

**BEFORE THE
ADMINISTRATIVE RULES COMMITTEE
OF THE
NORTH DAKOTA LEGISLATIVE COUNCIL**

**N.D. Admin. Code Chapters)
75-03-16 and 75-03-17)
Licensing of Group Homes and)
Residential Child Care Facilities)
and Psychiatric Residential)
Treatment Facilities for)
Children)
(Pages 453-506))**

**REPORT OF THE
DEPT. OF HUMAN SERVICES
March 11, 2014**

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For its report, the North Dakota Department of Human Services states:

1. The proposed amendments to N.D. Admin. Code chapters 75-03-16 and 75-03-17 are necessary, in part, to comply with 2013 Senate Bill No. 2068.
2. These rules are not related to changes in a federal statute or regulation.
3. The Department of Human Services (Department) uses direct and electronic mail as the preferred ways of notifying interested persons of proposed rulemaking. The Department uses a basic mailing list for each rulemaking project that includes the county social service board directors, the regional human service centers, Legal Services offices in North Dakota, all persons who have asked to be on the basic list, and internal circulation within the Department. Additionally, the Department constructs relevant mailing lists for specific rulemaking. The Department also places public announcements in all county newspapers advising generally of the content of the rulemaking, of over 50 locations throughout the state

where the proposed rulemaking documents may be reviewed, and stating the location, date, and time of the public hearing.

The Department conducts public hearings on all substantive rule-making. Oral comments are recorded. Oral comments, as well as any written comments that have been received, are summarized and presented to the Department's executive director, together with any response to the comments that may seem appropriate and a re-drafted rule incorporating any changes occasioned by the comments.

4. A public hearing on the proposed rules was held in Bismarck on December 27, 2013. The record was held open until 5:00 p.m. on January 6, 2014, to allow written comments to be submitted. Three sets of written comments were received. The "Summary of Comments" is attached to this report.
5. The cost of giving public notice, holding a hearing, and the cost (not including staff time) of developing and adopting the rules was \$2,430.14.
6. The proposed rules amend chapters 75-03-16 and 75-03-17. The following specific changes were made:
 - Section 75-03-16-01. Section 75-03-16-01 is amended to clarify definitions and language.
 - Section 75-03-16-02.6. Section 75-03-16-02.6 is created to address residential bed conversion and the number of licensed beds in a facility in response to 2013 Senate Bill No. 2068.
 - Section 75-03-16-12.1. Section 75-03-16-12.1 is amended to follow federal policy and to clarify language.
 - Section 75-03-16-13. Section 75-03-16-13 is amended to clarify language and remove outdated information.

Section 75-03-16-19.1. Section 75-03-16-19.1 is created to address sentinel event reporting.

Section 75-03-16-19.2. Section 75-03-16-19.2 is created to address suicide prevention.

Section 75-03-16-23. Section 75-03-16-23 is amended to follow federal policy regarding medication placed in a lock box during transport, to add policy requirements regarding the use of medication, and to clarify language.

Section 75-03-16-29. Section 75-03-16-29 is amended to clarify language and to add requirements addressing fire drills, locking outbuildings on the property and pet inoculations.

Section 75-03-16-31. Section 75-03-16-31 is created to address outcomes data collection.

Section 75-03-17-01. Section 75-03-17-01 is amended to add pertinent definitions and clarify language.

Section 75-03-17-02. Section 75-03-17-02 is amended to clarify the procedures for licensure, including requiring facilities to disclose to the department changes in their accreditation status, and requirements for provisional licensing.

Section 75-03-17-03. Section 75-03-17-03 is amended to clarify language relative to the organization and administration of facilities.

Section 75-03-17-04. Section 75-03-17-04 is amended to clarify the required admissions process.

Section 75-03-17-05. Section 75-03-17-05 is amended to clarify the diagnosis and treatment requirements for children during placement including therapeutic treatment

requirements.

Section 75-03-17-06. Section 75-03-17-06 is amended to clarify expectations regarding a facility's use of special treatment procedures.

Sections 75-03-17-07 and 75-03-17-09. Section 75-03-17-07 and 75-03-17-09 are amended to clarify language on medical care requirements and general health requirements, respectively.

Section 75-03-17-10. Section 75-03-17-10 is amended to revise the annual training requirements for staff.

Section 75-03-17-12. Section 75-03-17-12 is amended to revise discharge planning requirements for children.

Sections 75-03-17-13 and 75-03-17-14. Section 75-03-17-13 and Section 75-03-17-14 are amended to clarify language.

Section 75-03-17-15. Section 75-03-17-15 is amended to add a minimum requirement of the staff-to-child ratio during awake and sleeping hours along with night time bed checks.

Section 75-03-17-16. Section 75-03-17-16 is amended to clarify language, to revise the language on what constitutes a direct bearing offense, and to address minimum standards regarding the use of staff.

Section 75-03-17-16.1. Section 75-03-17-16.1 is amended to add a new subsection to require annual training on child abuse and neglect reporting for all staff.

Section 75-03-17-18. Section 75-03-17-18 is amended to revise standards for locking outbuildings on the property or campus of the facilities.

Section 75-03-17-20. Section 75-03-17-20 is amended to clarify language allowing the department to conduct licensure reviews.

Section 75-03-17-21. Section 75-03-17-21 is created to address the procedure for increasing or decreasing the number of licensed beds in a psychiatric residential treatment facility in response to 2013 Senate Bill No. 2068.

7. No written requests for regulatory analysis have been filed by the Governor or by any agency. The proposed amendments are not expected to have an impact on the regulated community in excess of \$50,000. A regulatory analysis was prepared and is attached to this report.
8. A small entity regulatory analysis and small entity economic impact statement were prepared and are attached to this report.
9. There is no anticipated fiscal impact resulting from the implementation of the proposed amendments.
10. A constitutional takings assessment was prepared and is attached to this report.
11. These rules were not adopted as emergency (interim final) rules.

Prepared by:

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Legal Advisory Unit
North Dakota Department of Human Services
March 11, 2014



Jack Dalrymple, Governor
Maggie D. Anderson, Executive Director

**SUMMARY OF COMMENTS RECEIVED
REGARDING PROPOSED AMENDMENTS TO
N.D. ADMIN. CODE CHAPTERS 75-03-16 AND 75-03-17
LICENSING OF GROUP HOMES AND RESIDENTIAL CHILD CARE FACILITIES AND
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN**

The North Dakota Department of Human Services (the Department) held a public hearing on December 27, 2013, in Bismarck, ND, concerning the proposed amendment to N.D. Administrative Code chapters 75-03-16 and 75-03-17, Licensing of Group Homes and Residential Child Care Facilities and Psychiatric Residential Treatment Facilities for Children.

Written comments on these proposed amendments could be offered through 5:00 p.m. on January 6, 2014.

Eleven individuals attended the public hearing. Three written comments were received within the comment period. The commentors were:

1. Dave Marion, 7785 St Gertrude St Raleigh, ND 58564
2. Don Pittman, 1102 7th Ave East Williston, ND 58801
3. Jay Johnson, 16351 I94, Sentinel Butte, ND 58654
4. Gayle Klopp, PO Box 1995 Bismarck, ND 58502
5. Jim Vetter, 1227 N 35th St Bismarck, ND 58501
6. Tim Eissinger, 3512 43rd Ave S Fargo, ND 58104
7. Diane Szudera, 16351 I-94 Sentinel Butte, ND 58654
8. Lynn Flieth, 413 3rd Ave North Wahpeton, ND 58075
9. Jane Brown, 1227 N 35th St Bismarck, ND 58501
10. Mary Weiler, 1505 5th Ave S Fargo, ND 58103
11. Susan Gerenz, 2600 Manchester St, Bismarck, ND 58504
12. Teresa Larsen, 400 East Broadway Suite 409 Bismarck, ND 58501

SUMMARY OF COMMENTS

Comment: Most of the changes do a lot to clarify language, ensure continuity, and work to enforce best practice when working with the adolescent populations we serve.

The following is input on two specific proposed rule changes we ask you to consider on the proposed amendments of North Dakota Administrative Code Chapter 75-03-16, specifically is the 2.6, Increase or Decrease Bed Capacity. The RCCF Association feels that only allowing a facility to request a bed capacity change at the time of license renewal or in the event of natural disaster is too restrictive. Adding this language along with the need to provide a projected 12-month budget when increasing or decreasing bed capacity does nothing to ensure the safety of the staff and residents or ensure best practice are followed by the facility. In fact, adding these stipulations could put a facility in the position where they have to decide between the best interest of the kids or the viability and the future of the facility. In the past 20 years, the reason bed capacity changes were made by our facilities was to not fall below the

mandated 75 percent occupancy that is currently in 75-03-15. Although this chapter is not a part of this hearing, it will be within the next few months and the Department will be proposing to change the 75 percent occupancy to 90 percent, which, if passed, will make it even harder or impossible for facilities to meet the occupancy rate in order to ensure full reimbursement of allowable expenses.

