures.

Written emergency evacuation procedures and an evacuation diagram specifying directions for egress in the event of an emergency shall be posted in a conspicuous place.

§ 23.254. Exit signs.

(a) Signs bearing the word "EXIT" in plain legible letters shall be placed at an exit.

(b) If the exit or way to reach the exit is not immediately visible, access to an exit shall be marked with readily visible signs indicating the direction of travel.

(c) Exit sign letters must be at least 6 inches in height with the principle strokes of letters at least 3/4 inch wide.

§ 23.255. Laundry.

(a) There shall be a laundry area which is separate from kitchen, dining and other living areas.

(b) Soiled linen shall be covered while being transported through food preparation and food storage areas.

§ 23.256. Dishwashing.

(a) Utensils used for eating, drinking, preparation and serving of food or drink shall be washed, rinsed and sanitized after each use by a mechanical dishwasher or by a method approved by the Department of Agriculture.

(b) A mechanical dishwasher must use hot water temperatures exceeding 140° F in the wash cycle and 180° F in the final rinse cycle or shall be of a chemical sanitizing type approved by the National Sanitation Foundation.

(c) A mechanical dishwasher shall be operated in accordance with the manufacturer's instructions.

§ 23.257. Child bedrooms.

A child's bedroom may not be more than 200 feet from a bathtub or shower and toilet.

Subchapter C. PARTICIPATION REQUIREMENTS

SCOPE OF BENEFITS

Sec.
23.281. Scope of benefits.

CONDITIONS FOR MA PAYMENT

23.282. Policy.

PROVIDER PARTICIPATION

23.291. General participation requirements for an RTF.
23.292. Participation requirements for an out-of-State RTF.
23.293. Participation requirements for an RTF that treats children for drug and alcohol diagnosis in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder.
23.294. Ongoing responsibilities of an RTF.
23.295. Changes of ownership or control.

SCOPE OF BENEFITS

§ 23.281. Scope of benefits.

(a) A child who is an MA recipient is eligible for medically necessary RTF services provided by an RTF enrolled in the MA Program.

(b) A child who is receiving services in an accredited RTF the day preceding the date of the child's 21st birthday continues to be eligible for RTF services until RTF services are no longer medically necessary or the individual is 22 years of age, whichever occurs first.

CONDITIONS FOR MA PAYMENT

§ 23.282. Policy.

(a) The Department pays for medically necessary services rendered to an eligible individual, as specified in § 23.281 (relating to scope of benefits), by an RTF enrolled in the MA Program.

(b) Payment in the fee-for-service delivery system is made for services provided by an RTF subject to the provisions of this chapter and Chapter 1101 (relating to general provisions).

(c) Payment in the managed care delivery system is made for services provided by an RTF subject to the provisions of this chapter and Chapter 1101, except that the Department may delegate responsibilities to the behavioral health managed care organizations as specified in § 23.319 (relating to Department delegation of responsibility to behavioral health managed care organizations).

(d) Payment for absence without authorization is as follows:

(1) The Department will make payment for up to 2 days of absence without authorization from an RTF when the following conditions are met:

(i) Upon determining that a child is absent without authorization, an RTF shall file a police report and notify the JPO if the child has one. The RTF shall also conduct a search of the RTF buildings, grounds and offsite areas where the staff believes the child might have gone.

(ii) If a child cannot be located within 2 hours of the initial determination that the child is missing, the RTF shall notify the following:

(A) The County MH/MR Office.

(B) The CCYA, if the child is in its custody.

(C) The supervising juvenile court, if the child is under the supervision of the juvenile court.

(D) The child's responsible family member or legal guardian, as appropriate.

(iii) An RTF shall search offsite for at least 4 hours during each 24-hour period that the child is absent without authorization.

(iv) When the child is found or returns voluntarily, the RTF shall notify previously notified parties that the child is no longer absent without authorization.

(v) An action taken to locate the child during the child's absence without authorization and the required notifications shall be documented in the child's medical record. Documentation of onsite and offsite searches must specify the date and hours of search, where the search was conducted, any pertinent findings and be signed by staff that conducted the search.

(2) If the child is readmitted to the same RTF within 5 days, the readmission will not be considered a new admission for program purposes but, rather, a continuation of the original admission.

PROVIDER PARTICIPATION

§ 23.291. General participation requirements for an RTF.

(a) The Department will regulate participation in the MA program and may refuse to allow an RTF to participate in the MA program. Before allowing enrollment, the Department will consider the MA Program's need for additional RTF services in the RTF's primary service area as the most important factor in determining whether to grant or deny a request for enrollment as an RTF.

(b) In addition to the participation requirements established in Chapter 1101 (relating to general provisions), to participate in the MA Program, an RTF shall:

(1) Be licensed by the Department as an RTF under this chapter.

(2) Have a service description approved by the Department.

(3) Provide the services described in the service description at the location stated in the service description.

(4) Have in effect a utilization review plan that meets the requirements set forth at 42 CFR Part 456, Subpart D (relating to utilization control: mental hospitals) and provide psychiatric services that meet the requirements of 42 CFR Part 441, Subpart D (relating to inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs).

(5) Be in compliance with Federal restraint and seclusion requirements and attest annually by July 21 of each year that the facility is in compliance with 42 CFR Part 483, Subpart G (relating to condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21) on a Department-specified form. A facility enrolling as a Medicaid provider shall meet this requirement at the time it executes a provider agreement with the Medicaid agency.

(6) Have a transfer agreement with an acute care hospital and inpatient psychiatric hospital.

(7) Receive and maintain accreditation as a child and adolescent RTF by CARF, COA, JCAHO or by another accrediting body approved by the Department as published in a notice in the *Pennsylvania Bulletin*.

(8) Provide services under the direction of a board-certified or board-eligible psychiatrist.

(9) Meet all ISP requirements as specified in § 23.223 (relating to development of the ISP).

(10) Meet all prior authorization and certification of need requirements as specified in § 23.314 (relating to evaluations and treatment plans).

§ 23.292. Participation requirements for an out-of-State RTF.

An out-of-State RTF shall meet the following requirements:

(1) Be licensed and participate in the Medicaid Program of the state in which the RTF is located, if that state recognizes facilities which provide equivalent services.

(2) Have a service description that meets the requirements in this chapter.

(3) Have a ban on prone restraint.

(4) Meet the requirements established in Chapter 1101 (relating to general provisions) and § 23.291(b)(2)—(8) (relating to general participation requirements for an RTF).

§ 23.293. Participation requirements for an RTF that treats children for drug and alcohol diagnosis in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder.

An RTF that treats children for drug and alcohol conditions shall:

(1) Meet the requirements established in § 23.291 (relating to general participation requirements for an RTF).

(2) Be licensed by the Department of Health to provide drug and alcohol treatment services, unless the RTF contracts with a licensed drug and alcohol agency to provide substance abuse treatment services.

(3) Comply with the Department's current requirements for co-occurring competent service provision found at www.pa-co-occurring.org, including universal screening and assessment for co-occurring disorders, referral protocols for appropriate interventions, the employment of qualified professionals to treat co-occurring disorders and certification as a co-occurring competent RTF.

§ 23.294. Ongoing responsibilities of an RTF.

In addition to the ongoing responsibilities established in § 1101.51 (relating to ongoing responsibilities of providers), an RTF shall:

(1) Comply with State and Federal regulations, statutes, policies and procedures.

(2) Maintain current agreements with general and psychiatric hospitals, community-based mental health services, drug and alcohol services and, to the extent necessary, other RTFs for the prompt and appropriate transfer or referral of a child who requires or may be expected to require care in another setting.

(3) Furnish complete and accurate copies if requested of a child's records and the RTF's fiscal records to the Department or its designees, or Federal and State reviewers within 14 days of the request, unless a different timeframe is specified in the request.

(4) Retain complete, accurate, legible and auditable clinical, medical and fiscal records as specified in § 23.244(a) and (b) (relating to record retention).

(5) Notify the Department of a program site change.

(6) Submit a new attestation that the facility is in compliance with 42 CFR Part 483, Subpart G (relating to condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21) when RTF management changes.

(7) Notify the Department of the RTF's plans for the orderly transfer of children within 5 days of notification from the Department of Health that it has determined that the RTF is out of compliance with 42 CFR Part 483, Subpart G and must close.

§ 23.295. Changes of ownership or control.

(a) If an RTF changes ownership and the new owner wishes to participate in the MA program, the RTF shall submit a new application on the form provided by the Department for participation in the MA program.

