CHAPTER 75-03-40
LICENSING OF QUALIFIED RESIDENTIAL TREATMENT PROGRAM PROVIDERS

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SECTION 1. Section 75-03-40-01 is amended as follows:

75-03-40-01. Definitions.

As used in this chapter:

1. "Accredited" means to be accredited and in good standing by an independent, not-for-profit organization approved by the department. Accreditation organizations preapproved include the commission on accreditation of rehabilitation facilities, the joint commission, or the council on accreditation. Any other accrediting bodies must be approved by the federal health and human service office before the department can consider approval.

2. "Aftercare" means followup support and services provided to a resident and family after discharge from a facility.

3. "Assessment" means the ongoing process of identifying and reviewing a resident and the resident's family's strengths and needs based upon input from the resident, the resident's family, and others, including community members and health professionals.

4. "Behavior management" means techniques, measures, interventions, and procedures applied in a systematic fashion to prevent or interrupt a resident's behavior and promotes positive behavioral or functional change fostering resident self-control.

5. "Care plan" or "case plan" means the plan developed by the child and family team that incorporates formal and informal services and supports into a comprehensive, integrated plan that, using the identified strengths of the resident and the resident's family, addresses the needs of the resident and the resident's family across life domains to support the resident and the resident's family to remain in or return to the community.

6. "Child and family team" means an advisory or recommending group in relation to the resident's case plan. The custodial agency and child and

family team, led by the resident and the resident's family, shall work cooperatively through multiagency and multidisciplinary approaches to provide a wider variety of support services to the resident, the resident's family, and foster care provider to carry out the permanency goals for the case plan.

7. "Contracted service providers" means a person or entity under contract or agreement with the facility to provide services and supports to residents.

8. "Custodian" means a person, other than a parent or guardian, to whom legal custody of the resident has been given by court order.

9. "Employee" means an individual compensated by the facility to work in a part-time, full-time, intermittent, or seasonal capacity for the facility. This definition is not inclusive to contracted service providers who come onsite to conduct trainings, treatment groups, individual therapy, or other program services.

10. "Facility" means a qualified residential treatment program.

11. "Guardian" means a person who stands in loco parentis to a resident or court appointed pursuant to North Dakota Century Code chapters 30.1-27 or 30.1-28.

12. "License" means a facility that is either licensed by the department or approved by the department if the facility is located within a tribal jurisdiction.

13. "Mechanical restraint" means any device attached or adjacent to the resident's body that the resident may not easily remove which restricts freedom of movement or normal access to the resident's body.

14. "Nonemployee" means an individual who is not compensated by the facility, such as a volunteer or student intern providing a specific service under the supervision of an employee.

15. "Normalcy" means a resident's ability to easily engage in healthy and age or developmentally appropriate activities that promote the resident's well-being, such as participation in social, scholastic, and enrichment activities.

16. "Nurse" means a nurse licensed in accordance with North Dakota Century Code chapter 43-12.1.

17. "Outcomes" means the results to which all performance targets must contribute, describing specific states or conditions that change, and which are influenced by the achievement of performance targets.

18. "Overnight hours" means a consecutive eight-hour period of time

designated as resident sleep hours defined by the facility.

19. "Personnel" means employees hired and nonemployees placed with or present in the facility.

20. "Qualified individual" means a trained professional or licensed clinician designated by the department to complete the assessment, which will assist in determining the resident's appropriate level of care.

21. "Reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a resident while at the same time encouraging the emotional and developmental growth of the resident participating in extracurricular, enrichment, cultural, and social activities.

22. "Resident" means an individual under the age of twenty-one admitted to and residing in the facility.

23. "Restraint" means a personal restraint~~, mechanical restraint, or drug used as a restraint~~ that only involves an application of physical force without the use of any device, for the purpose of restraining the free movement of a resident’s body.

24. "Seclusion" means involuntarily confining a resident alone in a room or area where the resident is prevented from leaving.~~ The immediate goal of seclusion is to defuse a dangerous situation, protect the resident and others from injury, and regain a safe and controlled environment.~~

25. "Trauma informed" is the services or programs to be provided to or on behalf of a resident and the resident's family under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma in accordance with recognized principles of a trauma informed approach and trauma specific interventions to address trauma's consequences and facilitate healing.

26. "Trauma informed treatment" means a treatment model designed to address the identified needs, including clinical needs as appropriate, of the resident with serious emotional or behavior disorders or disturbances and is able to implement the treatment identified for the ~~child~~resident by the assessment completed by the qualified individual.

27. "Treatment" means the use of interventions that prevent or cure disease, reducing symptoms, and restoring the resident to the highest practical functional level.

28. "Treatment plan" means a plan created by the facility which delineates goals, objectives, and therapeutic interventions regarding the appropriate

level of care based on the uniqueness of each resident, which considers the perspectives of the resident, the resident's clinical treatment team, family and significant others, which builds on the resident's strengths, and which incorporates a discharge focus.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-00.1, 50-11-03

SECTION 2. Section 75-03-40-09 is amended as follows:

75-03-40-09. Facility closure.

The facility shall have a policy to ensure proper and efficient procedure in the event a facility would close. Prior to closing, the facility administrator shall provide at least a sixty-day written notice to the department:

1. Detailing a plan for closure, including:

   a. Date of closure;

   b. Plan to notify each ~~resident's~~ custodian and parent or guardian;

   c. Identification of a North Dakota depository to maintain the facility's case, fiscal, employee, and nonemployee records; and

   d. Retention of all fiscal records for a period of ~~seven~~six years following account settlement.