Currently, the language in this proposed rule will tie facilities' hands by restricting the facility's ability to only request a bed capacity – occupancy change in the case of natural disaster or at license renewal time, which is every two years for some facilities and every one for others, depending upon the status of the facility's license. Example of -- examples of other factors that may cause an agency to request a bed occupancy change are: Turnover in residential staff due to availability of higher-paying oil field job. If a facility is not staffed or has a high number of new staff, it is not best practice for the children or staff to be at a high occupancy; In the case of a large number of discharges at one time, it is not best practice for the children or staff to bring in a large number of new residents at the same time. This disrupts the milieu to a degree where it is not beneficial to the new residents or the children currently in placement. New residents need more attention and monitoring; Number three, facilities do not have the ability to strategically plan discharges and admissions to regulate timely discharges with new admissions. All facilities experience, on a regular basis: Children being taken out of placement prior to the proposed discharge dates; accepting a new child and holding a bed for the child only to be notified days or weeks later that the child is not coming. These are only three reasons why a facility may ask for bed capacity change in order to meet the required occupancy rate, all of which are critical to the safety and welfare of the children we serve. Even though we are not addressing 75-03-15's upcoming proposed change in occupancy rate today, this proposed rule is completely and wholly connected to it. At this time, we are respectfully requesting the new proposed rule be amended to read as follows: A facility may not increase or decrease bed capacity without approval of the Department; To qualify for an increase, a facility must be in compliance with this chapter and submit a plan for the use of its beds; Number three, the Department shall review the facility's request and may approve or deny the request considering the programming needed for the beds and the number of beds available.

Response: The ND Department of Human Services appreciates the input and comments received. In regards to the comments made concerning section 75-03-16-2.6, the intent of adding this section is to emphasize the process of how to request a bed capacity change required under the residential bed conversion law passed in 2013 Senate Bill No. 2068 that went into effect on August 1, 2013. The Department's Children and Family Services Division and Mental Health and Substance Abuse Services Division will partner to oversee and administer statewide bed capacity as it relates to the Residential Child Care Facility (RCCF) and Psychiatric Residential Treatment Facility (PRTF) bed pool. The residential bed conversion effort was created to allow flexibility within our state system to convert bed capacity from PRTF to RCCF or RCCF to PRTF when necessary and if beds were available. The intent was not to allow facilities to increase and decrease bed capacity multiple times each year. In response to this comment, however, the Department is willing to allow

additional flexibility in the rule language for facilities to request a licensing amendment for bed capacity and has amended the proposed rule as follows:

75-03-16-02.6. ~~Increase or decrease bed capacity~~ Residential Bed Conversion.

1. A facility may not increase or decrease bed capacity without approval of the department. ~~A facility requesting a bed capacity change shall submit a request and projected twelve-month budget based on predictable funds for the forthcoming year of operation to the department licensor.~~
 - a. ~~At the time of the license renewal; or~~
 - b. ~~In the event of a natural disaster.~~
2. To qualify for a bed capacity increase, a facility must:
 - a. Be in compliance with this chapter;
 - b. Submit a plan for the use of its beds; and
 - c. Submit a projected twelve-month budget based on predictable funds for the forthcoming year of operation as required by subsection 3 of section 75-03-16-04.
3. The department shall review the facility's request and may approve or deny the request considering the programming need for the beds and the number of beds available.

Comment: Under 75-03-16-23, the language we have concern about in Number Three has to do with ensuring the custodian, parent, or guardian of a child in placement must each be informed of benefits, risks, side effects, potential effects of psychotropic medications prescribed for the child. Current practice is to get permission from the custodian, and if the custodian requests that the parent or guardian give permission, facilities will do that. One contact, verbal, followed by written permission ensures the child can be treated without delay following best practices. If facilities are held to getting permission from each parent and guardian, which can be three additional notifications, the child's treatment can be delayed for days or weeks. Some parents and guardians are extremely difficult to contact. The other part of the language we have concern about is the last sentence in Number Three which mandates that when psychotropic medication is prescribed or discontinued for a child in placement, the child's medication regime must be reviewed by a psychiatrist or prescribing medical doctor weekly for the first 30 days. Residential child care facilities are not psychiatric residential treatment facilities. With the exception of one agency who also has PRTFs, RCCFs do not have psychiatrists on staff. All children on psychotropic medications are seen by a licensed medical provider who has the medical authority to prescribe psychotropic medications and are seen regularly by the prescribing medical professional. A facility cannot dictate that medical professionals see children weekly. All facilities do ensure that the medical professional follow-up visits and labs.

At this time, we are respectfully requesting this newly proposed rule be amended to read as follows under 75-03-16-23, Number Three: Facilities shall have policies governing the use of psychotropic medications. The custodian must be informed of psychotropic medications prescribed for the child. Written consent for the use of the medication must be obtained and

placed in the child's file. When psychotropic medication is prescribed or discontinued for a child in placement, the child's medication regime must be reviewed by a psychiatrist or prescribing medical professional as deemed medically necessary.

Response: The intent of the statement, "the custodian, parent, or guardian of a child in placement must each be informed of benefits, risks, side effects, potential effects of psychotropic medications prescribed for the child" is to ensure each of these parties, when applicable, are made aware of the medications side effects and risks. To clarify responsibility further, the Department is willing to change the next sentence of that subsection to read as follows:

"Written consent from the legal custodian must be obtained for the use of the medication and must be placed in the child's file."

This section also referenced the need to have the medication regime reviewed by a psychiatrist or medical doctor weekly for the first thirty days. It is understood that RCCFs have less accessibility to weekly appointments when medication changes occur without a psychiatrist or medical doctor onsite. The intent was not to make scheduling and transportation difficult for facilities, rather to emphasize that facilities have a heightened awareness of the medical needs of the children in placement when psychotropic medication changes occur. Based on this comment, the Department has changed the proposed rule to read,

"When a psychotropic medication is prescribed or discontinued for a child in placement; the child's medication regime must be reviewed by a psychiatrist or medical doctor as determined medically necessary by the prescribing professional."

RCCF occupancy rates are not addressed in this rulemaking project. No change is made in response to this comment.

Comment: We just want to thank you for the opportunity that we can provide feedback on these new proposed regulations. And the proposed changes to Number 75-03-16[-13], A, B, and C, Minimum Staff Employee Requirements, will require us to implement a new night staffing program with a budget increase of approximately \$153,000. And we trust the Department can assist us with this by giving us a rate adjustment as it is a new program for us.

Response: The addition to require awake overnight direct care employees was added to rule. The Department is confident that this rule will only ensure the safety and well-being of children in placement providing additional oversight and awareness. The potential need for this rule has been discussed as a licensing priority for some time. The vast majority of the RCCFs in ND already engage in this practice. The houseparent model is unique and does offer a different perspective to youth in care. However, the increasing acuity of children in RCCF placement concerning behaviors, suicidal ideations, and treatment needs present

great concern to the ability of direct care staff to ensure safety, well-being, and needed oversight when employees are sleeping. To best meet the needs of children in placement this change to require "awake direct care employees" is viewed as significant and will not be changed. No change is made in response to this comment.

Comment: And the second rule I'd like to comment on is the proposed rule 75-03-16-02.6, Increase or Decrease Bed Capacity. And that's a concern to us as we want to be able to have the flexibility to serve our community to the fullest extent possible with our house-parent model, which we think is very unique and effective in shaping the lives and futures of our residents. We have no way of knowing what our daily census will be as there are too many variables. We never know when a child may cause himself to be removed from care or a custodian or court order decides to remove a child for various reasons. Also, discharges are planned for the best interest of the child academically, which sometimes results in several discharges at the same time at semester breaks.

Our recommendation would be that the percentage mandate be suspended entirely as we think all our facilities do all we can to obtain referrals and work with as many children as possible in the context of providing for their safety, well-being, and permanency. We do this with the house-parent model which we employ. And with these issues in mind, the proposed rule seems counterproductive to the efficient use of our facilities for the community and the state, and we would support the request of our RCCF Association spokesman, to remove all of the language in 75-03-16-02.6, Number 1, except the first phrase which states: A facility may not increase or decrease bed capacity without approval of the Department.

Response: The ND Department of Human Services appreciates the input and comments from Eckert Youth Homes. In response to a previously offered comment, the Department made several changes to proposed section 75-03-16-2.6, which the Department believes address the concerns raised in this comment.

Comment: Obviously, we're very much in support of everything that [the ND RCCF Coalition] had to say, but I have some additional comments as well. Regarding Rule 75-03-16-02.6, Increase or Decrease in Bed Capacity, although this section deals specifically with changing our license only during license renewal time, it is directly tied to the future proposed change to amend our required occupancy rate in order to receive full payment of our care rate. And although I say full payment, what we receive in our care rate covered only about 75 percent of our total cost of operation last fiscal year. When you deduct the unallowable expenses such as our fund development, on-site classroom, our working ranch, which is a valuable part of the therapeutic care to the kids, we had to raise over \$700,000 last fiscal year to cover operating costs. That is why, when we are challenged with another possible cut to payment for care provided, we must strongly object.