(b) When an RTF changes ownership, the Department will approve participation in the MA Program by the new owner if the Department determines the new owner to be eligible to participate in the MA program as described under § 23.291 (relating to general participation requirements for an RTF). The new ownership shall meet Federal and State requirements prior to approving the change.

Subchapter D. PAYMENT PROVISIONS

PAYMENT FOR RTF SERVICES

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PAYMENT FOR RTF SERVICES

§ 23.301. Allowable costs.

(a) *Allowable costs.*

(1) A facility's allowable costs incurred in providing services on the ISP are considered in the allocation of costs to the MA Program for its eligible recipients.

(2) Total allowable costs of an RTF shall be apportioned between third-party payors so that, within the limits of this subchapter, the share borne by the Department is based upon those actual services and costs related to children who are MA recipients.

(3) An RTF is responsible for the accounting of all costs and services. Miscellaneous costs shall be documented and justified to the Department.

(b) *Determination of allowable costs.* The Department will determine allowable costs in accordance with the following:

(1) The requirements of this subchapter.

(2) For items not specifically identified in this subchapter, the Medicare cost report requirements found in 42 CFR 413 (relating to principles of reasonable cost reimbursement; payment for end-stage renal disease services; optional prospectively determined payment rates for skilled nursing facilities) and the Medicare Provider Reimbursement Manual (HIM-15).

(3) For items not specifically identified in this subchapter, the Medicare cost report requirements found in 42 CFR 413 and the HIM-15, Generally Accepted Accounting Principles (GAAP).

(c) *Administrative costs.*

(1) Administrative costs include costs incurred for a common or joint purpose and are associated with supportive activities that are necessary to maintain the direct

effort involved in providing services to children. These costs are not readily assignable to a specific cost center or program unit.

(2) Administrative costs shall be apportioned as general administration or allocated to other cost centers.

(3) General administrative costs are limited to 13% of the total MA eligible costs less general administrative costs and less depreciation and interest on capital indebtedness.

(4) Allowable administrative costs include the following:

(i) Compensation, fringe benefits and payroll taxes of the RTF's director, controller, purchasing agent, personnel director and other persons performing general supervision or management duties.

(ii) License fees, association dues, legal costs, including attorney's fees if the provider prevails; management fees and advertising.

(iii) Costs associated with the provision of supporting services such as bookkeeping, accounting, data processing and auditing.

(iv) Costs of space used for administrative purposes, including depreciation and interest or rental.

(v) Purchase of supplies and equipment used for administrative purposes.

(vi) Operating costs associated with administrative purposes, such as travel and communications.

(vii) Costs associated with the owners, officers or operators of the facility in accordance with the following:

(A) The salary or compensation cost of owners, officers, operators or persons other than RTF's staff only if their time and involvement is documented, and they are involved in the management of the RTF.

(B) The allowable cost for an owner, officer, operator or person other than RTF staff who are involved in the management of the RTF may not exceed the customary compensation and fringe benefits that a staff would receive if staff performed the work.

(viii) Other costs incurred for a common or joint purpose and are associated with supportive activities necessary to provide the services to children.

(d) *Compensation and staffing costs.*

(1) Compensation for direct care, administrative and support staff is allowable up to the combined prevailing Commonwealth salaries and benefits for functionally equivalent positions for staffing levels and positions specified in the current approved service description as described in § 23.221 (relating to description of services).

(2) Personnel costs for services that are not provided through salaried complement for the provision of necessary services for an MA recipient are allowable. Contracts that specify the nature of the service and define the unit and cost of the service shall be maintained by the facility, in addition to detailed documentation of services rendered.

(e) *RTF maintenance expenses.*

(1) Costs necessary for the establishment, operation and maintenance of the RTF certification and license are allowable to the extent that the maintenance costs do not duplicate costs of services performed by staff.

(2) Maintenance service contracts shall specify the nature and cost of the service in order to be allowable.

(3) Detailed documentation of maintenance service contracts shall be maintained by the RTF with all documentation of services rendered in order to be allowable.

(f) *Unit-of-service contracts.* Costs associated with unit-of-service contracts where a payment is made for each service unit rendered are allowable if the following conditions apply:

(1) Units-of-service for which costs are claimed have been delivered.

(2) The unit-of-service arrangement is more economical and efficient than other contractual relationships.

(3) Services do not duplicate those provided by staff.

(g) *Cost of drug services.*

(1) Drug services costs for medically necessary over-the-counter drugs are allowable.

(2) Detailed and itemized documentation of the claimed expense for drug services shall be maintained.

(3) Drug services costs are allowable for a nonprescription drug such as laxatives, aspirin and antacids if the drug is provided directly to an MA recipient from the RTF's own drug supply, the drug is prescribed by a physician's written order, and is medically necessary.

(4) Payment for prescription medication will be made to an enrolled pharmacy and costs related to prescription drugs that are noncompensable under the MA Program are not considered as allowable costs for an RTF.

(5) The RTF may not solicit or receive remuneration directly or indirectly in cash or in kind from a person in connection with the furnishing of drugs or in connection with referring a recipient to a person for the furnishing of drugs.

(h) *Staff development and training costs.* Costs associated with staff development and training costs are allowable if the training and development are associated with the requirements for each level of staff in the approved service description as described in § 23.221.

(i) *Depreciation allowance.*

(1) Depreciation on capital assets used to provide compensable services to children, including assets for normal, standby or emergency use, and specialized equipment such as wheelchairs, is allowable as specified in this subsection.

(2) An RTF will be reimbursed for allowable depreciation costs only if the RTF is the recorded holder of legal title of the capital asset or specialized equipment.

(3) An RTF shall use the straight-line method of depreciation. Other methods, such as the accelerated method of depreciation are not acceptable.

(4) The amount of annual depreciation shall be determined by first reducing the cost of the asset by any salvage value and then dividing by the number of years of useful life of the asset.

(i) The useful life may be shorter than the physical life depending upon the usefulness of the particular asset to the RTF.

(ii) A useful life may not be less than the relevant useful life published by the Internal Revenue Service or the Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association for the particular asset on which the depreciation is claimed.

(5) Depreciation expense for the year of acquisition and the year of disposal is computed by using either the

half-year or actual time method of accounting. The number of months of depreciation expense may not exceed the number of months that the asset was in service. If the first year of operation is less than 12 months, depreciation is allowed only for the actual number of months in the first year of operation.

(6) The method and procedure, including the assigned useful lives, for computing depreciation shall be applied from year-to-year on a consistent basis and may not be changed, even if the facility is purchased as an ongoing operation.

(7) For depreciation to be allowed for an RTF that previously did not maintain fixed asset records as required in paragraph (13) and did not record depreciation in prior years, the RTF shall use the straight-line method of depreciation for the remaining useful life of the asset. The depreciation must be based on the cost of the asset at the time of original purchase or construction. Depreciation may not be taken on an asset that would have been fully depreciated if it had been properly recorded at the time of acquisition.

(8) Depreciation on an RTF that has no fixed asset records and is sold will be allowed to the extent to which the prior owner would have been allowed.

(9) Leasehold improvements shall be depreciated over the useful life of the asset.

(10) Gains on the sale of fixed and movable assets are considered to be equal to the salvage value which shall be established prior to the sale of the item. Gains on the sale of fixed and movable assets shall offset allowable costs for the period in which the gain was realized. Losses incurred on the sale or disposal of fixed or movable assets will not be reimbursed under the program.

(11) Allowable depreciation will be calculated using the cost basis of an asset, determined as follows:

(i) The cost basis of the depreciable assets of an RTF that are acquired as new shall be the purchase price of the asset.

(ii) The cost basis of the depreciable assets of an RTF that are acquired as used, shall be computed by the following method:

(A) The cost basis is the lower of the purchase price or the fair market value.

(B) Fair market value is the lowest of two or more bona fide appraisals at the time of sale.

(C) Depreciation that was taken or could have been taken by all prior owners shall be subtracted.

(D) Costs incurred during the construction of an asset, such as architectural, consulting, and legal fees, interest, and fund raising shall be capitalized as part of the cost of the asset.

(iii) If an asset is acquired by a trade-in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt as consideration paid.

(iv) Donated assets shall be recorded at the current appraisal value or the lower of the following if available:

(A) The construction cost.

(B) The original purchase price.

(C) The donor's original purchase price.

(v) The cost basis for depreciable assets of an RTF transferred between related parties shall be the net book value of the seller at the date of the transfer in order for the related depreciation to be allowed.

(vi) The cost basis for depreciable assets of a facility acquired through stock purchase will remain unchanged from the cost basis of the previous owner in order for the related depreciation to be allowed.