2. Written notification must be given at least forty-five days prior to closure for each ~~resident's~~resident in placement to a custodian and parent or guardian. Notification also shall be given to all former residents currently receiving aftercare services.

3. A facility that does not follow the closure standards may be subject to fiscal sanctions.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02 75-03-40-10.

SECTION 3. Section 75-03-40-10 is amended as follows:

75-03-40-10. Governance.

1. Each facility shall have a governing body responsible for the operation, policies, activities, practice, and overall operations of the facility. The governing body shall:

a. Be composed of at least five members. A list of the names and contact information of members of the governing body must be maintained and submitted to the department annually. Each board member annually shall disclose conflicts of interest. Members of the board may not be family or have conflicts of interest with the facility administrator or employees with budget or accounting duties;

b. Meet at least every six months;

c. Maintain records of the governing body's meetings;

d. Develop and review policies for member selection and rotation;

e. Ensure each member understands the facility operation and program goals;

f. Ensure the facility is funded, housed, staffed, and equipped in a manner required for the provision of services;

g. Provide the most recent fiscal year-end financial ~~statements and audits~~records to the department for ~~reimbursement~~payment purposes, upon request;

h. Ensure the facility has an active strategic plan with a schedule to review annually;

i. Employ a qualified facility administrator and delegate responsibility to that facility administrator for the administration of the facility;

j. Evaluate the performance of the facility administrator at least annually;

k. Adopt a written statement of the purpose and philosophy of the facility; and

l. Adopt written policies for the facility regarding administration, personnel, buildings, grounds, and program services. Personnel policies for the recruitment and retention of employees necessary to operate the facility must indicate expectations of employees and nonemployees, detail job descriptions for each position, and ensure a process to review policies and procedures with employee participation at least every three years.

2. All statements and policies required by this chapter must be in writing to demonstrate the intent of the standards are integrated into facility practice. The facility policy must be up to date.

History: Effective October 1, 2019; amended effective October 1, 2021.

General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 4. Section 75-03-40-18 is amended as follows:

75-03-40-18. Nurse.

1. The facility clearly shall define, in writing, the duties and responsibilities of the nurse which must be within the scope of North Dakota Century Code chapter 43-12.1.

2. A facility shall provide for an onsite nurse to accommodate the medical needs of residents.

3. The nursing employee may be an employee of the facility or a contracted provider available to provide onsite nursing services to residents.

4. The facility shall provide the nurse with a private office located on the property where the residents reside to allow for engagement during the day to meet resident's medical needs.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02 75-03-40-19.

SECTION 5. Section 75-03-40-24 is amended as follows:

75-03-40-24. Child abuse and neglect.

1. Upon hire and annually thereafter, all employees and nonemployees shall certify having read the law requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, and having read and received a copy of the facility's written child abuse and neglect procedures.

2. Each facility shall adopt written policies and procedures requiring employees and nonemployees to report cases of suspected child abuse or neglect. The procedures must include the following statement: "All employees and nonemployees will comply with North Dakota Century Code Chapter 50-25.1, child abuse and neglect. Therefore, it is the policy of this facility that if any employee or nonemployee who knows or reasonably suspects that a current resident or former resident receiving aftercare services whose health or welfare has been, or appears to have been, harmed as a result of abuse or neglect, that employee or nonemployee immediately shall report this information to the department. Failure to report this information in the prescribed manner constitutes grounds for dismissal from employment or placement of nonemployee and referral of the employee or nonemployee to the office of the state's

attorney for investigation of possible criminal violation."

3. The facility's policies and procedures must describe:

   a. To whom a report is made;

   b. When a report must be made;

   c. The contents of the report;

   d. The responsibility of each individual in the reporting chain;

   e. The status and discipline of an employee or nonemployee who fails to report suspected child abuse or neglect; and

   f. The status of the employee or nonemployee while the report is being assessed; if they are the subject of the report.

4. The facility shall cooperate fully with the department throughout the course of any assessment of any allegation of child abuse or neglect made concerning care furnished to a resident. The facility, at a minimum, shall provide the assessors with all documents and records available to the facility and reasonably relevant to the assessment and permit confidential interviews with employees, nonemployees, and residents. Internal facility interviews and investigations are not permitted to occur concurrent with a department assessment or law enforcement investigation.

5. In the case of an indicated determination, the facility shall notify the department licensing administrator, in writing, of the corrective action the facility has taken, or plans to take, to comply with any resulting recommendations from the ~~institutional~~state child protection team. The facility shall make assurances that revised facility practice will reduce the risk of the incident reoccurring. The facility shall respond within thirty days of receiving written notification of the ~~finding~~determination.

6. A facility shall establish written policies specific to how the facility will proceed when a current or former employee or nonemployee is known to be:

   a. Involved in any capacity in a reported incident of institutional child abuse or neglect; ~~or~~

   b. Involved in any capacity in a reported incident of suspected child abuse or neglect; or

   c. The subject ~~of a services required decision~~ in a child abuse or neglect report that occurred outside of the facility, where the subject has been confirmed to have abused or neglected a child.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02, 50-25.1-03

SECTION 6. Section 75-03-40-28 is amended as follows:

75-03-40-28. Minimum employee requirements.

1. For purposes of this section:

   a. "Reside" means to sleep and keep personal belongings; and

   b. "Structure" means a building that is or may be free standing. The existence of a walkway, tunnel, or other connecting device on, above, or below ground is not effective to make one structure from two or more component structures.