[Our] board of directors asks that the language regarding making changes to the facility license only during license review be omitted and language be added that allows facilities to

increase and decrease their license based on the ebb and flow of their population, especially if this rule regarding a 90 percent occupancy is enforced and variances in occupancy rates are only allowed for a natural disaster. [We do] not want to be put in the position where we're forced to decide whether we shall take children that are inappropriate for our facility's care or risk being financially punished to the point of an inability to finance our current level of therapeutic program that is in the best interest of the children we serve or even the future survival of [our facility] as a residential care facility.

Response: In response to a previously offered comment, the Department made several changes to proposed section 75-03-16-2.6, which the Department believes address the concerns about that section raised in this comment.

The other concern raised in this comment is relative to RCCF occupancy rate requirements. RCCF occupancy rates are not addressed in this rulemaking project. No change is made in response to this comment.

Comment: 75-03-16-29(13)(b) – We would suggest that the term “non-ambulatory” be clarified. For example, we have heard the phrase “a child who is ambulatory with the aid of a walker”. For the purpose of these rules and for safety reasons, a child who uses such equipment should also not sleep above or below the ground floor. “Ambulatory” should be specific to a child who can move independently without the use of another person, equipment or a device.

Response: This term is not being addressed in this set of rules. This request may be discussed in conjunction with a future rulemaking project.

Comment: 75-03-16-19(1) – Sentinel event definition. We discussed the definition and it appears to be consistent with the CMS definition.

Response: No change is requested in this comment.

Comment: 75-03-16-23(3) – Medical care. We would suggest that this section add “alternative treatments” to the section regarding “benefits, risks, side effects, and potential effects. The guardian, custodian, or parent being informed of alternative treatments is also a necessary part of informed consent, so we believe “alternative treatments” should be added.

Response: The Department believes that it is the responsibility of a prescribing medical professional to discuss alternative treatments before the prescription is written; not the responsibility of the administering facility to offer alternatives after the prescription is written. The intent of the proposed rule is to inform all parties of the use and possible effects of the use of certain medications prescribed by a prescribing medical doctor or psychologist. If the consent is not granted by the custodian of the child in placement, the discussion to offer alternative medications or non-medications is determined in a joint effort by the custodian, facility and the prescribing professional. No change is made in response to this comment.

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Comment: On the 16 category, I do agree with everything that my counterparts have said, so [we do] support the changes there.

Response: No change is made in response to this comment.

Comment: 75-03-17-01 (10) (f) Current code does not include LMFTs and LPCCs as defined under "Mental Health Professional". Consider adding these higher licensures as many mental health professionals are licensed as this as the licensure requirements are more stringent than LPC.

Response: This definition is not being addressed in this set of rules. This request may be discussed in conjunction with a future rulemaking project.

Comment: 75-03-17-02 (1) (d) Specify/define what "Comprehensive Plan" includes.

Response: A comprehensive plan in this context would be a plan for the implementation of all policies and procedures required by this chapter. The Department has changed the word "comprehensive" to "detailed", in response to this comment.

Comment: 75-03-17-03; exceeds National Accreditation Standards. The governing bodies – Board of Control; Board of Directors are volunteer participants and provide oversight.

Two other commenters agreed with this comment.

Response: The Department is not sure what this comment means. Presumably, it relates to the changes to subsection 1 setting forth the governing body's responsibility. Upon further review of the proposed change, the Department is removing the proposed language as the responsibilities of the governing body of a facility are set forth in the remainder of subsection 1 of section 75-03-17-03.

Comment: On the 75-03-17, the PRTF rule, I guess I'm more asking for some clarity and having some questions on what some of the rules are. On page 20, in section 12, under 75-03-17-03, there's a line in there about quality assurance: The applicant shall implement a quality assurance program approved by the Department for assessing and improving the quality of services and care provided to residents. My question for clarity would be, is that the Cbs process?

Response: Yes, this is the Community Based Standards outcome measurement process (CbS). No change is made in response to this comment.

Comment: The Department received the following comments on the proposed addition of subsection 6 of 75-03-17-03 related to occupancy rates:

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1) Number 6, which is also on page 20, talks about occupancy rates, which in there says, in order to progress to the 90 percent occupancy rate, a facility must demonstrate 80 percent occupancy rate by July 1st, 2014. So my question would be: Is that -- what's the time spent on -- did that already start June 30th of 2013? Or what's the measurement of that? My question really is, I was just -- because if we have to have 80 percent by July 1st of 2014, what the period of measurement is.

2) We respect and desire to meet the expected occupancy rates as noted with provisions/exceptions where an open bed is "person-center" and the facility is not harmed by meeting the need of those in need of services.

Two other commenters agreed with this comment.

3) Disagree with a provision to provide exception in the event of catastrophic event or national disaster (i.e. Flood of 2011)

Two other commenters agreed with this comment.

4) The impact for each locations of 16 licensed beds, the intent of regulation would require that for each 16 bed program, to meet the utilization standards we would need 14.4 bed occupied at all times. Each facility is limited to 16 beds per location per PRTF regulations. With this rule, we would not be able to provide a continuum of care within the healthcare system as we would not be able to "save" a bed for any pending/planned admissions, have an open bed, either via a planned or unplanned discharge, the child is referred and accepted pending insurance/payor. For example, related to systems beyond our control we are not capable of same day admissions as in a hospital. Cannot admit a referral the day of application related to the needed and supporting documentation that approves the care such as "CON" – Certificate of Need that is required for Medicaid. Typically requires three days for completion, submission and response. Private insurers each have their own preauthorization requirements. The recommendation is to provide provisions in this rule that are "person-centered" when a bed is not utilized.

Two other commenters agreed with this comment.

5) Biennial Approval – decreases the ability to be flexible to meet the changing needs of our state. The anticipated outcome, if we didn't meet the anticipated utilization percentage would be to decrease licenses and capability to provide services would be diminished for two years with an expected outcome of sending more children out of state.

Two other commenters agreed with this comment.

Response: While the Department is committed to adopting an occupancy rate standard, it has decided to remove this proposed subsection from the rules at this time while it explores ways to address the situations and concerns raised by the commenters. . The occupancy rate standard will be presented in a future rulemaking project.

Comment: 75-03-17-04: Admissions 2. (a) Please consider clearer indication of what specifically is needed prior to admissions.

Response: The Department believes the criteria of what is needed prior to admission are clearly set forth in subsection 2 of section 75-03-17-04. No change is made in response to this comment.

Comment: 75-03-17-04: Admissions Access to third party information for CON's

Response: The Department is uncertain what this comment means as there is no reference to Certificate of Need (CON) in section 75-03-17-04. The CON requirements are federal requirements and each facility should work with the third party to determine appropriate access to information. No change is made in response this comment.

Comment: A question on page 23,75-03-17-05, Number 1, Duties of Facility, it says up there: Provide for medical and psychological assessments of each child within 72 hours of admission and thereafter as needed by the child. Our current practice is that our RNs do that assessment of the child when they first come in. And my question would be if that is going to continue to be an acceptable practice moving forward, or is there – it doesn't say what provider does that, so –

Response: The use of Registered Nurses in this capacity is an acceptable practice. No change is made in response to this comment.

Comment: 75-03-17-05(1)(b) What is and is not considered secure methods of therapeutic telemedicine?

Response: The Department may not advise a facility of which method of telemedicine to use; rather, it is a requirement that the method chosen be compliant with the Health Insurance Portability and Accountability Act, and that it safeguard confidential information. No change is made in response to this comment.

Comment: 75-03-17-05(1)(g) Please consider clearer naming this an assessment as opposed to treatment plan.

Response: This is not another assessment. The referenced requirements set forth the expectation for creating a treatment plan that is based on the individual needs and assessments of the child. No change is made in response to this comment.

Comment: Page 24, H, on the top of the page there, under the same section [75-03-17-05(1)], it's more of a concern than a change, but: Therapeutic leave such as weekend overnight visits or day passes with the family will be documented in the child's case file and be tied to family therapy and therapeutic goals of the child and family. My concern with that one is that many of the kids we have in the PRTF level right now are private-pays or they and their parents are the referral, and the parent in some of them are -- have the ability to take kids and create home visits and those types of things that are probably within our -- without our recommendations. So just some -- if there's a way to clarify that in some way that therapeutic leave -- how would we document then that parents are kind of making the decision, because they don't have a legal referral because the parent is a legal guardian? So that's a concern we have with that rule.

Response: There is no intent to differentiate between referral sources on the therapeutic leave and documentation guidelines; however, the Department recognizes the concern identified above and how the proposed language could be problematic in the described scenarios. Accordingly, the Department is revising the proposed language to read as follows:

- h. Therapeutic leave such as weekend overnight visits or day passes with family must be documented in the child's case file and be tied to family therapy and therapeutic goals of the child and family, or it must be documented in the child's case file why weekend overnight visits or day passes are not tied to therapy and therapeutic goals of the child and family.