(vii) The cost basis for depreciable assets of an RTF purchased in types of transactions other than those specified in subparagraphs (ii)—(iv) and (viii) may not exceed the seller's basis under this subchapter, less all depreciation that was taken or could have been taken by all prior owners.

(viii) The cost basis for depreciation on any asset the ownership of which changes shall be the lesser of the remaining allowable cost basis of the asset to the first owner of record or the allowable cost basis to the new owner; however, the cost basis must exclude costs, including legal fees, accounting and administrative costs, travel costs, or the cost of feasibility studies, attributable to the negotiation or settlement of the sale or purchase (by acquisition or merger) for which the MA Program previously made payment.

(12) Reasonable cost of depreciation will be allowed for the construction and renovation of buildings to meet applicable Federal, State or local laws and building codes.

(13) Allowable depreciation shall be documented in a fixed asset record that includes the following:

(i) Depreciation method used.

(ii) Description of the asset.

(iii) Date the asset was acquired.

(iv) Cost of the asset.

(v) Salvage value of the asset.

(vi) Depreciation cost.

(vii) Estimated useful life of the asset.

(viii) Depreciation for the year.

(ix) The accumulated depreciation.

(14) Depreciation cost is not allowable for assets expensed under another State or Federal payor.

(j) *Interest.*

(1) Necessary and proper interest on capital and current indebtedness is allowable.

(2) An RTF will be reimbursed for allowable interest on capital indebtedness with respect to an asset only if the facility is the recorded holder of legal title of the assets involved.

(3) Allowable interest on capital indebtedness shall not exceed the amount that a prudent borrower would pay. Interest on capital indebtedness will not be considered prudent if the provider cannot demonstrate that the rate does not exceed the rate available from lenders in this Commonwealth to similar borrowers on the date of the loan commitment.

(4) To be considered allowable, the interest expense shall be incurred and paid within 90 days of the close of the cost reporting period on a loan made to satisfy a financial need of an RTF and for a purpose reasonably related to providing services to children.

(5) Necessary interest on capital indebtedness applying to mortgages, bonds, notes, or other securities on the property and plant of the RTF will be allowed subject to the limitation of the amount recognized for depreciation

purposes. The total value of mortgages, bonds, notes, or other securities on which interest on capital indebtedness is allowed may not exceed the depreciation basis of the assets.

(6) Investment income shall be used to reduce allowable interest expense on capital and current indebtedness unless the investment income is from one of the following:

(i) Gifts, donations and grants that are not restricted by the donor for payment of allowable costs.

(ii) Funded depreciation if the interest earned remains in the funds.

(iii) An RTF's qualified pension fund if the interest earned remains in the fund.

(iv) Interest income from gifts, if the funds on which the interest is derived are not commingled with funds that offset allowable costs.

(v) Fundraising efforts.

(7) Investment income that reduces allowable costs, including income on operating capital, shall be used to reduce interest expense on capital indebtedness first, and then used to reduce noncapital indebtedness.

(8) Interest expense shall be allowable if paid on loans from an RTF's donor-restricted funds, the funded depreciation account, or the RTF's qualified pension fund. The upper limit on allowable interest may not exceed the prime interest rate charged at the time funds are borrowed.

(9) Moneys borrowed for the purchase or redemption of capital stock will be considered as a loan for investment purposes, and the interest paid on those borrowed funds is not an allowable cost.

(10) Interest expense on funds borrowed for capital purchases are not allowable until all funds in the RTF's funded depreciation account are fully expended.

(k) *Rental costs.*

(1) Rental costs for space that is used by the RTF is allowable.

(2) Leasing or rental costs for buildings are allowable if parties are unrelated and the facility demonstrates that the rental or lease is an arm's length transaction and continues as such.

(3) Exceptions to paragraph (2) are allowed if the rental costs are based on a fair market rental appraisal as outlined in paragraph (5), or documented costs of ownership, except that return on equity is not permitted. Documented mortgage interest charges and depreciation are allowable costs.

(4) An RTF shall maintain adequate documentation to substantiate rental costs. Documentation must include copies of the Department's approval specified in paragraph (3), if applicable, the lease, and bills for taxes, insurance, and interest.

(5) An RTF shall maintain documentation of a fair market rental appraisal for all rental properties, from an individual who is a member of the Appraisal Institute, which includes the documented market value of three similar properties including land in the same geographic area.

(6) The maximum allowable annual rental shall be computed as follows:

(i) The property value is based upon the documented fair market value as determined in paragraph (5).

(ii) Net equity is obtained by reducing the property value by the estimated selling costs and any outstanding debt.

(iii) Net equity will be multiplied by the rate for return on equity capital as published by CMS in the "Average Trust Fund Interest Rates," and announced in an annual bulletin published by the Department, for the beginning of the current fiscal year.

(iv) The actual cost of real estate taxes, insurance and interest on any debt, for the current fiscal year, are added to the amount in subparagraph (iii).

(v) The maximum annual rental may not exceed the sum of subparagraphs (iii) and (iv).

(7) An RTF shall maintain documentation of the calculation required in paragraph (6).

(8) Rent is allowable up to the maximum allowable annual rental value.

(9) If an RTF has a multiple-year lease, allowable rental costs are determined by new appraisals or by updating the existing appraisals using the interest rate as published by CMS in the "Average Trust Fund Interest Rates," and announced in an annual bulletin published by the Department, and including current costs for taxes, insurance, and interest as specified in paragraph (6)(iv).

(10) A new appraisal shall be issued for every new lease or lease renewal in order to determine the allowable rental costs.

(l) *Vehicle costs.*

(1) Leasing or rental costs of automobiles are allowable if the RTF can demonstrate that the transaction is an arm's length transaction.

(2) Leasing or rental costs of automobiles are allowable if the automobile is leased or rented from a parent corporation if the RTF can demonstrate it is leasing or renting at less than or equal to the amount other vendors are charging for a similar automobile.

(3) An RTF shall use a competitive bidding process to purchase or lease vehicles.

(4) An RTF shall explore cost differentials between leasing and purchasing of vehicles and choose the least expensive alternative to be allowable.

(5) The expenses related to the personal use of RTF-owned or leased motor vehicles by staff, owners or officers are not allowable.

(6) Daily logs detailing use of vehicles as well as the maintenance activities and costs shall be maintained by the RTF.

(m) *Purchases.* Purchase of services, major renovations, capital equipment and supplies that exceed $5,000 annually are allowable if they are made through a competitive bidding process or a request for proposal process.

(1) Professional services including those of health care practitioners and attorneys are exempt from this requirement.

(2) A bid may be obtained for a maximum of 3 years.

(3) An RTF may not purchase in a piecemeal fashion to avoid the $5,000 limit.

(4) Purchases without bids shall be based upon sole source justification supported by documentation of the uniqueness or the limited availability of the service.

(n) *Transportation.*

(1) Transportation expenses are allowable for travel, lodging, subsistence and related items incurred by staff traveling on official business. Reimbursement for transportation expenses may not exceed that paid to employees of the Commonwealth.

(2) Costs incurred in transporting the parent and, when applicable, the guardian or custodian to a family therapy appointment at the facility where the child is present are allowable.

(o) *Start-up costs.*

(1) Start-up costs are costs that were incurred prior to the first day of officially operating as an RTF. Start-up costs are allowable and shall be capitalized as deferred charges and amortized over a minimum of 5 years.

(2) Start-up costs include the following:

(i) Administrative salaries.

(ii) Utility costs.

(iii) Taxes.

(iv) Insurance.

(v) Mortgage and other interest.

(vi) Staff training costs.

(vii) Repairs and maintenance.

(viii) Housekeeping.

(ix) Other allowable costs incurred prior to the first day of officially operating as an RTF.

(3) Costs that are properly identifiable as organization costs or capitalizable as construction costs shall be classified as such and excluded from start-up costs.

(4) Costs related to changes in ownership as defined in subsection (i)(11) are not allowable as start-up costs.

(5) Amortized start-up costs shall be reported in General Administration on the budgeted cost report or the cost report. The costs shall be documented on the budget narrative or the cost report. A 60-month amortization period is allowed for these costs.

§ 23.302. Income and offsets to allowable costs.

In the cost report, the RTF should report income from the following as sources to offset allowable costs in the determination of operating costs:

(1) Payment made by a child or assessed liability that is deducted from the amount billed for the child.

(2) Gifts, donations, endowments, bequests and contributions restricted by the donor for allowable costs.

(3) Refunds and cash discounts.

(4) Grants designated for allowable costs.

(5) Income from the National School Lunch Program.

(6) If a child is eligible to participate in the Supplemental Nutrition Program (SNAP), it is the RTF's responsibility to contact the local county assistance office and utilize food stamps accordingly.