2. Each facility shall adopt a policy specific to employee coverage for facility operations, including holidays, weekends, on-call clinical team rotations, daytime and overnight hours. Policy must address:

   a. Designated employees required for the facility on-call clinical team;

   b. Number of qualified employees onsite to sufficiently meet the needs of residents and respond to emergency situations;

   c. Evaluation of the number of employees necessary to meet the age, developmental level, length of treatment, and the service needs of the resident population;

   d. Ability to schedule same gender or cross gender supervision if indicated by resident treatment needs; and

   e. Employees hired specific to the onsite educational program may not be counted as direct care employees, treatment coordinator employee, family engagement specialist, facility administrator, or a clinical director during any time educational services are provided.

3. Each facility that operates more than one structure in which residents reside shall count the total number of residents admitted to the facility, residing in all structures collectively for purposes of determining the required number of clinical and treatment employees to meet employee-to-resident ratios.

4. Each facility shall comply with the following minimum employee-to-resident ratio requirements:

   a. A rotating on-call clinical team must be available twenty-four hours

a day, seven days a week to meet the needs of resident emergency and crisis situations. The on-call clinical team must include at a minimum one nurse and one clinical employee;

b. No less than one half-time facility administrator for a facility providing treatment for up to nine residents;

c. No less than one full-time facility administrator for a facility providing treatment for ten or more residents;

d. No less than one full-time clinical director;

e. No less than one full-time nurse;

f. No less than one full-time treatment coordinator employee for each ten residents; and

g. No less than one full-time family engagement specialist for each ~~eighteen~~twenty residents or aftercare clients.

5. During awake hours each facility shall ~~have no fewer than two employees qualified to provide direct care working on the property with at least one direct care employee on duty for each six residents~~meet the standards of the facility's accrediting body or the ratios set forth in this subsection, if the ratios set forth in this subsection are greater than the of employee-to-resident ratios set by the accrediting body.

a. Two employees who are qualified to provide direct care for one to twelve residents; and

b. One additional employee who is qualified to provide direct care for every one through six additional children thereafter.

6. During overnight hours each facility shall have:

a. Awake employees at all times;

b. ~~No fewer than two employees qualified to provide direct care working on the property with at least one direct care employee on duty for each ten residents~~Employee-to-resident ratio at a rate not less than:

(1) Two employees who are qualified to provide direct care for one to twenty residents; and

(2) One additional employee who is qualified to provide direct care for every one through ten additional children thereafter; and

c. A policy that includes a requirement that an employee will check on residents during overnight hours at a minimum of every fifteen minutes, and more frequently if the acuity of the resident demands greater supervision. The overnight checks must be ~~conducted~~:

(1) Documented and available for review; and

(2) Conducted in the least invasive manner to not disrupt the residents.

7. The facility shall notify the department, in writing, if the minimum employee-to-resident ratios are not met based on position vacancies. An interim plan to cover the employee duties must be approved by the department.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 7. Section 75-03-40-29 is amended as follows:

75-03-40-29. Employee professional development.

1. All employees in contact with residents shall receive at least twenty hours of training per year, with evidence of completion in the employee file.

2. Required trainings to prepare employees to meet the needs of residents served by the facility include:

a. Certified first aid;

b. Certified cardiopulmonary resuscitation and automated external defibrillator training;

c. Certified nonviolent crisis intervention training;

d. ~~Mental health technician training for direct care employees~~Institutional child abuse and neglect training;

e. Facility trauma informed care training;

f. Child abuse and neglect mandated reporter training;

g. Children's emotional and developmental needs; and

h. Suicide prevention training, including identification of signs and facility response measures.

3. A certified instructor shall provide training for nonviolent crisis intervention,

first aid, cardiopulmonary resuscitation, and automated external defibrillator. A formal certificate must be provided to each employee demonstrating their competencies in the specific training area. A copy of the certificate must be placed in the employee file. Until a new employee has completed these required trainings, the facility administrator shall ensure that another employee, current in the required trainings, is scheduled to work on the same shift as the new employee pending training.

4. Prior to a new employee working independently with residents, the facility shall provide orientation training to the employee covering all of the following areas, with evidence of completion present in the employee file:

   a. ~~Overall facility~~Facility philosophy and program goals;

   b. ~~Review of administrative~~Administrative procedures, policy, and protocols;

   c. ~~Review of personnel~~Personnel policies;

   d. ~~Review of programs~~Programs and services~~, policy, and protocols~~ offered onsite to residents;

   e. ~~Discuss the nature of residents'~~Residents' emotional and physical needs;

   f. ~~Discuss the expected~~Facility daily routine, activities, transportation, treatment group schedules, and meals;

   g. Expected employee conduct toward residents~~, expected~~;

   h. Expected resident conduct~~, and the facility's~~ while residing onsite;

   i. Facility's behavior management, including de-escalation techniques;

   ~~g.~~j. ~~Provide an overview~~Overview of trauma and facility trauma informed treatment;

   ~~h.~~k. ~~Review protocol~~Protocol for observing and reporting resident behavior;

   ~~i.~~l. ~~Review resident~~Resident rights and grievance procedures;

   ~~j.~~m. ~~Identification~~Protocol for identifying and reporting of child abuse and neglect;

   ~~k.~~n. ~~Review suicide~~Suicide prevention, including identifying signs and

facility response;

~~l.~~o. ~~Review disaster planning and evacuation procedures~~Disaster plan;

~~m.~~p. Resident search procedures and policies;

~~n.~~g. ~~Review confidentiality~~Confidentiality standards;

~~o.~~r. ~~Review facility procedures~~Procedures for reporting a runaway;

~~p.~~s. Fire safety and evacuation procedures;

~~q.~~t. ~~Emergency~~Protocol for emergency medical procedures ~~and~~;

u. Protocol for facility ~~emergency~~ security measures and ~~procedures~~access to visitors; and

~~r.~~v. Discuss interest in becoming certified for medication distribution~~; and~~

~~s. Review facility daily routine, activities, cleaning, transportation, treatment group schedules, and meals~~.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 8. Section 75-03-40-30 is amended as follows:

75-03-40-30. Resident file.