Comment: 75-03-17-06 – The proposed changes to the “special treatment procedures” section appear to be constructive. However, to be consistent with licensure requirements of facilities serving individuals with intellectual disabilities, and for safety reasons, P&A would strongly encourage DHS to prohibit the use of prone restraints in all facilities/programs that it licenses. Studies have shown that this can be an especially dangerous technique to use with children. We agree with the new language requiring that all deaths be reported to P&A. We also agree with the language that stresses least restrictive measures be tried and documented in the area of physical restraints and believe this should also apply to time out, physical escorts, and seclusion. It is suggested that this language be placed throughout this section or as a broad statement to clarify that least restrictive techniques should be attempted prior to any of these procedures.

Response: While the Department agrees that consistency among licensing requirements is preferred where appropriate, it also recognizes that not all facilities have comparable clients they serve, so not all requirements will be appropriate as to all facilities. The Department believes it has added language throughout this section, as appropriate, that clarifies that least restrictive techniques should be attempted. No change is made in response to this comment.

Comment: 75-03-17-06: 1. Time out Based on best practices the resident's bedroom may be the least restrictive intervention and an appropriate coping mechanism as defined in the person-centered treatment plan.

One other commenter agreed with this comment.

Response: To move toward creating trauma-informed psychiatric residential treatment facilities and reducing serious occurrences, such as suicide attempts, which may occur in the bedroom of a child when the child is in there for a time out, it is the Department stance the bedroom is an inappropriate use for time out. No change is made in response to this comment.

Comment: 75-03-17-06: Include definition of time away.

Response: "Time away" is not used in these rules. No change is made in response to this comment.

Comment and Response: While no comment was offered at the hearing and no written comments were received on subdivision b of subsection 3 of section 75-03-17-06, it was called to the Department's attention that the term "safety hold" is outdated and inconsistent with the terminology used in the rest of subsection 3. The appropriate term would be "restraint". In response to this concern and because it is not a clarification and not a substantive change, the Department is changing subdivision b of subsection 3 of section 75-03-17-06 as follows:

- b. All ~~safety holds~~ restraints must be applied by staff trained who are certified in the use of ~~safety holds~~ restraints and emergency safety interventions; and

Comment: The Department received the following comments on subsection 4 of section 75-03-17-06 dealing with "Seclusion":

- 1) On page 27, under seclusion, under special procedures, the question was on C, the statement, new rule is: The seclusion room is not locked. So my concern is, if you can't lock a seclusion room, then you won't really -- there's no safe way to do a seclusion then. So the question had been, when we talked earlier, is something like a mag lock or a different style of lock preferable or able to be substituted for the word "not locked." So our concern is not being able to lock is dangerous for staff.
- 2) 75-03-17-06: 4. C. Seclusion Room Current practice is our seclusion rooms have the ability to be locked with constant staff monitoring. Newer facilities have a push button locking systems. \$10,000 to convert manual locking system to a "push" button locking system. Current policy and procedure is that two staff are present to monitor the youth while in seclusion. The locked door is used to contain an out of control youth to

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provide protection to other youth and staff. Seclusion room intervention is only implemented for an out of control resident where the risk of injury to self or other residents are imminent. The inability to not be able to lock the door will result in greater resident injury and more admissions to acute care psychiatric units.

- 3) 75-03-17-06: 4. C. Seclusion Room Not applicable – Luther Hall’s time out rooms are not locked. Staff are present at all times and continuously observing while residents are in the time out room.
- 4) 75-03-17-06: 4. C. Seclusion Room They are prepared to replace two push button locks in their seclusion rooms. Due to imminent danger of children and others it may be important to have the availability of containment for safety purposes, such as runaway and multiple assaults to other children. Seclusion is far safer than restraints.

Response: The seclusion room is to be used as a last resort after all other trauma informed, less restrictive interventions have been unsuccessful and there is immediate risk of safety or harm to the youth and others. As a safety measure the door of a seclusion room if equipped with a locking device, must be one that is push button in nature that requires constant pressure on the device by staff to keep the door locked. This will require the staff to be in the proximity of the child to allow for visual and auditory contact with the child at all times. When the button is released, the door becomes unlocked. To include this option, the Department has revised subdivision c of subsection 4 of section 75-03-17-06 to read as follows:

- c. The seclusion room is not locked, or is equipped with a lock that only operates with staff present such as a push-button lock that only remains locked while it is being pushed;

Comment: 75-03-17-06: 7. B. Accreditation Notification To adhere to accrediting standards for any serious occurrence.

One other commenter agreed with this comment.

Response: The Department is uncertain what this comment means. The Department believes each facility must adhere to the standards of its accrediting body. No change in made in response to this comment.

Comment: The Department received the following comments on the proposed changes to subdivision d of subsection 9 of 75-03-17-07 related to consent for the administration of medications:

- 1) Page 31, Number 1, (d)(1): The facility shall obtain written consent from a person who lawfully may act on behalf of the child for newly prescribed medication. Our concern is that currently we would get a verbal consent similar to what is written in Number 2, verbal consent or e-mail consent and followed by a letter. Our concern with Number 1

is that if we have to have a written consent in the file when returned, that it may delay quite a bit of their treatment, because a lot of parents and -- most parents are wonderful. I just want to say some parents and some referrals don't get us the information back quick enough, so it would delay that. Our preference would be that it would be more like Number 2, where the facility shall obtain verbal or e-mail consent and then follow up with written consent.

- 2) On page 31 and 32, I have some confusion with Number 4, because there's a medication -- Number 1, 2, and 3 lay out medication procedures, but then Number 4 lays it out again but only mentions psychotropics. So is there a distinction being made between psychotropic meds and regular meds? I know if you want to make a nurse in our program livid, tell her psychotropic meds are important and the other meds aren't. That's -- for us, we like to keep it at -- you know, as one consistent documentation for medications and for psychotropic medications, but the two kind of counter each other. So I don't know if there's an intent to have a psychotropic policy different than a regular medication policy. And then the first one allows verbal and e-mail consent for dosage changes and the second one only allows written consent for dosage changes, so the two are contradictory to each other, in my opinion.
 - 3) d. 2 and d. 4 are contradictory. Suggest a verbal consent followed by the written consent.
 - 4) Current practice is to allow verbal informed consent, followed by written consent when starting a medication. The requirement to require written consent would delay the start of treatment. For example, to start an antibiotic could create an emergent condition.
 - 5) Agree with [prior comment]. Concern with ability to obtain a written consent prior to making any changes whether up or down including discontinuations;
 - (1) Which requires written consent for all new meds.
 - a. The issue with this is it states it can be given in emergency situations (what does this mean by definition); we are not able to use medications for a chemical restraint which this could be construed as.
 - (2) States verbal consent will work for changes with written in 14 days.
- All psychotropic changes whether up or down or discontinuations require written consent prior to administering the change. This is a problem because a decrease in a medication should be able to be administer because the prescriber has stated it needs to decrease, which puts us in a professional dilemma especially with parents who are uninvolved in treatment or we need to rely on regular mail for correspondence due to where they live in the state.
- 6) A delay in receiving written consent will delay medical treatment which will increase length of stay.

Response: It is expected that each facility will comply with 42 CFR 483.350-483.376 in its use of restraints, including chemical restraints. The cited federal regulation includes provision for the use of restraints in an emergency situation. In response to this comment, the Department changed the rule as follows:

- d. (1) The facility shall obtain written consent, including via electronic mail, or shall obtain verbal consent witnessed by another person, from a person who lawfully may act on behalf of the child prior to administering:
- (a) A newly prescribed medication to the child except in an emergency situation,
 - (b) A psychotropic medication, or
 - (b) A medication dosage change.
- A person who lawfully may act on behalf of the child who receives medication must be informed of benefits, risks, and the potential side effects of all prescribed medication. The facility shall obtain written consent within fourteen days verifying verbal consent received. The facility shall document and file all consents in the child's case file.
- (2) The facility shall have-institute policies and procedures governing the use of psychotropic medications. A person with lawful authority to act on behalf of a child who receives psychotropic medication must be informed of benefits, risks, side effects, and potential effects of medications. Written consent for use of the medication must be obtained from that person and filed in the child's record, which require documentation in the case file justifying the necessity and therapeutic advantages for the child receiving psychotropic medication. Documentation must reflect that a trauma screen has been completed and that the symptomology that the psychotropic medication is attempting to treat is not more effectively treated through therapeutic interventions that specifically address symptomology related to trauma.