(7) Income from space rental, vending machines and similar items.

(8) Fundraising efforts restricted for allowable costs

(9) Interest earned on items specified in paragraphs (1)—(8).

§ 23.303. Bed occupancy.

(a) In calculating an RTF's per diem rate, the Department will compute the number of RTF days of care used at 85% of available days of care if a provider reports an occupancy percentage of less than 85%.

(b) The average annual rate of occupancy is computed by dividing the total actual days of care provided by the total certified bed days available during the fiscal period. The total actual days of care provided include all days of service actually provided plus hospital reserve bed days in full up to the limits specified under § 23.307(b)(1) (relating to general payment policy). Reserved beds counted as actual days of service shall not be filled.

§ 23.304. Cost allocation.

(a) *Cost allocation method.*

(1) If a provider operates an RTF as well as other types of programs, the provider shall document at the time of the independent audit how various costs are allocated between the multiple programs, under § 23.301(c) (relating to allowable costs).

(2) The account of the cost allocation must include the following:

(i) Salary costs for individuals responsible for more than one program.

(ii) Staff fringe benefits for individuals responsible for more than one program.

(iii) Rental costs that apply to more than one program.

(iv) Motor vehicles that are used by more than one program.

(v) Other related expenses shared by more than one program.

(b) *Disclosure.*

(1) If costs have been allocated between programs and supporting services, disclosure shall be made in the independent audit and in accordance with generally accepted accounting principles in the independent audit.

(2) An RTF shall disclose in the independent audit the existence of any affiliate and its relationship to the established RTF, including the nature of any financial transaction between the affiliate and the RTF.

(c) *Cost centers.* An RTF that operates RTFs in different locations, but uses a consolidated financial report shall designate cost centers for each location in the independent audit. Information accompanying the independent audit must include the basis used to allocate income and expenses to each location.

§ 23.305. Related-party transactions.

(a) An RTF may include in its allowable costs, services and supplies furnished to the RTF by a related-party at an amount equal to the cost of the services and supplies to the related-party.

(b) The cost of services and supplies procured by the RTF through a related-party transaction may not exceed the cost of comparable services and supplies if purchased elsewhere.

(c) The related party's costs include reasonable costs incurred in the furnishing of services and supplies to the provider.

§ 23.306. Costs, limitations and services excluded from the RTF per diem rate.

(a) *Excluded costs.* The following costs are excluded from the operating costs as described in § 23.301(a) (relating to allowable costs) and not included in the RTF per diem rate:

(1) Costs for legal services relating to litigation against the Commonwealth, including administrative appeals, if the litigation is ultimately decided in favor of the Commonwealth.

(2) Administrative costs in excess of 13% of allowable medical assistance costs as specified in § 23.301(c).

(3) Costs for which Federal Financial Participation is precluded by statute including any services not on the ISP or services on the ISP not provided by and in the facility to residents of the RTF.

(4) Education costs associated with the child's Individual Educational Plan, Individual Family Service Plan and ISP which are to be paid for by the child's school district.

(5) Costs related to direct medical education, residency programs and education field placements, including staff costs.

(6) Costs for a service if payment is available from another public agency, insurance or health program, or any other source.

(7) Expenses not related to providing services to MA recipients.

(8) The Department will not contribute to a return on equity for proprietary programs.

(9) Costs associated with the following:

(i) Advertising (excluding employment opportunities).

(ii) Charitable contributions.

(iii) Staff recognition, such as gifts, awards and dinners.

(iv) Staff social functions, such as picnics and athletic teams.

(v) Nonstandard fringe benefits

(vi) Fundraising and marketing

(vii) Life insurance for officers and directors of the governing board, including life insurance premiums necessary to obtain mortgages and other loans.

(viii) Membership fees for social, fraternal and other organizations involved in activities unrelated to the program or an organization defined as a lobbying group under 65 Pa.C.S. Chapter 13A (relating to lobbying disclosure).

(ix) Meals for visitors.

(x) Political activities.

(xi) Related-party rental, leases or other payments in excess of the provision outlined in § 23.305 (relating to related-party transactions).

(xii) Reorganization costs.

(xiii) Federal, State or local income and excess profit taxes.

(xiv) Taxes from which exemptions are available to the provider.

(xv) Bad debts and contractual adjustments.

(xvi) Barber and beautician services.

(xvii) Client allowances.

(xviii) Clothing and shoes for children placed in the RTF.

(xix) Living expenses for live-in employees, including lodging, meals and personal laundry.

(xx) Meals for employees, except for employee meals provided as part of client training activities documented in the child's treatment plan.

(xxi) Penalties, fines or late charges assessed by any source, whether or not related to the RTF.

(xxii) Personal hygiene items for children placed in the RTF.

(xxiii) Personal travel for employees, including personal use of an RTF vehicle.

(xxiv) Transportation and living costs associated with onsite family visits.

(xxv) Nonworking officer salaries

(xxvi) Free care or discounted services.

(xvii) Personal telephone service.

(xviii) Personal radio and television service.

(xxix) Direct and indirect costs related to nonallowable cost centers as follows:

(A) Gift, flower and coffee shops.

(B) Homes for administrators or pastors.

(C) Convent areas.

(D) Nurses' quarters.

(xxx) Pennsylvania Capital Stock and Franchise Tax.

(xxxi) Collection expenses associated with bad debts.

(xxxii) Travel expenses for members of the governing body unrelated to the program.

(xxxiii) Vocational rehabilitation services.

(xxxiv) Parties and social activities not related to providing care to MA recipients.

(xxxv) Recreation costs not related to providing care to MA recipients.

(xxxvi) Charity, in-kind and courtesy allowances.

(xxxvii) Extraordinary costs related to, or precipitated by, bankruptcy.

(10) The following services are not included in the per diem and may not be included as a facility cost and will not be reimbursed by Medicaid for any residents of the RTF:

(i) Health care, which is not related to behavioral health.

(ii) Prescription drugs.

(iii) Ambulance services.

(iv) Methadone maintenance.

(v) Diagnostic procedures or laboratory tests.

(vi) Dental services.

(vii) Inpatient hospitalization.

(viii) Emergency room visits.

(ix) Diagnostic or therapeutic procedures for experimental, research or educational purposes.

(x) Experimental or investigation procedures or clinical trial research and services that are not in accordance with customary standards of medical practice or are not commonly used.

(b) *Limitations on reimbursement.*

(1) Costs that are not recognized as allowable costs in a fiscal year may not be carried forward or backward to other fiscal years for inclusion in allowable costs.

(2) Costs of services otherwise included in the ISP that are provided by and in the RTF may be billed by the RTF's subcontractors. However, if the service is not listed on the ISP or is not provided by and in the RTF, Medicaid reimbursement to a subcontractor of the RTF or independent provider is not permitted, including the following:

(i) Health care, which is not related to behavioral health.

(ii) Prescription drugs.

(iii) Methadone maintenance.

(iv) Diagnostic procedures or laboratory tests.

(v) Dental services.

§ 23.307. General payment policy.

(a) *General payment policies.* An admission to an RTF is subject to a retrospective review by the Department in addition to prior authorization review. If the medical record does not support the medical necessity of the admission or continued stay, or if care rendered is found to be inadequate, inappropriate, or harmful to a child, payment may be denied for all or part of the stay. Suspected cases of fraudulent practices by the RTF may be referred for further investigation to the Office of the Attorney General, Medicaid Fraud Control Unit or other agencies, as appropriate.

(b) *Limitations on payment.*

(1) Payment for hospital-reserved bed days:

(i) Payment to an RTF to reserve a bed when a child is hospitalized will only be made if the child is admitted to a licensed hospital or hospital unit accredited by the JCAHO as a hospital, the hospitalization occurs during an RTF stay, and the child is expected to return to the RTF.

(ii) Payment for hospital-reserved bed days is limited to 15 days per calendar year, per child, whether the child was in continuous or intermittent treatment at one or more RTFs during the calendar year. If a child does not return to the RTF, the child shall be deemed discharged on the date of admission to the hospital and hospital-reserved bed days will not be paid for.

(iii) Payment for hospital reserved bed days will begin on the date of the child's admission to the hospital and will be paid at the rate of one-third of the RTF's approved per diem payment rate.

(2) Payment for absence without authorization. The Department will make payment for up to 2 days of absence without authorization from an RTF when the conditions specified in § 23.282(c) (relating to policy) are met.

(c) Payment is not made to an RTF for:

(1) A day of care solely for the purpose of performing evaluations, diagnostic tests or tests not related to a diagnosis that requires behavioral health services in an RTF.