1. Upon placement, a resident's case record is confidential and must be protected from unauthorized examination unless permitted or required by law or regulation. The facility shall adopt a policy regarding the retention of resident records.

2. The resident record must include on file:

   a. A file inventory with dates of admission, discharge, aftercare, referral source, and emergency contact information;

   b. The resident's full name, date of birth, and other identifying information;

   c. A photo of the resident;

   d. The name and contact information of a ~~resident's~~ custodian and parent or guardian at the time of admission, as well as contact information of additional family members approved to engage in

visitation and maintain family connections;

e. The date the resident was admitted and the referral source;

f. Signed care agreement or contract, including financial responsibility and expectations of all parties. The placement agreement must indicate a clear division of responsibility and authority between the facility and the custodian and parent or guardian;

g. Signed written consents, as applicable;

h. A copy of the initial and all ongoing assessment reports completed by the department approved qualified individual or documentation indicating placement approval or denial if the resident is ~~placed for thirty-day assessment period, documentation indicating the resident is placed for assessment must be on file~~accepted for an emergency placement;

i. A copy of required interstate compact forms, as applicable;

j. If the resident is in public custody, a current court order establishing the placement authority of a public agency;

k. ~~If the resident is in public custody, a copy of initial and any ongoing judicial reviews granting approval for the qualified residential treatment program placement;~~

~~l. If the resident is in public custody, a copy of the quarterly child and family team meeting notes or foster care case plan must be in the resident's file;~~

~~m. Progress~~Treatment progress reports must be provided to the resident, custodian and parent or guardian monthly, or upon request. ~~This must include~~Any progress reports received at the facility from an outside agency or professional providing services to the resident ~~outside of the facility~~, shall be summarized and embedded in the resident's treatment plan;

~~n.~~l. Ongoing documentation and case activity logs detailing progress;

~~o.~~m. Documentation of discharge planning;

~~p.~~n. Visitation records. The facility shall have a formal plan for visitation signed by the custodian and parent or guardian detailing opportunities for the resident to engage in onsite visitation and home visits with family;

~~q.~~o. Education records;

~~r.~~p. All incident reports involving the resident; and

~~s.~~q. Documentation the clinical director, facility administrator, or designated employee has reviewed the resident case record monthly.

3. Resident medical information, including:

a. Consent for medical care. The facility has obtained written, signed informed consent that gives the facility, resident's physician, or health care consultant the following authority to:

(1) Provide or order routine medical services and procedures;

(2) Delegate and supervise administration of medications by authorized employees and for such employees to handle, provide the medication to the resident, and provide monitoring of resident self-administration;

(3) Obtain medical information, as needed, on the resident; and

(4) Provide or obtain an order for medical services and procedures when there is a life-threatening situation, emergency medical procedures, including surgery, when it is not possible to reach the person or authority authorized immediately to give signed written specific informed consent;

b. Documentation about any special nutritional or dietary needs identified;

c. Documentation of health history;

d. Documentation of any medical treatments received while residing in the facility, including:

(1) Dates and person administering medical treatment;

(2) Immunizations;

(3) Laboratory tests;

(4) Routine and emergency health care examinations;

(5) Dental examinations and treatment; and

(6) Eye examinations and treatment;

e. Medication administration records; and

f. A copy of the treatment plan prepared by the facility.

4. The resident record must include aftercare supports for six months postdischarge. Information to include:

a. Contact information for the custodian and parent or guardian and others determined necessary for aftercare;

b. Date of discharge and six-month aftercare date of completion;

c. Documentation from the family engagement specialist detailing the aftercare or family treatment plan progress;

d. Documentation of ongoing communication with the resident, ~~resident's~~ custodian and parent or guardian, and local providers; and

e. Upon six-month completion of aftercare, the resident file must include:

(1) Summary of the six-month aftercare services provided; and

(2) A copy of the department-approved outcomes survey.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02, 50-11-05

SECTION 9. Section 75-03-40-32 is amended as follows:

75-03-40-32. Respite.

A facility may operate an optional respite care program with approval of the department. Respite care is defined as temporary relief care for a ~~child~~resident with special medical, emotional, or behavioral needs, which requires time-limited supervision and care by a licensed foster care provider. A respite care episode is a specified period of time during which respite care is provided by a licensed provider.

1. Eligibility. Residents eligible for respite care offered by an approved facility include a foster child in public custody and a former qualified residential treatment program resident engaged in the six-month aftercare.

2. Admission and discharge. A facility operating a respite care program shall have the written policies and procedures for admissions and discharge for respite care, including eligibility into the respite program, admissions criteria, required belongings, medications needed upon admission, required identification documentation, authorizations needed, written consents for emergency medical care, medications, and discharge

planning.

3. Staffing. A facility shall assign an employee to have primary responsibility for the facility's respite care program. Employee-to-resident ratios at a minimum, must meet the ratio as described in this chapter for direct care.

4. Program and services. A facility respite program must be developed which allows for a short-term refocus of service delivery and supports for a community placement. Respite care placements are exempt from the medical examination requirements due to the short period of stay.

5. Respite care plan. A facility shall develop an abbreviated plan for each resident admitted to the facility for respite care. The abbreviated plan must provide for services to meet social, emotional, medical, and dietary needs. The respite plan must address daily routine, engagement in recreational activities, ongoing education, and discharge planning. The respite plan may include a list of facility-based and community-based services and supports the resident and family is currently receiving or will receive upon discharge.