Comment: The Department received the following comments on the proposed changes to subdivision e of subsection 9 of 75-03-17-07 related to administration of the abnormal involuntary movement scale:

- 1) On page 32, DBGR has a concern with E on the top: Additionally, facility's nursing staff shall complete an abnormal involuntary movement scale... An abnormal involuntary movement scale will be repeated every seven days following the completion of an initial abnormal movement scale. Our concern for both our nursing and our doctors, that that's not a best practice to do it that often, every week. Right now, we would do one before they start the med and then every 30 days or more if needed. But doing

every kid every seven days, it would seem they get a little test savvy and they kind of figure out what we're doing with them, so I don't know. Best practice generally is 30 to 90 days for doing the AIMS or the DISCUS, which is also in there. And generally, the AIMS is only done with neuroleptics or antipsychotics and not all psychotropics, so – so that's just a distinction, if we could take a look at that, because it would be more antipsychotics, and then less frequent, was our concern with that one.

- 2) RN staffing cost required to perform assessment that may not be medically necessary. Best practices indicate that the assessment frequency is on the initial and every three months. (Additional cost would be approximated at \$30/assessment).

One other commenter agrees with this comment.

- 3) abnormal involuntary movement scale should specify neuro-leptics rather than all psychotropics. Discuss scale or other similar scales should be allowed. Concern that weekly testing will make the youth “test” savvy. Initial nursing assessment and completed monthly thereafter.

- 4) Revised to indicate that nursing staff complete the appropriate tests per best practice standards and guidelines. The proposed verbiage limits the ability to maintain best practice standards for newer generation psychotropic medications.

One other commenter agrees with this comment.

Response: In response to the comments on subdivision e, the Department has changed the rule as follows:

- e. Upon admission, when a new psychotropic medication is prescribed, and when a psychotropic medication is discontinued, a child's psychotropic medication regime must be reviewed by the attending psychiatrist every seven days for the first thirty days and every thirty days thereafter. Additionally, the facility's nursing staff shall complete an involuntary movement assessment prior to the start of, or a change in the dose of, a psychotropic medication. An involuntary movement assessment must be repeated every three months, or sooner if determined necessary, following completion of the initial involuntary movement assessment to monitor the child for side effects of the psychotropic medication.

Comment: 75-03-17-09: 1. Sleep Recommend deleting the word “Must.” It would be difficult to comply with this regulation as there are events where a child may not be able to sleep but would be encouraged to rest unless medicated.

Two other commenters agreed with this comment.

Response: This is not a substantive change; it has been made to comply with legislative drafting form and style. No change is made in response to this comment.

Comment: The Department received the following changes on subdivision a of subsection 2 of section 75-03-17-10 related to staff training:

- 1) On page 33, under 75-03-17-10, Number 2, just a little -- letter A, there's "therapeutic crisis intervention and crisis prevention intervention," and I believe that should be an "or", because they're -- one serves the same as the other. And then under universal infection control precautions, the CDC no longer uses that line. They use standard precautions, they call it, so it would be more up to date with that. That would be a better -- or we'd recommend having standard precautions than universal infection control, because that's an outdated term.
- 2) "Universal infection control" to be changed to "standard precautions" to meet CDC verbiage.
- 3) And then the definition of that same number -- or letter A is, prior to having direct contact with residents, all this training is required. Our concern is that a sizeable place ... we may only hire two staff in a six-week period, so it would be hard for us to have all those trainings prior to them having direct contact with the kids. That's about, you know, 30, 40 hours of training and we'd only have one or two staff, kind of. We don't have enough critical mass to do some of that training. So we would ask that maybe something like a shadowing or a training period or something where they could actually get on the -- they wouldn't have to be one-on-one with kids or be counted in their count, but they could have some shadowing ability or some ability to learn things while they're doing the training.
- 4) Current practice is that staff are in an "orientation" phase until training is completed this is in alignment with other healthcare practices. This requirement would create challenges with hiring employees and retaining new employees. The labor market is very tight and it is difficult to recruit staff. When a staff is hired, we want to have them on the payroll as soon as possible. Best practice for crisis prevention intervention is a 16 hour class; however it is recommended to have a minimum of three students. For our smaller facilities where we hire less staff per month, it may extend the ability for the employee to start orientation for greater than 30 days.

One other commenter agreed with this comment.

- 5) Recommend that training be done within 30 days of hire versus prior to actively working with residents. Please note that Mandatory Child Abuse and Neglect Training is always completed prior to staff working with residents. Please clarify that TCI and CPI training are not both required and that the verbiage states "or" instead of "and".

- 6) Orientation staff are always under the supervision of experienced staff and are never left alone with the children.

Response: The Department agrees and will make changes so that subdivision a of subsection 2 will read as follows:

- a. All staff members on duty must have satisfactorily completed annual training on current first aid, therapeutic crisis intervention or crisis prevention intervention, suicide awareness and prevention training, standard precautions as used by the centers for disease control and prevention, and cardiopulmonary resuscitation training and have on file at the facility a certificate of satisfactory completion prior to having direct contact with residents. A staff member who is in orientation status, who has successfully completed the background check, and who is in the process of completing the required trainings may be allowed to job shadow with a staff member who has a minimum of one year of experience at the facility and who has successfully completed all of the required training. The facility that ensure that staff who are in orientation status are always under the supervision of experienced staff and are not left alone with the children until all required training has been completed.

Comment: 75-03-17-10: 3 e Please clarify what youth-guided, family-driven plan of discipline entails.

Response: Youth-guided, family driven is when the youth and family have an active part in the person-centered treatment planning for the child's care at the PRTF level of care. This was covered at the October 28 & 29, 2013 Trauma Informed Care & Transformation Towards Positive Outcomes training to which each PRTF sent a team of staff members to create trauma-informed facilities. No change is made in response to this comment.

Comment: On page 35, Number 3, again, it talks about: The discharge committee will review and approve each discharge from a facility prior to discharge. The discharge committee must include..., and a list of people. But our concern we have is that the CON process, a number of times the date that a child leaves or when a child leaves is determined more by the outside entity of the Certificate of Need process than it is by some of our committee, so just some thought on how we could get the CON process to intermingle with the discharge, with that. And also with that, the new regulations don't mention anywhere in there the CON process and how that interacts, because CONs will sometimes delay admissions or it will have a kid discharged sooner than we'd like, or that, and it also has a lot to do with – hitting 90 percent is going to have a lot to do with kind of CON, so there's just no mention of the CON process in the new regulations and how that could affect or stymie what we do.

Response: The CON is a federal process facilities are required to follow for payment purposes. No change is made in response to this comment.

Comment: 75-03-17-12 Address unplanned discharges.

Response: While there may be an occasional unplanned discharge, each facility needs to have a discharge committee that reviews and approves each discharge plan to work towards successful discharges to reduce recidivism. The rule requires discharge planning to start the very first day of placement. The interdisciplinary teams at the PRTF level of care should be continually reviewing and planning for discharge from the first day the youth is placed at the PRTF level of care to the discharge date from the facility whether it is planned or unplanned. No change is made in response to this comment.

Comment: The Department received the following comments on section 75-03-17-15 related to staff to child ratios:

- 1) On page 37, we have a concern with how it's written, the A, B, C, and D for staff ratios, not necessarily the staff ratios, because we have -- we meet those ratios, but the "must be present," I don't know what that means exactly. Because if I have 15 kids and one staff takes a kid to a dentist appointment, then I would have four staff and 14 kids. Would that put me out of compliance, or is it kid -- staff that are on duty or scheduled or -- because we meet the 5-to-15 for people on the schedule working, but there won't necessarily be that ratio at times in the building if someone is at a dentist appointment or takes a kid downstairs to cool off in a gymnasium. So the way it's written in RCCF regs is more that they will be on duty or they will be in shift. And "must be present," if it's interpreted just exactly as it's written, we'd have to add quite a number of staff and be probably a half million to a \$900,000 cost for us.
- 2) 75-03-17-15: 1. Staff to child ratio This proposed change should be similar to the RCCF legislative proposal. This standard promotes individual person-centered treatment plans. The challenge with this staffing standard is the verbiage "direct care must be present". Direct care is not inclusive of all the other disciplines that are involved in the care of the residents such as professional staff such as licensed therapists, nurses, case managers, occupational therapists, teachers who are present and provide direct care. The cost for [us] to maintain this level of "direct" care staff would be minimum of \$744,600 for the first year. We have three different facilities with 16 beds at each location. Our utilization has been near 90% and therefore we would need to hire additional FTE's to meet the standard of thirteen and sixteen residents. Our staffing patterns are now based on a mix between minimum number of staffing and individual resident needs.
- 3) Although [we] only [have] one location, we share similar concerns [to those expressed in the preceding comment] in relation to budget. The state may need to consider increasing higher rates if these statutes are implemented.