(2) A day of care during which the child was absent from the facility:

(i) Absence without authorization, unless the absence meets the criteria in subsection (b)(2).

(ii) Elopement.

(iii) Discharge against medical advice.

(iv) Hospitalization, unless the hospitalization meets the criteria in subsection (b)(1).

(v) Therapeutic leave.

(vi) Administrative leave of any kind.

(3) Custodial-care related or unrelated to court commitments. Payment for services provided to a child in an RTF under a court commitment will be made only if the RTF services are medically necessary and the child was not placed in the facility by the court system.

(4) Unnecessary admissions and days of care due to conditions which do not require services in an RTF.

(5) A day of care for a child who no longer requires services in an RTF.

(6) A day of care for a child who does not have a current DSM diagnosis including Axes I-V or ICD-9-CM diagnosis along with Axes III-V of the most current DSM supported by clinical documentation.

(7) A day of care not certified in accordance with the Department's admission and continued stay review process described in §§ 23.315 and 23.316 (relating to information required to request admission or continued stay; and admission authorization and continued stay authorization request).

(8) A day of care caused by a delay in requesting or performing necessary diagnostic studies or consultations.

(9) A day of care on or after the effective date of a court-commitment to another RTF.

(10) A day of care due to a delay in applying for a court-ordered commitment.

(11) A day of care provided to a child who is suitable for an alternate nonresidential treatment type or level of care, regardless of whether the child is under voluntary or involuntary commitment.

(12) The day of discharge or transfer to another facility.

(13) A day of care disallowed by the inspection of care requirements specified in § 23.331 (relating to inspection of care reviews: general).

(14) A day of care where the ISP was not in place under §§ 23.223 and 23.224 (relating to development of the ISP; and content of the ISP).

(d) If a determination is made, by an audit or other determination, that the RTF received excess funds in the form of an overpayment from the Department, the funds shall be returned to the Department within 6 months from the date the facility is notified.

§ 23.308. Third-party liability.

(a) RTFs shall utilize available third-party resources, including Medicare Part B for services a child receives while in the RTF.

(b) If expected payment by a third-party resource is not received, an RTF may bill the Department for days of care authorized by the Department and provided to the child.

(c) If an RTF receives reimbursement from a third-party subsequent to payment from the Department, the RTF shall repay the Department by submitting a replacement of prior claim, according to instructions in the Department's Provider Handbook and Billing Guide.

(d) If a child or the legal representative of a child requests a copy of the record of payment or amounts due, an RTF shall submit a copy of the invoice and the request to the Department's Office of Administration, at the address specified in the Department's Provider Handbook and Billing Guide.

(e) Except as specified in subsection (f), if a child has private insurance benefits, the Department will pay the lesser of the following:

(1) An RTF's per diem payment rate multiplied by the number of covered days, minus any third party resources available to the child for the care, including any Medicare Part B payment.

(2) The amount of the insurance plan's deductible and coinsurance minus any other third party resource available to the child for care, including any Medicare Part B payment.

(f) If the third party resources available to a child for care equal or exceed the RTF's per diem rate multiplied by the number of compensable days, the Department will not make payment.

§ 23.309. Payment for services in an out-of-State RTF.

(a) The Department will pay for services furnished by an out-of-State RTF enrolled to participate in the MA program only if the facility meets state requirements and one of the following applies:

(1) The RTF is in a state contiguous to this Commonwealth and located closer to the child's residence than an in-State RTF.

(2) The out-of-State RTF provides a specific program that is medically necessary for a child and is not available in this Commonwealth, as documented in the request for authorization.

(3) An RTF bed is not available in this Commonwealth after referrals to at least three in-State RTFs and all three were unable to accept the child.

(b) The per diem rate for services provided by an out-of-State RTF as established in § 23.312 (relating to general rate-setting policy) will not exceed the lesser of the following:

(1) An RTF's home-state Medicaid per diem payment rate for equivalent services.

(2) The average bed-weighted prospective per diem payment rate for RTFs located in this Commonwealth adjusted, if appropriate, for specialized care not available within this Commonwealth.

(c) The Department will pay the per diem rate established in accordance with this section minus any payments from the child, a legally responsible relative or a third-party resource.

§ 23.310. Billing requirements.

(a) An RTF shall submit invoices to the Department pursuant to the instructions in the Department's Provider Handbook and Billing Guide and subsequent instructions issued by the Department.

(b) Original and resubmitted claims, including replacement claims, must be received for final adjudication within 365 days following the last date of service on the invoice.

(c) If the service spans 2 fiscal years, a separate invoice must be prepared for each fiscal year.

(d) If the service spans 2 different per diem rates, a separate invoice must be prepared for each time period covered by the different rates.

(e) Except as specified in § 23.306 (relating to costs, limitations and services excluded from the RTF per diem rate), services and items provided to the child while in the facility are included in the per diem and shall be included in the RTF services bill and may not be invoiced separately.

§ 23.311. Annual cost reporting.

(a) *Cost reporting.*

(1) An RTF shall provide the Department with an annual cost report and an independent audit performed by an independent public accountant.

(i) The audit must include a schedule prescribed by the Department containing the financial activity of the RTFs.

(ii) The cost report shall be prepared on an accrual basis as required in this subchapter and clarified in the Department's cost report instructions.

(2) An RTF shall identify allowable services, administration, ancillary and related organization costs based on financial and statistical records maintained by the RTF. The cost information contained in the cost report must be current and accurate.

(3) The cost report must cover a fiscal period of 12 consecutive months, from July 1 to June 30, except as noted in paragraph (5).

(4) The cost report for the preceding fiscal year ending June 30 must be submitted to the Department by September 30 of that year.

(5) When an RTF begins operating after the start of the fiscal year, the cost report must cover the period from the date of approval for participation by the Department to June 30.

(6) If the cost report is not submitted by September 30, the Department will assess a daily penalty of $100.

(b) *Review of a cost report.*

(1) The Department will utilize the cost report and the annual independent audit to establish the per diem rate applicable to the next fiscal year.

(2) The Department may adjust costs reported in the cost report based upon the findings of current or closed audits, cost settlements, approved service description as defined in § 23.221 (relating to description of services), or as a result of other information the Department requests or is made aware of.

(3) The Department will inform the RTF in writing of adjustments to the cost report.

(4) If the Department does not inform the RTF in writing within 180 days of receiving the cost report of adjustments to the cost report, the cost report submitted by the RTF will be accepted by the Department as submitted.

(5) When an RTF files for protection under the bankruptcy laws, a cost report must be filed except where the debtor, RTF, rather than a trustee operates the RTF after

the commencement of the bankruptcy. For example, the situation where the debtor, RTF, is the debtor in possession.

§ 23.312. General rate-setting policy.

Establishment of per diem rate.

(1) The cost report submitted by the provider, as adjusted by the Department, as specified in § 23.311(b) (relating to annual cost reporting), shall be used for the calculation of the per diem rate.

(2) The per diem rate for an RTF will be established by dividing the total projected operating costs by the number of days of care reported in the cost report subject to a minimum of 85% of the maximum number of days based on the number of beds specified on the RTF's Certificate of Compliance.

(3) The total projected operating cost is calculated as follows:

(i) For a new RTF, the total MA allowable costs from the budgeted cost report, including adjustments for income and nonallowable, limited and excluded costs, as determined by the Department.

(ii) For an existing RTF, the cost report filed September 30 as specified in § 23.311, including adjustments for income and nonallowable, limited and excluded costs, as determined by the Department.

(iii) An adjustment factor for each fiscal year, specified by the Department and announced in a bulletin published by the Department annually, is used to project the amount in subparagraph (i) or (ii) for each fiscal year through the end of the fiscal year in which the rate is to be effective. The adjustment factor is applied to the total operating costs on the cost report in subparagraph (i) or (ii), less depreciation on capital assets, limited to buildings and fixed equipment, and interest on capital indebtedness.

(iv) Add to the total operating cost depreciation on capital assets, limited to buildings and fixed equipment, and interest on capital indebtedness to obtain the total projected operating cost.

(v) Add an allowance for retained revenue using a percentage specified by the Department and outlined in a bulletin published by the Department annually.

(4) Once established, the per diem rate shall remain in place throughout the current fiscal year, unless the per diem rate is adjusted as a result of an audit or another determination.

(5) The costs incurred in providing all behavioral health treatment, including staff psychiatrist professional component of physician costs, and room and board are included in the per diem payment for RTF services and may not be billed separately or in addition to the per diem payment rate by the RTF or any other entity with which the RTF may have an agreement to provide such services.