6. Length of stay. A respite care placement may not extend beyond seven days per episode.

7. Discharge. When a resident is discharged from respite care, the facility shall document in the resident's respite file the dates of the resident's stay, a summary of the resident's stay, the name of the person to whom the resident was discharged, and a list of all personal belongings and medications that went with the resident upon discharge. A final plan must be provided to the custodian and parent or guardian upon discharge.

8. Respite resident file. A facility with a respite care program shall include:

    a. The resident's full name, date of birth, and other identifying information;

    b. The contact information of the ~~resident's~~ custodian and parent or guardian at the time of admission;

    c. The date the resident was admitted and discharged;

    d. Signed respite care agreement;

    e. Signed written consents, including consent to nonemergency use of psychotropic medication and consent for use of secured unit, if applicable;

f. If the ~~child~~resident is in public custody, a current court order establishing the facility's authority to accept and care for any resident under the custody of a public agency;

g. Copy of the abbreviated plan prepared by the facility; and

h. Medication administration records, if applicable.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02 75-03-40-33.

SECTION 10. Section 75-03-40-33 is amended as follows:

75-03-40-33. Admissions and assessment.

1. Admissions policies and procedures. A facility shall have written resident admission policies and procedures that describe the primary treatment offered onsite, range of presenting behaviors the facility shall treat, and procedures for admitting a resident.

2. Admissions and discharge committee. A facility shall have an admissions and discharge committee with written policy specific to employees on the committee~~, how often the committee meets,~~ and the timeliness the committee has in responding to referrals. The committee shall meet on at least a weekly basis. ~~Before a prospective resident is admitted to the facility, the committee shall evaluate the needs of the prospective resident using information and procedures described in policy and determine whether the facility can meet the identified needs of the prospective resident.~~

3. Admission determination. The admissions committee shall complete a written, dated, and signed admission determination on a prospective resident which includes a preadmission review and identification of the prospective resident's primary presenting needs. ~~The committee shall provide a written statement recommending reasons for or against admission based on the ability of the facility to meet the prospective resident's needs.~~ The facility shall provide the admission determination ~~and decision~~ to the referral within seven days of receipt of the completed application. Referral may be completed by:

   a. A public agency, if a prospective resident is in foster care and a public agency is granted custody and given full placement authority pursuant to law or court order; or

   b. A parent or guardian, if a prospective resident is pre-approved by the department as a private placement.

4. ~~Preplacement visit. Whenever possible, a facility shall arrange with the custodial agency for a preplacement visit for the prospective resident and the parent or guardian, to provide them with an orientation to the facility. If the ability to arrange onsite visitation is not possible, a virtual meeting is acceptable.~~

~~5.~~ Admission conditions. A facility may admit a prospective resident ~~if the facility can meet the prospective resident's needs~~, as determined by the admission determination and the following conditions are met:

a. Qualified individual - Level of care assessment.

(1) Completed assessment. The facility has received documentation from the department-approved qualified individual granting approval for the resident to be admitted to a qualified residential treatment program based on the North Dakota level of care assessment; or

(2) ~~Thirty-day assessment period approval. The facility has received documentation from the department-approved qualified individual granting approval for the resident to be admitted for a thirty-day assessment period~~Emergency placement. A resident may ~~not~~ be admitted to the facility for ~~the~~an emergency placement for a thirty-day assessment period ~~without the approval of the qualified individual~~. Emergency placements denied for continued placement may not exceed thirty days from admission. For residents placed in the facility during the thirty-day assessment period ~~to determine appropriateness of a qualified residential treatment program placement~~, the facility shall allow access to the qualified individual and collaborate in the completion of the required level of care assessment;

b. Juvenile court approval. For foster children, custodial case managers must receive confirmation from the juvenile court ~~must be on file~~ approving the qualified residential treatment program placement within sixty days of the resident's date of entry into the facility. A facility is not required to have a copy of the confirmation on file;

c. Interstate placements. In accepting a prospective resident from outside the state of North Dakota, the facility shall receive prior written approval under the interstate compact on the placement of children and meet all requirements of section 75-03-40-34;

d. Nondiscrimination against a resident; and

e. All documentation required for the resident record, including

medical consent, medical history, family contact information, family history, placement care agreement, and financial responsibility.

~~6.~~5. Orientation. Upon admissions, each resident shall receive orientation to facility living. An employee shall:

a. Orient the new resident and the ~~resident's~~ custodian and parent or guardian to the facility program~~, if no preplacement visit occurred~~;

b. Help the new resident to adjust to the effects of separation from family and to the residential placement; and

c. Provide the new resident and the ~~resident's~~ custodian and parent or guardian copies of the ~~house~~facility rules, including rules on visiting, expected behavior and consequences for rule infractions, resident rights, and grievance and complaint procedures, with explanations of the documents.

~~7.~~6. Initial screenings. ~~Upon admissions, a~~A facility shall complete for each resident a:

a. Suicide risk screening ~~within twenty-four hours~~;

b. Mental health screening ~~within twenty-four hours~~; and

c. Health screening completed by the facility nurse ~~within twenty-four hours~~. The health screening may include documenting height, weight, and identification of any distinct markings such as a resident's birthmark, tattoos, bruises, or cuts.

~~8.~~7. Discharge date. Each admission must have preliminary plans for discharge.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 11. Section 75-03-40-34 is amended as follows:

75-03-40-34. Interstate compact on the placement of children.