- 4) Staffing is based on individual's needs, "must be present" may preclude the ability to send children to medical appointments, etc.
- 5) And then on Number 2 just below that, again, we have a concern with the: Evening staff shall perform bedroom checks at a minimum of every 15 minutes to assure the child is in her room and safe. We do bedroom checks, but even our 30-minute checks, some of the children find that to be quite intrusive, to be going in their rooms and checking and making sure they're okay. Every 15 minutes would be pretty hard for some of our kids to get a good night's sleep. We do have procedures in place for anyone that's on, like, a high observation or a suicide watch; that would be that frequent, or a continuous line-of-sight. But requiring every kid's door to be opened and staff to walk in and check those kids every 15 minutes would be disruptive to their sleep, in our thoughts. So if we can maybe -- that's just one of our concerns. The kids voiced that concern, too. When I showed them some of the regulations, they thought 15 minutes was a lot for staff to come in. But there are cases where that is needed, but some kids would have a hard time with that.
- 6) 75-03-17-15: 2. Bedroom Checks_Room checks should be based on "person centered" treatment plans. For residents that are determined not to be at risk for self-harm or elopement; this interrupts their sleep pattern.
- 7) [We] currently [conduct] 15 minute room checks both during the day and at night. Additionally, bedroom doors are required to be open at night.
- 8) [We conduct] 15 minute room checks.

Response:

1. If a person centered treatment plan requires a specific staffing ratio for a youth's safety and care the facility is required to provide that level of supervision (1:1).
2. Direct care staffing ratios are for residents who are not in school. Direct care staff are the staff who are responsible for working directly with the youth when they are not in school to achieve the activities of daily living whether it be waking them up, getting them ready for school, to breakfast, to the nurses station, assist the youth with navigating through their daily tasks, groups meetings, appointments etc. Direct care staff provides supports, therapeutic environment and behavioral plans in partnerships with clinical staff to enhance the quality of life for the children placed at the PRTF level of care.
3. The staff to child ratio in 75-03-07-15 is based on the staff to child ratio from the Council on Accreditation for Residential Treatment Services.
4. To minimize the level of safety risk at the PRTF level of care the department will maintain the requirement that bedroom checks be at a minimum of every 15 minutes. The checks do not need to be intrusive and do not interrupt a child's

sleep, but they are intended to ensure the presence and well-being of the children in the facility.

While some of the concerns presented can be resolved through planning and time management, such as scheduling more than one child for an appointment offsite to maintain the proper staff to child ratios where the children are, the Department agrees that the changes as written require the presence of direct care staff. The intent is for other qualified staff to be able to assist on those occasions where direct care staff are spread too thin because of offsite errands or appointments with children. Accordingly, the Department changes section 75-03-17-05 to read as follows:

75-03-17-15. Staff to child ratio.

1. The ratio of staff to children during must meet the standards of the facility's accrediting body and be included in the facility's policies and procedures. The facility shall follow the staff to child ratio set by its accrediting body, or the ratios set forth in this subsection, if the ratios set forth in this subsection require a greater number of staff to children than the ratios set by the accrediting body. The staff to child ratio for waking hours is dependent on the needs of the children and the requirements of the individualized individual person-centered treatment plans, but may not be less than two:
 - a. Two direct care staff members or a combination of no fewer than two direct care staff and other staff qualified to provide direct care must be present for one to six residents.
 - b. Three direct care staff or a combination of no fewer than three direct care staff and other staff qualified to provide direct care must be present for seven to nine residents.
 - c. Four direct care staff or a combination of no fewer than four direct care staff and other staff qualified to provide direct care must be present for ten to twelve residents
 - d. Five direct care staff or a combination of no fewer than five direct care staff and other staff qualified to provide direct care must be present for thirteen to sixteen residents.
2. At night, from 10:30 p.m. until 6:00 a.m., the ratio of staff to children is dependent on the needs of the children and the requirements of the individualized treatment plans and must meet the minimum standards of the accrediting body. All night staff must be awake and within hearing distance of children and other staff must be available to be summoned in an emergency. Evening and night staff shall perform bedroom checks at a minimum of every 15 minutes to assure that each child is in his or her assigned room and is safe.
- 2-3. The ratio of professional staff to children is dependent on the needs of the children.

Comment: Page 39, under background checks, Number 8, letter A, [of section 75-03-17-16] the new wording says: The facility shall complete a background check prior to employing an

individual and annually for all employees. Would that be with the current process of background checks? Because that kind of slows us down the way it is already. Now, if we have to do a background check on every -- what does that mean? Can you hire an outside consultant or could you -- and how deep do you want the background check to be? Because the cost of background checks depends upon how deep you dig on each person. The concern is with the current process doing background checks, it gets held up on some of our hiring, so if we have to do it annually for all employees, what does that mean? What does it mean to say the facility shall do it? So we have a concern on that one, how that would play out and how would you get that done quickly.

Response: Upon further review, the Department believes the addition of this language creates a potential ambiguity. In response to this comment and to avoid potential ambiguity, the Department changes this subsection to read as follows:

- 7-8 a. A The facility shall ensure that a prospective employee shall consent to and have completed background checks in criminal conviction records and child abuse or neglect records prior to direct care and contact with children residing in the facility.
- b. All employees of psychiatric residential treatment facilities shall have background checks to determine whether the employee is disqualified from employment under subsection 2.

Comment: And the same on Number 10 [of section 75-03-17-16], same page, 39: The facility shall perform a background check for the reported suspected abuse and neglect each year on each facility. And again, the question would be: How do we make that process happen? Right now we fill out the forms and send them to the Human Service Center or send them in. But again, it was switched to the facility shall perform a background check. And I don't know if we have the ability to do the abuse and neglect checks. We'd have to send them in. Just to make sure that's a timely process that we would understand better. So that was another concern we have with clarity on that one.

Response: This change requires the facility to initiate the review. The request will still be submitted to the Department to determine whether the employee has been recently suspected of child abuse or neglect. The Department proposes changing subsection 10 to read as follows to facilitate this process:

10. ~~The department may~~ The facility shall perform a background check for reported suspected child abuse or neglect each year on each facility employee. Each employee, including direct care staff, supervisors, administrators, administrative, and facility maintenance staff, shall complete a department-approved authorization for child abuse and neglect background check form no later than the first day of employment and annually thereafter to facilitate the background checks required under this subsection.

Comment: The Department received the following comments on section 75-03-17-21:

- 1) 75-03-17-21 License Change Inhibits and organization's ability to be flexible to meet the changing needs of the state of ND.

Two other commenters agreed with this comment.

- 2) Limiting the ability to increase or decrease licenses every two years removes the flexibility to provide services proactively to the changing needs of the person's served needing services. The inability to increase licenses could limit the access to care, with a result of requiring more children to be placed out of state for services that could have been provided closer to their home.

Two other commenters agreed with this comment.

- 3) Please consider clearer definition of statutes to avoid misinterpretation (i.e. Is it required to wait until next licensure renewal period to increase/decrease?).

Response: The residential bed conversion effort was created to allow flexibility within our state system to convert bed capacity from PRTF to RCCF or RCCF to PRTF when necessary and if beds were available. The intent was not to allow facilities to increase and decrease bed capacity multiple times each year. In response to this comment, however, the Department is willing to allow additional flexibility in the rule language for facilities to request a licensing amendment for bed capacity and has amended the proposed rule to read as follows:

75-03-17-21. Increase or decrease in the number of licensed beds in a facility.

1. A facility may not increase or decrease bed capacity without approval of the department. A facility requesting a bed capacity change shall submit a request to the department licensuror. To qualify for an increase, a facility must:
 - a. Be in compliance with this chapter.
 - b. Submit a plan for the use of its beds.
2. The department shall review the facility's request and may approve or deny the request considering the programming need for the beds and the number of beds available.

Comment: I'd like to echo sentiments [of one of the previous speakers] about [our] support of our peers' comments to this point. I just have one additional suggestion that I'd like to offer. In April 2013, the moratorium on expansion of psychiatric residential treatment facility beds was put in place, and that language read that the Department may not issue a license under this chapter for any additional bed capacity for a PRTF unless a needs assessment is conducted by the Department, indicates a need for that licensing of additional bed capacity.

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In some ways, my comments reflect on both 75-03-16 and 75-03-17, under occupancy adjustment, but could there be a consideration of the addition of an annual needs assessment by the Department that could be done in conjunction with and utilizing data from current RCCF and PRTF providers, and using that needs assessment, allowing it to serve as the basis for licensing adjustments over the course of the licensing periods rather than at the one- and two-year periods currently specified? And it would be hoped that that could be useful for both the Department and PRTF, RCCF agencies' strategic planning processes. My apologies if there's a current needs assessment process that I'm not aware of, but we would offer that as a suggestion, as a possible solution to keep it from falling with that one- and two-year interval. Thank you.

Response: Annual needs assessments are not addressed in this rulemaking project; however, the Department would be willing to discuss this idea further in conjunction with a future rulemaking project.

Comment: I would like to provide input and perspective from County Social Services related to modifications of administrative code and policies relating to North Dakota's residential treatment facilities. This perspective reflects the challenges that the custodians of foster children face in accessing services for North Dakota children IN the state of North Dakota.