(6) If there is more than one accounting method for handling a cost item, the method initially elected by the RTF shall be followed consistently in subsequent cost reports, unless the RTF submits prior written justification and receives approval from the Department for using a different method.

§ 23.313. Financial records.

(a) An RTF shall maintain adequate financial and statistical records for determination of costs payable under the MA Program for 5 years after the date of last payment.

(b) An RTF shall maintain the following records:

(1) General financial ledgers, journals and books.

(2) Original evidence of cost, such as purchase requisitions, purchase orders, vouchers, vendor invoices, requisitions for supplies, inventories, time cards, payrolls and bases for apportioning costs, that relate to the determination of reasonable costs and that are auditable.

(3) Records related to allocated administrative costs.

(4) Records relating to each cost report.

(5) Cash disbursement journals.

(6) Cash receipts journals.

(7) Payroll journals or computer printouts.

(8) Fixed asset ledgers or equivalent records.

(9) Inventory control records.

(10) Charts of accounts that parallels or cross-walks to the cost report format issued by the Department.

(11) Statement listing all sources of revenue to the RTF, including Federal, State, local and private sources.

(12) Accounting records.

(13) Documentation of staff compensation, by RTF positions and functionally equivalent Commonwealth positions.

§ 23.314. Evaluations and treatment plans.

(a) After admission, the team members specified in § 23.223(d), (e) and (f) (relating to development of the ISP) shall perform and prepare within the scope of their practice medical, psychiatric and psycho-social evaluations within the following time frames:

(1) Within a maximum of 30 days prior to the Department's receipt of an admission certification request or continued stay request; or

(2) Before authorization for payment, if the child becomes eligible for medical assistance after admission.

(b) Team members specified in § 23.223(d) and (e) shall, within their scope of practice, prepare the treatment plan. The plan must document the active treatment to be provided and be designed to achieve the child's discharge at the earliest possible time. RTF treatment plans must comply with the requirements in 42 CFR 441.155(b) and 456.180(b) (relating to individual plan of care; and individual written plan of care) based upon face-to-face contact.

(c) A written report of each evaluation, the treatment plan portion of the ISP and update must be entered in the child's record. RTF reports must be completed at the time of admission or if the individual is already in the facility, immediately upon completion of the evaluation or plan.

§ 23.315. Information required to request admission or continued stay.

(a) Certification of need for RTF services must be included in the documentation specified in subsection (e) and certified by:

(1) The interagency service planning team, prior to admission.

(2) The child's treatment team in concert with the interagency service planning team for continued stay.

(b) For an individual who is an MA recipient when admitted to a facility or program, the interagency service planning team must be independent of the RTF and:

(1) Include a physician.

(2) Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry.

(3) Have knowledge of the individual's situation.

(c) For an individual who applies for Medicaid while in the RTF, such as delayed coverage, the certification must be:

(1) Made by the team responsible for the ISP as specified in § 23.223(d), (e) and (f) (relating to development of the ISP).

(2) Cover any period before application for which claims are made.

(d) The Interagency Service Planning team shall certify the following:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the child.

(2) Proper treatment of the child's psychiatric condition requires services on an inpatient basis under the direction of a physician.

(3) The service can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed.

(e) Documentation prepared by the ISPT specified in subsection (a) to request admission certification or by the RTF utilization review committee to request continued stay certification in accord with the Department's Utilization Review Manual must include the following:

(1) The Department-designated form signed by the prescribing physician or designee.

(2) The most recent psychiatric evaluation signed by the treating psychiatrist. The evaluation must be performed no more than 30 days before the planned admission date or the date the request was received by the Department. The child must have a face-to-face psychiatric evaluation that supports a DSM diagnosis, Axes I through V or an ICD-9-CM diagnosis along with Axes III through V of the most current DSM.

(3) The child's current or proposed treatment plan which meets the requirements under § 23.314 (relating to evaluations and treatment plans).

(4) The child's current or proposed plan of care summary.

(f) The completed Department form which describes services considered and tried prior to the recommendation for RTF services and indicates whether the County MH/MR Office recommends admission or continued stay in the facility.

§ 23.316. Admission authorization and continued stay authorization request.

(a) Admissions to and continued stays in an RTF must be prior authorized by the Department or its designee.

(b) A request for prior authorization must be made in accordance with the process specified in the Department Utilization Review Manual and contain the information required in § 23.315 (relating to information required to request admission or continued stay.)

(1) Except as specified in paragraph (2), an admission to an RTF must occur within 30 days of the date the Department approves the admission. If the admission does not occur, a new authorization request must be completed to update the status of the child and certify that RTF care is still medically necessary.

(2) The certification request for a child receiving service through the CCYA or under the jurisdiction of the juvenile court is the same as paragraph (1), unless the child needs immediate admission to an RTF for treatment of behavioral health needs and has associated child-safety or protection needs as determined by CCYA or the juvenile court. For immediate admissions, the following criteria shall be met:

(i) The child has a DSM-IV (or subsequent version) diagnosis, Axes I through V or ICD-9-CM (or subsequent version) diagnosis, along with Axes III through V, and is not in a mental health or substance abuse crisis.

(ii) The child requires admission because of child-safety or protection issues.

(iii) The interagency service planning team recommends RTF admission to meet the child's treatment needs.

(iv) If the child is admitted to an RTF in accordance with this paragraph, all information to support the admission required under § 23.316 (relating to admission authorization and continued stay authorization request) must be received by the Department within 14 days of the child's admission.

(v) If the Department denies the admission certification, the Department will not make payment for RTF services for the child.

(c) The following apply to recertification for continued stay:

(1) The request for continuation of stay must be made 30 days prior to the expiration of the certified length of stay.

(2) Either of the following conditions apply to request for delayed coverage:

(i) The request must be made within 30 days of the date the child was determined eligible for MA.

(ii) The request must be made within 30 days of the notification by a third-party resource, originally expected to cover the child's treatment, that the requested service is not covered or coverage is exhausted.

(d) This process does not apply to a period of service which was not covered by another payor because the service was not medically necessary using the other payor's criteria, or the other entity's payment policies were not followed and, therefore, resulted in a rejection.

§ 23.317. Authorization determination.

(a) The documentation and information submitted for the authorization request submitted to the Department must include accurate and detailed medical information to establish medical necessity for the admission or continued stay.

(b) The authorization request must include all information specified in § 23.314 (relating to evaluations and treatment plans). If the required information is not present, the request will be returned to the county case manager.

(c) The Department will determine whether the requested RTF services are medically necessary, and compensable so that the recipient receives written notice within 21 days of the date the Department received the request. The requested services will be deemed approved if a determination is not made within 21 days.

(d) Department approval is for medical necessity of care and does not assure the child is, will be, or will continue to be eligible for MA services on the date service is provided.

§ 23.318. Effective date of coverage.

(a) *Admissions.*

(1) *Payment.* Except as specified in paragraph (2):

(i) An RTF will receive payment beginning on the date of admission if the admission occurs within 30 days of the date the Department authorizes the admission.

(ii) An RTF shall inform the Department of the date the child was admitted to the RTF.

(2) *Immediate child-safety or protection admission.*

(i) If the child is admitted under § 23.316(b)(2) (relating to admission authorization and continued stay authorization request) and approvable information is submitted to the Department within 14 days of admission to the facility, the certified days are effective on the date of admission.

(ii) If the child was admitted under § 23.316(b)(2) but the documentation is not received by the Department within 14 days of admission to the facility, the effective date of the approval will be the date complete and approvable information is received by the Department.

(b) *Continued stay.*

(1) *Recertification for a continued stay.*

(i) If an approvable recertification request is received by the Department 30 days prior to the expiration of the certified length of stay, the effective date is the first day after the last day of previously certified stay.

(ii) If the recertification request is received by the Department less than 30 days prior to the expiration of the certified length of stay, and the stay is approved after the expiration of the previously approved stay, each day of delay in requesting an extension subsequent to the last previously certified stay shall result in the reduction of a corresponding number of days approved.

(2) *Delayed coverage.*

(i) If admission procedures were consistent with the requirements in § 23.316 and the child was not determined eligible for MA subsequent to admission, the effective date of the approval will be the date the continued stay certification was requested and approved if the request is made after eligibility was determined, or the date the child is determined eligible for medical assistance coverage if the request was initiated before eligibility was determined.

(ii) If other insurance was expected to pay in full for the service but failed to materialize, the effective date will be the later of the following:

(A) The admission date.

(B) The date the child became eligible for services after the admission.

(iii) If other insurance was expected to pay in full for the service but coverage was exhausted; the effective date will be the later of:

(A) The date coverage was exhausted.