1. All placements of children made from out-of-state must follow the interstate compact on the placement of children or the interstate compact on juveniles and be in full compliance with the appropriate interstate compact. It is the responsibility of the facility to ensure, prior to the placement in the facility, all necessary procedures pursuant to the interstate compact on the placement of children or the interstate compact on juveniles have been completed.

2. Before admitting an out-of-state resident, a facility shall make arrangement with the referral to assure a lawful return of the resident to the sending state without regard to the circumstance under which the resident is discharged.

3. The sending state is responsible for costs of the initial and ongoing qualified individual assessments required for the resident to enter a facility licensed under this chapter.

4. Out-of-state referrals must adhere to all requirements of this chapter.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 14-13, 27-22

SECTION 12. Section 75-03-40-36 is amended as follows:

75-03-40-36. Discharge plan.

Each resident must have their discharge plan developed upon admission and reviewed ongoing as part of the treatment plan.

1. Persons involved in discharge planning should include:

   a. Resident;

   b. Resident's parent or guardian;

   c. Custodian, if applicable;

   d. Psychiatrist, if applicable;

   e. Therapist, if applicable;

   f. Clinical director;

   g. Treatment coordinator employee;

   h. Facility nurse;

   i. Facility educator or community teacher;

   j. Direct care employee;

   k. Foster parents, if applicable;

   l. Juvenile court, if applicable; and

   m. Other individuals important to the resident and family.

2. The discharge plan must address the following:

   a. The date of admission;

   b. The anticipated date of discharge;

   c. Details of the events and circumstances leading to the decision to discharge;

   d. The name and address of the individual or agency to whom the resident must be discharged and the rationale for planning a discharge to that individual or agency;

   e. A summary of services provided during placement;

   f. A summary of goal achievement;

   g. A summary of the resident's continuing needs, including health care, educational or vocational training, psychiatric, medical, psychological, social, behavioral, developmental, and chemical dependency treatment needs;

   h. Appointments scheduled, including individual therapy, psychiatric services, educational services, and other services or supports as needed;

   i. Medication plan, including a seven-day supply of needed medication and a prescription for medication to last through the first outpatient visit with a prescribing provider;

   j. A summary of community-based service needs for the resident and resident's family;

   k. A summary of efforts made by the facility to prepare the resident and the resident's family for discharge; and

   l. The facility's plan for the six months of aftercare services for the resident and the resident's family.

3. The discharge committee shall review and approve each anticipated discharge thirty days prior to the discharge and provide the completed discharge plan to the custodian at least seven days prior to the anticipated discharge. A discharge planning meeting involving the resident, custodian, parent or guardian, facility treatment team, additional family members, community service providers, and foster care provider ~~if the resident is being discharged to another level of foster care~~, if applicable must take place at least seven days prior to discharge to review and sign the discharge plan to ensure the continuity of services consistent with the

resident's treatment needs after discharge.

4. ~~For discharges that were~~If a discharge is not anticipated at least thirty calendar days ahead of time, the discharge is considered unplanned and the facility shall ~~finalize a discharge plan and provide a written copy to the~~:

   a. Hold a discharge planning meeting involving the resident, custodian, parent or guardian, facility treatment team, additional family members and any other relevant parties. This meeting must allow relevant parties time to review the discharge plan, aftercare engagement strategies, while discussing services needed to best meet the needs of the resident.

   b. Create and provide in writing a finalized discharge and aftercare plan to the custodian and parent or guardian ~~and custodial agency~~ at least seven days prior to the resident's discharge. ~~A discharge planning meeting to discuss efforts the facility engaged to maintain the placement must take place to review and sign the discharge plan to ensure the continuity of services consistent with the resident's treatment needs after discharge.~~

   c. Provide the discharge plan and aftercare plan no greater than seven days postdischarge, if an immediate discharge occurred.

~~5. For unplanned discharges due to the emergency nature of the resident's needs, the facility verbally shall notify the parent or guardian and custodial agency as soon as possible and no longer than twenty-four hours after discharge from the facility. The facility shall send the written discharge plan within seven days after the resident's unplanned emergency discharge.~~

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 13. Section 75-03-40-38 is amended as follows:

75-03-40-38. Aftercare.

The facility shall have written policies and procedures regarding how the six-month aftercare requirements must be implemented to best meet the needs of residents and families. Aftercare policy applies to all residents accepted into the facility for treatment. If a resident is placed as an emergency placement and not approved for treatment, aftercare services are not required. The six-month followup period must begin the day following the resident's discharge from the facility. The facility shall implement the aftercare plan developed as part of the discharge planning process. The facility may directly provide aftercare services and supports or coordinate with local service providers. The facility shall conduct a department approved post-residential

outcomes survey at the conclusion of the six-month required aftercare period. Postdischarge aftercare services shall be provided by the facility as follows:

1. If a resident discharged from the facility remains in foster care, the facility shall collaborate with the custodial agency to implement the six-month ~~followup period~~postdischarge plan.

2. If a resident is discharged and no longer in foster care, the facility shall coordinate the ongoing six-month aftercare with the resident and resident's family. ~~The facility may directly provide aftercare services and supports or coordinate with local service providers. The facility shall conduct a department approved postresidential outcomes survey at the conclusion of the six-month required aftercare period~~If the resident's family declines continued engagement with the facility, the facility is required to continue to attempt to maintain at least monthly contact with the family for a period of six months.

3. If a resident is successfully discharged, but does require re-admission to a facility, the aftercare services will discontinue and a new aftercare period will begin postdischarge from the current facility placement.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 14. Section 75-03-40-40 is amended as follows:

75-03-40-40. Incident and sentinel event reporting.