From a custodial perspective, the flexibility granted by recent legislation for facilities to exchange beds from the group home level of care to the PRTF level of care, dependent upon need, is a welcome change. This flexibility allows facilities to attempt to better meet the needs of children, and in a more timely manner. The proposed changes in identifying that facilities shall grant or deny admission within 14 days, is also appreciated from the custodial perspective. Often times, children in need of residential levels of care are in crisis, failing in the foster home setting, and immediate changes need to be secured for the safety of the child, as well as the community in some instances.

It is understood the changes in Occupancy Rate requirements may cause difficulties for certain facilities, however, it should be noted that North Dakota has higher than national average numbers of foster children seeking residential services out of state. Most frequently, these children are placed in neighboring states, but in certain circumstances, placement needs to occur throughout the U.S. When children are placed so far from home, it makes reunification so much more difficult. Children are unable to have regular contact with their parents, siblings, other relatives, case managers, etc. These connections are vital to their treatment and wellbeing.

There is currently a "foster care crisis" in North Dakota, with a shortage of placements available to children along all spectrums of need...from county foster homes, to therapeutic foster homes, to varying levels of residential treatment. Being in a border county, our agency often times finds success in placing children in Minnesota. There are times when the placements are simply closer to the child's home community (for example, 3 miles away in Breckenridge, MN, versus 250 miles away in Bismarck).

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However, there are other times when we find that providers in Minnesota are more flexible in their treatment models, and will develop programming that meets the child's needs, rather than denying a child that doesn't fit their current programming practices. It is hoped that the increased occupancy rates will make more beds available to serve our kids closer to home, and that increased flexibility in programming will be a secondary outcome.

It would also be the hope, or maybe a better word could be "wish list", of many custodial agencies that there be creative new solutions to ease the 'foster care crisis' when immediate placement changes are needed, specifically, access to clinical assessment beds. In this setting, a thorough assessment could take place which would assist in determining the most appropriate level of care for a child. Too often, children are housed in inappropriate settings while this assessment occurs on an informal level, while waiting for the first available bed.

There are efforts throughout the state by various partners in the foster care system to push for needed changes and greater resources within our state. Examining all placement options in North Dakota is essential to continuing to best meet the needs of our most vulnerable children. Thank you for your consideration.

Response: The Department appreciates the input. No action on the rules under consideration was requested, therefore, there is no change made in response to this comment.

Comment: The Department received the following comments in response to the Regulatory Analysis created by the Department for chapter 75-03-17:

Regulated Cost: Not in excess of \$50,000

75-03-17-15 is an estimated initial annual cost of \$769,000 to meet the "must be present" direct care staff. This is related to adding additional day staff during the school year. It is anticipated that there would be an increase of 5% per year related to benefit and salary adjustment costs. Options to meet this standard would potentially result in decreasing the number of beds available as staff are difficult and challenging to recruit and retain in this market. To offset the cost, we would need to decrease other disciplines such as occupational therapy, recreational therapy, case management. These staffing guidelines would jeopardize individual treatment needs and care of the person centered cared. In order to meet the standard, we currently transport children off campus for a variety of health and therapeutic appointments. The responsibility would need to shift to the guardian (which may be the county case worker, DJS worker or parent). Currently DBGR Foundation supports to the Psychiatric Residential Treatment Programs of Dakota Boys and Girls Ranch approximately \$500,000 for general operating expenses. These funds aren't inclusive of capital equipment or capital improvements.

Two other commenters agreed with this comment.

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[Additionally,] they also take youth to appointments, etc. and term "must be present" should be clarified to allow for this. During school hours, 3 teachers and 2 DSP's are present.

Response: Given the changes made to the rules in response to these comments, in particular in response to the staff to child ratios, the specific concerns stated in this comment should not generate the costs stated in this comment. Many of the requirements being added to the rules are based on existing accreditation standards or existing requirements of the federal certificate of need laws to which PRTFs are subject and under which they must operate.

Prepared by:

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January 29, 2014

cc: Kelsey Bless, CFS
Wendy Borman, MHSA
Debbie Baier, Medical Services

MEMO

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Kelsey Bless, RCCF/LCPA Licensing Administrator, Children and Family Services.

RE: Regulatory Analysis of Proposed North Dakota Administrative Code chapter 75-03-16.

DATE: May 24, 2013

The purpose of this regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08. This analysis pertains to proposed to North Dakota Administrative Code chapter 75-03-16. These amendments are not anticipated to have a fiscal impact on the regulated community in excess of \$50,000.

Purpose

The purpose of ND Admin Code chapter 75-03-16 is to provide directions of compliance for Licensing Group Homes and Residential Child Care Facilities across the state of North Dakota. The proposed amendment to 75-03-16-02.6 is to add a new subsection regarding residential bed conversion and the number of licensed beds in a facility in response to 2013 House Bill No. 2068. The proposed amendments are also to provide updates and clarification to the chapter 75-03-16 since the last update (April 2004) and to comply with federal mandates.

Classes of Persons Who Will be Affected

The classes of person who will most likely be affected by these rules are:

1. Group Homes and Residential Child Care Facilities

Group homes and residential child care facilities will be affected by the proposed amendments. It is intended that these placement providers will receive the clarification needed to provide quality and consistent service across the state. Facilities will be benefitted by the further clarification; it is not intended that facilities be negatively affected by the proposed amendments. However, facilities will need to revise policy and may have to adjust their way of training employees,

how they document and update files, and how often they complete a fire drill with staff and children in placement.

Probable Impact

Providing updates and clarification will positively impact group home and residential child care facilities across the state. Necessary updates and clarification to rule will assist providers in delivering safe, consistent, and quality service to children and families.

Probable Cost of Implementation

There are minimal expected costs to group home and residential child care facilities as some may have to hire additional overnight employees in order to meet the awake overnight staff requirement, others may have to be innovative in how they train their employees.

The projected costs for DHS associated with the proposed amendments would be newspaper advertisements (\$2500) to inform the community of the Administrative Code chapter 75-03-16 amendment process as well as a mailing to inform County Social Services, Division of Juvenile Services, Tribal Social Services, and eleven ND Group Home and Residential Child Care Facilities of the process (\$100).

Consideration of Alternative Methods

The Department could consider no amendment and continue to license group homes and residential child care facilities with the existing rule; however rule would remain outdated and uncertain to providers in areas listed as proposed rule amendments.

MEMO

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Wendy Borman, Children's Mental Health Administrator

RE: Regulatory Analysis of Proposed North Dakota Administrative Code chapter 75-03-17, Psychiatric Residential Treatment Facilities for Children.

DATE: March 21, 2013

The purpose of this regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08. This analysis pertains to proposed to North Dakota Administrative Code Article 75-09.1. These amendments [~~are~~**are not**] anticipated to have a fiscal impact on the regulated community in excess of \$50,000.

Purpose

The purpose of this regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This impact statement pertains to proposed amendments to N.D. Admin. Code chapter 75-03-17. Federal law does not mandate the proposed rules.

Classes of Persons Who Will be Affected:

Licensed Psychiatric Residential Treatment Facilities for the placement of children and adolescents under the age of twenty-one who are in need of twenty-four hour, therapeutic treatment.

Probable Impact

The proposed amendments may impact the regulated community as follows:

The proposed amendment will strengthen the services provided at the Psychiatric Residential Treatment Facilities in North Dakota that will increase the success rates for youth completing treatment.

Probable Cost of Implementation

There are no anticipated costs of the implementation of these rule changes.

Consideration of Alternative Methods

There are no alternative methods.

MEMORANDUM

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Kelsey Bless, LCPA/RCCF Licensing Administrator, Children and Family Services.

DATE: May 24, 2013

SUBJECT: Small Entity Regulatory Analysis Regarding Proposed Amendments to N.D. Admin. Code chapter 75-03-16

The purpose of this small entity regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This regulatory analysis pertains to proposed amendments to N.D. Admin. Code chapter 75-03-16. The proposed amendments do include changes mandated by federal law; one rule change is to incorporate language regarding psychotropic medication use, the other is for criminal background checks rehabilitation year be changed from fifteen to five years as states desire. The proposed amendments include a new section regarding residential bed conversion and the number of licensed beds in a facility in response to 2013 House Bill No. 2068.

Consistent with public health, safety, and welfare, the Department has considered using regulatory methods that will accomplish the objectives of applicable statutes while minimizing adverse impact on small entities. For this analysis, the Department has considered the following methods for reducing the rules' impact on small entities:

1. Establishment of Less Stringent Compliance or Reporting Requirements

Due to the minimal impact and health and safety concerns, the establishment of less stringent compliance or reporting requirements were not considered as appropriate.

2. Establishment of Less Stringent Schedules or Deadlines for Compliance or Reporting Requirements for Small Entities

N/A

3. Consolidation or Simplification of Compliance or Reporting Requirements for Small Entities

N/A

4. Establishment of Performance Standards for Small Entities to Replace Design or Operational Standards Required in the Proposed Rules

The proposed amendments reflect minimum standards of compliance for group homes and residential child care facilities all who partner with Children and Family Services and the Department. North Dakota requires that all group homes and residential child care facilities are visited annually for an onsite review to ensure the facility structure and grounds is meeting minimum standards to care for children in placement.