(B) The date the request for certification was received by the Department.

(C) The date the child became eligible for services after the admission.

§ 23.319. Department delegation of responsibility to behavioral health managed care organizations.

Consistent with § 23.282(c) (relating to policy), the Department may delegate specific responsibilities to the behavioral health managed care organizations including, but not limited to, rate setting, medical necessity review, so long as the certifications in § 23.315(c) (relating to information required to request admission or continued stay) are performed by an independent team meeting the requirements, and the establishment of operational procedures.

UTILIZATION CONTROL

§ 23.321. Scope of claim review process.

RTF services provided to a child are subject to the utilization review procedures in this chapter and Chapter 1101 (relating to the general provisions).

§ 23.322. RTF utilization review.

(a) An RTF shall have an RTF utilization review plan.

(b) An RTF shall have a utilization review committee composed of two or more physicians, one of whom is knowledgeable in the diagnosis and treatment of mental diseases, and assisted by other professional personnel.

(c) An RTF utilization review committee may not include an individual who is directly responsible for the care of a child whose care is being reviewed or has a financial interest in the RTF.

(d) An RTF utilization review committee shall:

(1) Conduct reviews of a child's need for admission to an RTF and continued need for residential treatment services.

(2) Ensure that complete documentation is obtained.

(3) Ensure that reauthorization request for continued stay is submitted to the Department with the appropriate time frames specified in § 23.315 (relating to information required to request admission or continued stay).

(e) An RTF shall maintain the original signed copy and continued stay copies of the request documentation and the notification of the number of days certified with the child's medical records. Another copy of the notification of days certified shall be maintained with the RTF billing records.

(f) An RTF's utilization review committee representative shall notify the Department, according to the schedule established by the Department of the following:

(1) A child's admission to the RTF.

(2) A child's discharge from the RTF.

(3) Denial of admission or continued stay.

(g) An RTF shall maintain utilization review records for a minimum of 6 years from the date of submission of that year's end cost report or until any audit or litigation is completed, whichever is later.

(h) The RTF shall submit all clinical and fiscal records and other documents to the Department upon request within the time frame specified by the Department in the request.

§ 23.323. Adverse determinations.

When the RTF utilization review committee denies admission or continued stay, an adverse determination letter must be sent to the county MH/MR office, the Department, the behavioral health MCO, the CCYA with custody of the child, if applicable, and the JPO, if applicable.

INSPECTION OF CARE REVIEWS

§ 23.331. Inspection of care reviews: general.

(a) The Department will conduct an unannounced onsite visit as deemed appropriate by the Department to determine if the RTF continues to meet State and Federal regulations.

(b) An RTF shall provide the Department with a list of MA recipients in the RTF on the date of the visit.

(c) An RTF shall make the medical records of an MA recipient available to the Department representatives reviewing the RTF.

(d) An RTF shall ensure that MA recipients are available to meet in person with the Department representatives reviewing the RTF.

(e) The Department will determine through its review whether State and Federal regulations are met.

§ 23.332. Inspection of care reports.

(a) The Department or a designated agent will report the outcome of the inspection of care review to an RTF.

(b) If the individual or team reviewing the RTF recommends alternate care for a child:

(1) The Department or a designated agent will notify the child or the child's representative and the RTF director of the intended denial of payment authorization.

(2) The child or the child's representative has 30 days from the date the notice is mailed to grieve the decision or request a fair hearing. The RTF does not have the right to grieve or request a fair hearing unless it is acting as a child's representative.

(3) If the child or the child's representative requests a fair hearing within 10 days from the date the notice is mailed, payment for RTF care will continue pending the outcome of the hearing.

(4) If a fair hearing is requested more than 10 days from the date the notice is mailed, payment for RTF care is discontinued effective with the day the individual or team reviewing the RTF recommended alternative care.

(c) If the report from the individual or team reviewing the RTF cites deficiencies, the following apply:

(1) An RTF shall submit a written response to the identified Department office within 30 days of the control date shown on the summary report. The response must outline the RTF's planned course of action including the timeframes for correcting deficiencies.

(2) The individual or team reviewing the RTF will conduct follow-up visits to determine if the deficiencies have been corrected.

ADMINISTRATIVE SANCTIONS

§ 23.341. Provider abuse.

(a) If the Department determines that an RTF has billed for services inconsistent with this chapter, provided services outside the scope of customary standards of medical practice, or otherwise violated the standards set forth in the provider agreement, the RTF shall be subject to the sanctions in Chapter 1101 (relating to general provisions) up to and including termination from the MA program.

(b) If the Department determines that services or items provided by the RTF were not provided according to standards of practice for the particular discipline providing the service or were not medically necessary or were inappropriate, or otherwise noncompensable, the Department will deny payment for the services and items and related services and items and recover payment already made for the services and items and related services and items.

§ 23.342. Administrative sanctions.

If the RTF utilization review committee fails to conduct a continued stay review or fails to notify the Department within 30 days of the expiration of the previously assigned length of stay, the Department will not certify those days between the expiration of the previously assigned length of stay and the date the request for continued stay is received.

PROVIDER RIGHT OF APPEAL

§ 23.351. Provider right of appeal.

(a) An RTF may appeal adverse actions, including authorization, certification and payment, of the Department under Chapter 41 (related to Medical Assistance provider appeal procedures).

(b) RTF staff and subcontractors do not have the right to appeal under this chapter or Chapter 41.

(c) If an RTF appeals a decision by the Department to fully or partially deny payment for a child, the Department will withhold the denied payments pending a decision on the appeal. If a child is in an RTF and receiving services from an RTF, payment will continue.

(d) A child, parent and, when applicable, guardian or custodian, may appeal a denial of authorization, or the provider may appeal on behalf of the child as specified in Chapter 275 (relating to appeal and fair hearings and administrative disqualification hearings).

CHAPTER 3800. CHILD RESIDENTIAL AND DAY TREATMENT FACILITIES

GENERAL PROVISIONS

§ 3800.3. Exemptions.

This chapter does not apply to the following:

* * * * *

(8) Community residences **[for individuals with mental illness that provide care to both children and adults in the same facility or community residential host homes for individuals with mental illness that are]** certified under Chapter 5310 (relating to community residential rehabilitation services for the mentally ill).

* * * * *

(12) Residential treatment facilities licensed under Chapter 23 (relating to residential treatment facilities).

CHAPTER 5310. COMMUNITY RESIDENTIAL REHABILITATION SERVICES FOR THE MENTALLY ILL

Subchapter A. GENERAL PROVISIONS.

§ 5310.3. Applicability.

* * * * *

(b) This chapter **[does not apply] applies** to child residential facilities which serve exclusively children **[, which are governed by Chapter 3800 (relating to child residential and day treatment facilities)]**.

* * * * *

[Pa.B. Doc. No. 10-2002. Filed for public inspection October 22, 2010, 9:00 a.m.]

FISH AND BOAT COMMISSION

[58 PA. CODE CH. 51]

Administrative; Royalty Rates

The Fish and Boat Commission (Commission) proposes to amend Chapter 51 (relating to administrative provisions). The Commission is publishing this proposed rulemaking under the authority of 30 Pa.C.S. (relating to the Fish and Boat Code) (code).

A. *Effective Date*

The proposed rulemaking, if approved on final-form rulemaking, will go into effect on January 1, 2011, or publication in the *Pennsylvania Bulletin*, whichever occurs later.

B. *Contact Person*

For further information on this proposed rulemaking, contact Laurie E. Shepler, Esq., P. O. Box 67000, Harrisburg, PA 17106-7000, (717) 705-7810. This proposed rulemaking is available on the Commission's web site at www.fish.state.pa.us.

C. *Statutory Authority*

The proposed amendment to § 51.92 (relating to royalty rates) is published under the statutory authority of section 503(c) of the Conservation and Natural Resources Act (CNRA) (71 P. S. § 1340.503(c)).

D. *Purpose and Background*

There are five companies that currently dredge material from the navigable waters of this Commonwealth and pay royalties to the Commission. Royalties from sand and gravel extracted from Commonwealth waters are paid to the Fish Fund, which is administered under Chapter 5 of the code (relating to fiscal affairs).

Under section 503(c) of the CNRA, the Commission, with the concurrence of the Department of Environmental Protection (Department), is authorized to adjust the amount of royalty payments per ton or cubic yard of usable or merchantable, or both, sand or gravel, or both, extracted from Commonwealth waters. The current royalty rate schedule in § 51.92, which was adopted in 1997, will expire on December 31, 2010.