5. Exemption of Small Entities From All or Any Part of the Requirements Contained in the Proposed Rules

It is expected that all group homes and residential child care facilities will meet the minimum standard of compliance set forth in N.D. Admin. Code chapters 75-03-16 to ensure health and safety of any child cared for or placed by a custodial agency or private provider.

MEMORANDUM

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Wendy Borman, Children's Mental Health Program Administrator

DATE: March 21, 2013

SUBJECT: Small Entity Regulatory Analysis Regarding Proposed Amendments to N.D. Admin. Code chapter 75-03-17

The purpose of this small entity regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This regulatory analysis pertains to proposed [new/amendments to] N.D. Admin. Code chapter 75-03-17. Federal law does not mandate the proposed rules.

Consistent with public health, safety, and welfare, the Department has considered using regulatory methods that will accomplish the objectives of applicable statutes while minimizing adverse impact on small entities. For this analysis, the Department has considered the following methods for reducing the rules' impact on small entities:

1. Establishment of Less Stringent Compliance or Reporting Requirements

The only small entities affected by these proposed amendments are Psychiatric Residential Treatment Facilities licenses by the Department of Human Services. Due to the minimal impact, the establishment of less stringent compliance or reporting requirement were not considered.

2. Establishment of Less Stringent Schedules or Deadlines for Compliance or Reporting Requirements for Small Entities

The proposed amendments will not impact small entities. For this reason, the establishment of less stringent schedules or deadlines for compliance or reporting requirements for these small entities was not considered.

3. Consolidation or Simplification of Compliance or Reporting Requirements for Small Entities

The proposed amendments will not alter in any material way any required compliance or reporting requirements psychiatric residential treatment facilities. For this reason, the establishment of less stringent schedules or deadlines for compliance or reporting requirements for these small entities was not considered.

4. Establishment of Performance Standards for Small Entities to Replace Design or Operational Standards Required in the Proposed Rules

The Psychiatric Residential Treatment Facilities are responsible to meet performance standards as well as operational standards imposed by their accrediting body. For this reason, the establishment of less stringent schedules or deadlines for compliance or reporting requirements for these small entities was not considered.

5. Exemption of Small Entities From All or Any Part of the Requirements Contained in the Proposed Rules

The requirements of the proposed amendments are imposed only on ND licensed Psychiatric Residential Treatment Facilities. For this reason, the proposed rules exempt small entities from all or any part of the requirements contained in the proposed rules.

MEMORANDUM

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Kelsey Bless, RCCF/LCPA Licensing Administrator, Children and Family Services

DATE: May 24, 2013

SUBJECT: Small Entity Economic Impact Statement Regarding Proposed Amendments to N.D. Admin. Code chapter 75-03-16.

The purpose of this small entity economic impact statement is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This impact statement pertains to proposed amendments to N.D. Admin. Code chapter 75-03-16. The proposed rule adjustments does include changes mandated by federal law; one rule change is to incorporate language regarding psychotropic medication use, the other is for criminal background checks rehabilitation year be changed from fifteen to five years as states desire. The proposed rules should not have an adverse economic impact on small entities.

1. Small Entities Subject to the Proposed Rules

The small entities that are subject to the amended rules are:

- *Group Homes and Residential Child Care Facilities*

The following small entities may also be subject to the rule: *N/A*

2. Costs For Compliance

The administrative and other costs required for compliance with the proposed rule are expected to be: *Little cost increase to group homes or residential child care facilities to hire staff to meet the "awake" overnight staff change, however this cost would be considered reimbursable and included in their maintenance rate. Training of all staff could incur some costs for facilities, but most facilities have internal trainers that would not require bringing staff into the facility at a charge to train employees.*

3. Costs and Benefits

The probable cost to private persons and consumers who are affected by the proposed rule: *N/A*

The probable benefit to private persons and consumers who are affected by the proposed rule: *A benefit of the amendments is that the changed to NDAC 75-03-16 will provide clear expectation to group homes and residential child care facilities ensuring safety and wellbeing of children in placement.*

4. Probable Effect on State Revenue

The probable effect of the proposed rule on state revenues is expected to be: *None, there will be no impact on state revenues. Costs for printing and dissemination of amended rules will be provided by the foster care administrative budget.*

5. Alternative Methods

The Department considered whether there are any less intrusive or less costly alternative methods of achieving the purpose of the proposed rules. Those alternatives included: *Continuing to license existing group homes and residential child care facilities with existing rule. The alternatives were not selected because updates and clarification to rules are necessary as it has been eight years since rule was promulgated (April 1, 2004).*

M E M O R A N D U M

TO: Julie Leer, Director, Legal Advisory Unit

FROM: Wendy Borman, Children's Mental Health Program Administrator

DATE: March 21, 2013

SUBJECT: Small Entity Economic Impact Statement Regarding Proposed Amendments to] N.D. Admin. Code chapter 75-03-17.

The purpose of this small entity economic impact statement is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This impact statement pertains to proposed amendments to N.D. Admin. Code chapter 75-02-01.2.

1. Small Entities Subject to the Proposed Rules

The small entities that are subject to the proposed amended rules are Psychiatric Residential Treatment Facilities

2. Costs For Compliance

The administrative and other costs required for compliance with the proposed rule are expected to be: No administrative or other costs are required by the small entities for compliance with the proposed rules.

3. Costs and Benefits

The probable cost to private persons and consumers who are affected by the proposed rule: There will not be probable cost to private persons or consumers for the proposed rules.

The probable benefit to private persons and consumers who are affected by the proposed rule: No anticipated benefits to private persons or consumers by the proposed rules.

4. Probable Effect on State Revenue

The probable effect of the proposed rule on state revenues is expected to be: No effects on state revenue expected because of the proposed rules.

5. Alternative Methods

The Department considered whether there are any less intrusive or less costly alternative methods of achieving the purpose of the proposed rules. Because small entities will not experience administrative costs or other costs and no probable effect on State Revenue, exploring alternative methods was not necessary.



Jack Dalrymple, Governor
Maggie D. Anderson, Executive Director

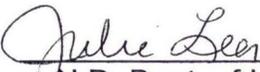
TAKINGS ASSESSMENT

concerning proposed amendment to N.D. Admin. Code chapter 75-03-16.

This document constitutes the written assessment of the constitutional takings implications of this proposed rulemaking as required by N.D.C.C. § 28-32-09.

1. This proposed rulemaking does not appear to cause a taking of private real property by government action which requires compensation to the owner of that property by the Fifth or Fourteenth Amendment to the Constitution of the United States or N.D. Const. art. I, § 16. This proposed rulemaking does not appear to reduce the value of any real property by more than fifty percent and is thus not a "regulatory taking" as that term is used in N.D.C.C. § 28-32-09. The likelihood that the proposed rules may result in a taking or regulatory taking is nil.
2. The purpose of this proposed rule is clearly and specifically identified in the public notice of proposed rulemaking which is by reference incorporated in this assessment.
3. The reasons this proposed rule is necessary to substantially advance that purpose are described in the regulatory analysis which is by reference incorporated in this assessment.
4. The potential cost to the government if a court determines that this proposed rulemaking constitutes a taking or regulatory taking cannot be reliably estimated to be greater than \$0. The agency is unable to identify any application of the proposed rulemaking that could conceivably constitute a taking or a regulatory taking. Until an adversely impacted landowner identifies the land allegedly impacted, no basis exists for an estimate of potential compensation costs greater than \$0.
5. There is no fund identified in the agency's current appropriation as a source of payment for any compensation that may be ordered.
6. I certify that the benefits of the proposed rulemaking exceed the estimated compensation costs.

Dated this 24th day of May, 2013.

by: 
N.D. Dept. of Human Services



Jack Dalrymple, Governor
Maggie D. Anderson, Executive Director

TAKINGS ASSESSMENT

concerning proposed amendment to N.D. Admin. Code chapter 75-03-17.

This document constitutes the written assessment of the constitutional takings implications of this proposed rulemaking as required by N.D.C.C. § 28-32-09.

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3. The reasons this proposed rule is necessary to substantially advance that purpose are described in the regulatory analysis which is by reference incorporated in this assessment.
4. The potential cost to the government if a court determines that this proposed rulemaking constitutes a taking or regulatory taking cannot be reliably estimated to be greater than \$0. The agency is unable to identify any application of the proposed rulemaking that could conceivably constitute a taking or a regulatory taking. Until an adversely impacted landowner identifies the land allegedly impacted, no basis exists for an estimate of potential compensation costs greater than \$0.
5. There is no fund identified in the agency's current appropriation as a source of payment for any compensation that may be ordered.
6. I certify that the benefits of the proposed rulemaking exceed the estimated compensation costs.

Dated this 21st day of March, 2013.

by: Julie Leen
N.D. Dept. of Human Services