With an eye towards establishing a new rate schedule, the Commission's Executive Director established a workgroup consisting of Commission and Department staff and five representatives from the sand and gravel dredging industry and asked them to collaboratively work together and develop a fair and equitable process for setting royalty rates for the 10-year period of January 1, 2011, through December 31, 2020. The workgroup formally met in April and May 2010 to discuss issues pertaining to setting royalty rates, including the need to simplify the annual rate calculation process and employ a market based approach.

With input from the Department and the industry representatives, the Commission proposes to amend § 51.92 to read as set forth in Annex A.

E. *Summary of Proposal*

The Commission proposes the following schedule for imposition of the updated sand and gravel royalty rates:

(1) During the period January 1 through December 31, 2011, the greater of $1,000 or $0.48 per dry ton.

(2) During the period January 1, 2012, through December 31, 2015, the greater of $1,000 or 6.75% of the immediately preceding year's published price, average value, dollars per metric ton (converted to United States ton) for the commodity sand and gravel in the United States Geological Survey, Mineral Commodity Summary per dry ton, provided that the rate per dry ton is not less than $0.48.

(3) During the period January 1, 2016, through December 31, 2020, the greater of $1,000 or 7.0% of the immediately preceding year's published price, average value, dollars per metric ton (converted to United States ton) for the commodity sand and gravel in the United States Geological Survey, Mineral Commodity Summary per dry ton, provided that the rate per dry ton is not less than $0.48.

F. *Paperwork*

The proposed rulemaking will not increase paperwork and will not create new paperwork requirements.

G. *Fiscal Impact*

The proposed rulemaking will impose increased costs on the private sector, namely, those businesses engaged in dredging in this Commonwealth. In 2009, those businesses paid the Commission a royalty rate of $0.4371 per dry ton and they reported that in 2009, they sold 1,537,131 dry tons of merchantable sand and gravel. They, therefore, paid royalties totaling $671,880 in 2009. If the companies continue to dredge material in similar quantities in the future and pay the proposed minimum rate of $0.48 per dry ton, the increased costs will total, at a minimum, approximately $65,943 per year for all business engaged in dredging. The proposed rulemaking may have a nominal fiscal impact on customers of sand and gravel, including the Commonwealth, its political subdivisions and the general public, if the businesses currently engaged in dredging pass their increased costs on to their customers.

H. *Public Comments*

Interested persons are invited to submit written comments, objections or suggestions about the proposed rulemaking to the Executive Director, Fish and Boat Commission, P. O. Box 67000, Harrisburg, PA 17106-7000 within

30 days after publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Comments submitted by facsimile will not be accepted.

Comments also may be submitted electronically by completing the form at www.fishandboat.com/regcomments. If an acknowledgment of electronic comments is not received by the sender within 2 working days, the comments should be retransmitted to ensure receipt. Electronic comments submitted in any other manner will not be accepted.

JOHN A. ARWAY,
Executive Director

Fiscal Note: 48A-220. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 58. RECREATION

PART II. FISH AND BOAT COMMISSION

Subpart A. GENERAL PROVISIONS

CHAPTER 51. ADMINISTRATIVE PROVISIONS

Subchapter J. ROYALTIES FOR SAND AND GRAVEL PERMITS

§ 51.92. Royalty rates.

Persons holding permits granting them nonexclusive rights and privileges of dredging, excavating, removing and carrying away merchantable sand and gravel under agreements between the permittees and the Department of Environmental Protection shall pay royalties in accordance with the following schedule.

(1) **[During the period, January 1 through December 31, 1998—15¢ per dry ton or 25¢ per cubic yard; or $1,000, whichever is greater.**

(2) During the period, January 1, 1999 through June 30, 2000—20¢ per dry ton or 30¢ per cubic yard; or $1,000, whichever is greater.

(3) During the period, July 1, 2000 through December 31, 2001—25¢ per dry ton or 37.5¢ per cubic yard; or $1,000, whichever is greater.

(4) During the period, January 1, 2002 through December 31, 2002—30¢ per dry ton or 40¢ per cubic yard; or $1,000, whichever is greater.

(5) During the period, January 1, 2003 through December 31, 2010—30¢ per dry ton or 40¢ per cubic yard plus or minus an amount equal to the change in the producer price index (PPI) for sand and gravel from the base year (2002), provided that the rate per dry ton may not be less than 25¢.]

During the period, January 1 through December 31, 2011, the greater of $1,000 or $0.48 per dry ton.

(2) During the period, January 1, 2012, through December 31, 2015, the greater of $1,000 or 6.75% of the immediately preceding year's published price, average value, dollars per metric ton (converted to U.S. ton) for the commodity sand and gravel in the *United States Geological Survey, Mineral Commodity Summary* per dry ton, provided that the rate per dry ton is not less than $0.48.

(3) During the period, January 1, 2016, through December 31, 2020, the greater of $1,000 or 7.0% of the immediately preceding year's published price, average value, dollars per metric ton (converted to U.S. ton) for the commodity sand and gravel in the *United States Geological Survey, Mineral Commodity Summary* per dry ton, provided that the rate per dry ton is not less than $0.48.

[Pa.B. Doc. No. 10-2003. Filed for public inspection October 22, 2010, 9:00 a.m.]

[58 PA. CODE CH. 71]

Fishing; Stocking of Designated Waters

The Fish and Boat Commission (Commission) proposes to amend Chapter 71 (relating to propagation and introduction of fish into Commonwealth waters). The Commission is publishing this proposed rulemaking under the authority of 30 Pa.C.S. (relating to the Fish and Boat Code) (code).

A. *Effective Date*

The proposed rulemaking, if approved on final-form rulemaking, will go into effect upon publication in the *Pennsylvania Bulletin*.

B. *Contact Person*

For further information on this proposed rulemaking, contact Laurie E. Shepler, Esq., P. O. Box 67000, Harrisburg, PA 17106-7000, (717) 705-7810. This proposed rulemaking is available on the Commission's web site at www.fish.state.pa.us.

C. *Statutory Authority*

The proposed amendment to § 71.4 (relating to stocking of designated waters) is published under the statutory authority of section 2102 of the code (relating to rules and regulations).

D. *Purpose and Background*

The proposed rulemaking is designed to improve, enhance and update the Commission's administrative regulations. The specific purpose of the proposed amendment is described in more detail under the summary of proposal.

E. *Summary of Proposal*

Section 71.4 currently provides that it is unlawful to place fish in waters that have been designated by the Commission as catch and release, wilderness trout or wild trout management waters except with the express written consent of the Executive Director or a designee. Considering the fact that some waters managed under catch and release programs, including Catch-and-Release, Catch-and-Release Fly-Fishing Only and Catch-and-Release All Tackle, are managed by the Commission with the planting of hatchery trout, § 71.4 should be amended to delete the reference to catch and release. In addition, this section should be amended to make it clear that wild trout management waters listed as Class A waters or Wild Brook Trout Enhancement waters are not to be

stocked. This is in accord with the Commission's statement of policy in § 57.8a (relating to Class A wild trout streams), which prohibits stocking in Class A wild trout waters.

The Commission therefore proposes to amend § 71.4 to read as set forth in Annex A.

F. *Paperwork*

The proposed rulemaking will not increase paperwork and will not create new paperwork requirements.

G. *Fiscal Impact*

The proposed rulemaking will not have adverse fiscal impact on the Commonwealth or its political subdivisions. The proposed rulemaking will not impose new costs on the private sector or the general public.

H. *Public Comments*

Interested persons are invited to submit written comments, objections or suggestions about the proposed rulemaking to the Executive Director, Fish and Boat Commission, P. O. Box 67000, Harrisburg, PA 17106-7000 within 30 days after publication of this proposed rulemaking in the *Pennsylvania Bulletin*. Comments submitted by facsimile will not be accepted.

Comments also may be submitted electronically by completing the form at www.fishandboat.com/regcomments. If an acknowledgment of electronic comments is not received by the sender within 2 working days, the comments should be retransmitted to ensure receipt. Electronic comments submitted in another manner will not be accepted.

JOHN A. ARWAY,
Executive Director

Fiscal Note: 48A-221. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 58. RECREATION

PART II. FISH AND BOAT COMMISSION

Subpart B. FISHING

CHAPTER 71. PROPAGATION AND INTRODUCTION OF FISH INTO COMMONWEALTH WATERS

§ 71.4. Stocking of designated waters.

It is unlawful to place fish in waters that have been designated by the Commission as **[catch and release,]** wilderness trout**, wild brook trout enhancement** or **Class A** wild trout **[management]** waters except with the express written consent of the Executive Director or **[his] a** designee. This section does not prohibit a person from returning fish unharmed to the waters from which they were caught or taken.

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