The facility shall have written policy outlining the documentation of incidents and sentinel events that occur while the resident is in placement. Policy must include:

1. Description of an incident as an unplanned occurrence that resulted or could have resulted in injury to people or damage to property, specifically involving the general public, residents, or agency employees.

   a. Incidents involving law enforcement, including in the case of a runaway, criminal activity, behavior resulting in harm to others, or restraint injury. An incident also may involve issues, such as outbreak of a serious communicable disease, harassment, violence, and discrimination.

   b. Notification must be made to the ~~resident's~~ custodian and parent or guardian immediately or no more than ~~twenty-four~~twelve hours.

2. Description of a sentinel event as an unexpected occurrence involving death or serious physical or psychological injury not related to the natural course of a resident's illness or underlying condition, including any

process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome.

a. Sentinel events include serious injury or trauma to a resident, attempted suicide by the resident, death of a resident, or inappropriate sexual contact.

b. Notification must be made to the ~~resident's~~ custodian and parent or guardian, and the department immediately or no more than twelve hours.

3. Documentation of an incident or sentinel event must be completed and placed in the resident's record ~~within twenty-four hours~~. The report must include:

a. Resident's name, age, and sex;

b. A description of the incident or event;

c. The date, time, and location of the incident or event;

d. The name of each employee or nonemployee involved;

e. Methods used to address the resident's behavior, including duration of each intervention;

f. Detailed description of the technique or approach engaged with the resident at the time of the incident or event;

g. Results achieved from methods used to address resident behavior; and

h. Injuries received by either the resident or an employee in using physically enforced separation or ~~physical hold~~ restraint, how the injuries occurred, and any medical care provided.

4. The facility shall maintain a log of written reports of incidents involving residents.

5. Direct care employees must be given time at the beginning of each shift to be informed of or review incident reports occurring since their last shift.

6. Employees, nonemployees, and residents must be given time to debrief the incident with clinical staff.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 15. Section 75-03-40-43 is amended as follows:

75-03-40-43. Medication management.

1. For purposes of this section:

   a. "General supervision" means regular coordination, direction, and inspection of the exercise of delegation of medication administration by a physician or nurse of an employee not licensed to administer medications.

   b. "Medication administration" means proper administration of medication to a resident by an employee designated and trained for the administration of medications.

   c. "Monitoring of resident self-administration" means distributing the medication to the resident by a designated and trained employee according to physician and medication label instructions and observing and ensuring the proper ingestion, injection, application, or inhalation of the medication by the resident.

2. The facility shall adopt comprehensive written policies and procedures for medication administration and monitoring of resident self-administration. Each employee responsible for administering medication or monitoring of resident self-administration shall receive a copy of the facility policies and procedures for medication administration and monitoring of resident self-administration and shall be knowledgeable of them. The policies and procedures must include:

   a. Medications administration:

      (1) Having written informed consent on file;

      (2) Having information in each resident's health record about any health allergies or health-related restrictions;

      (3) Having on file written authorization from a physician or nurse for each employee permitted to administer medications or to monitoring of resident self-administration;

      (4) Instructions for employees concerning administration of medications and monitoring of resident self-administration of medications, secure storage of medications, and recording medication administration information in the resident's health record;

      (5) Immediate notification to the facility nurse of all medication errors;

(6) Immediate notification of a physician in the event of a resident's adverse drug reaction; and

(7) Medications distributed onsite may only occur when an employee authorized by the facility is present;

b. For prescription medications, all of the following apply:

(1) Require the medication be administered by employees certified to distribute medication to a resident only when:

(a) The resident's attending physician or medical consultant provides employees with clear written instructions for administering the medication and authorizes the facility to administer the medication;

(b) The administration takes place under the general supervision of a physician or nurse. Employees certified to distribute medication are supervised by the facility nurse; and

(c) The label on the medication container gives clear instruction for administration of the medication and, if not clear, the facility shall contact the physician or pharmacy for clarification before administration of the medication; and

(2) Allowing a medication to be self-administered onsite by a resident only while the resident is under direct supervision of an employee and if self-administration is authorized in writing from the prescribing physician or facility medical consultant;

c. Information to employees, a resident, and the ~~resident's~~ custodian and parent or guardian about any medication prescribed for the resident and when a physician orders any changes to the resident's medication. Information must include expected benefits and potential adverse side effects that may affect the resident's overall treatment. Employees also shall be informed on procedures of what to do if the resident refuses medication;

d. Instructions for employees on what to look for in monitoring physical or mental changes to a resident that may occur from a medication, what to do if physical or mental changes are observed, and documentation needed in the resident's health record;

e. Arrangement for a second medical consultation when a resident or the ~~resident's~~ custodian and parent or guardian has concerns about

any medication received by the resident or the resident's medication plan;

f. The resident's physician or facility medical consultant review a resident's prescription when there are noted adverse effects from the medication. Documentation showing the date of review and reviewer's name must appear in the resident's health record;

g. The use of any nonprescription medication is based on an assessment by a physician or nurse and is approved by either a physician or nurse;

h. Arrangement for administration of prescribed medications to a resident when the resident is away from the facility. A resident may not be given access to medications if there is reason to believe the resident may harm themself through abuse or overdose;

i. Medications storage. A facility shall comply with all the following requirements for storage of medications:

(1) Medications must be kept in locked cabinets or containers and under proper conditions of sanitation, temperature, light, moisture, and ventilation to prevent deterioration;

(2) A facility immediately shall dispose properly of all outdated prescriptions, over-the-counter medication, and all prescription medication no longer in use; and

(3) The facility shall maintain a log of the medication properly disposed, which employee disposed of it, and what and how much was disposed;

j. Medication administration record. A facility shall have in each resident's health record a written medications administration record which lists each prescribed and over-the-counter medication the resident receives. The record must contain the following information:

(1) For an over-the-counter medication, the resident's name, type of medicine, reason for use, times and day of administration, and employee authorizing its use; and

(2) For a prescription medication, all of the following apply:

(a) The name of the resident;

(b) The generic or commercial name of the medication;

(c) The date the medication was prescribed;

(d) The name and telephone number of the prescriber to call in case of a medical emergency;

(e) The reason the medication was prescribed;

(f) The dosage;

(g) The time or times of day for administering the medication;

(h) Documentation of all medication administered with the date and time of administration or, if not administered, with the date and time of resident refusal to take it;

(i) The method of administration, such as orally or by injection;

(j) The name of the employee who administered or monitored resident self-administration of the medication;

(k) Any adverse effects observed; and

(l) Any medication administration errors and corrective or other action taken; and

k. Psychotropic medications. In this subdivision, "psychotropic medication" means any drug that affects the mind and is used to manage behavior or psychiatric symptoms.

(1) Nonemergency procedures. A facility serving a resident for whom psychotropic medications are prescribed shall ensure all of the following requirements are met:

(a) Arrangements have been made for a physician or medical consultant to complete a medical screening of the resident for the type of psychotropic medication to be prescribed;

(b) The resident, if fourteen years of age or older, and the ~~resident's~~ custodian ~~and parent or guardian~~ have signed written consent forms agreeing to the use of the psychotropic medication. The facility shall pursue consent from a parent or guardian with the final consent made by the custodian; and

(c) The facility has obtained from the prescribing physician or medical consultant a written report within the first forty-five days after the resident has first received a psychotropic medication and at least every sixty days thereafter. The report must state in detail all of the following:

[1] Reasons for the initial use of the medication;

[2] Reasons for continuing, discontinuing, or changing the medication;

[3] Any recommended change in treatment goals or program; and

[4] The method and procedures for administering or monitoring of resident self-administration of a psychotropic medication must have been approved by the prescribing physician or medical consultant.

(2) Emergency procedures. For emergency administration of a psychotropic medication to a resident, a facility shall:

(a) Have authorization from a physician;

(b) Notify the ~~resident's~~ custodian and parent or guardian as soon as possible following emergency administration. The facility shall document the dates, times, and individuals notified in the resident's record; and

(c) Document the physician's reasons for ordering the emergency administration of psychotropic medication.

(3) Revocation of consent or refusal. A resident~~,~~ or custodian~~, and parent or guardian~~ may at any time revoke consent for nonemergency use of psychotropic medications. The facility shall consider the consent or refusal of the resident’s parent or guardian. When a consent is revoked, the facility shall do all of the following:

(a) Document the reasons for refusal;

(b) Employee who personally witnessed the refusal shall sign a written statement indicating the event and place it in the file;

(c) Notify the resident's physician or medical consultant; and

(d) Notify the custodian and parent or guardian. Notification must be provided immediately if the resident's refusal threatens the resident's well-being and safety.

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03 39
Law Implemented: NDCC 50-11-02

SECTION 16. Section 75-03-40-45 is amended as follows:

75-03-40-45. Emergency safety interventions.

The facility shall provide and administer emergency safety interventions as follows:

1. For purposes of this section:

   a. "Drug used as a restraint" means any drug that:

      (1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;

      (2) Has the temporary effect of restricting the resident's freedom of movement; and

      (3) Is not a standard treatment for the resident's medical or psychiatric condition.

   b. "Emergency safety intervention" means the use of restraint ~~or seclusion~~ as an immediate response to an emergency safety situation involving unanticipated resident behavior that places the resident or others at threat of serious violence or serious injury if no intervention occurs.

   c. "Emergency safety situation" means a situation where immediate risk of harm is present due to unanticipated resident behavior that places the resident or others at threat of serious violence or serious injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

   d. "Personal restraint" means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident to calm or

comfort him or her, or holding a resident's hand to safely escort a resident from one area to another, or a physical escort which means a temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a resident who is acting out to walk to a safe location.

e. "Tier ~~1~~2 mental health professional" has the same meaning as the term defined in subsection ~~8~~9 of North Dakota Century Code section 25-01-01.

2. Education and training related to emergency safety interventions:

a. Individuals who are qualified by education, training, and experience shall provide employee education and training.

b. Employees must be trained and demonstrate competency before participating in an emergency safety intervention.

c. The facility shall document in the employee personnel records that the training and demonstration of competency were successfully completed.

d. All training programs and materials used by the facility must be available for review by the accreditation body and the state agency.

e. The facility shall require employees to have ongoing education, training, and demonstrated knowledge and competency of all of the following, no less than semiannually:

(1) Techniques to identify employee and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;

(3) The safe use of restraint ~~and seclusion~~, including the ability to recognize and respond to signs of physical distress in residents who are restrained ~~or in seclusion~~; and

(4) Training exercises in which employees successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

3. Emergency safety intervention:

a. Facilities shall have a policy for the safe use of emergency safety interventions;

b. Restraint ~~and seclusion~~ may be used only when a resident poses an immediate threat of serious violence or serious injury to self or others and must be discontinued when the immediate threat is gone. The use of seclusion by a facility is prohibited;

c. Employees shall document all interventions attempted to de-escalate a resident before the use of ~~seclusion or~~a restraint ~~are implemented~~;

d. When restraint is deemed appropriate, personal restraint is allowed. Mechanical restraints, prone restraints, and drugs used as a restraint are prohibited;

e. Employee training requirements must include procedures:

(1) For when ~~seclusion or~~ restraint may and may not be used;

(2) That safeguard the rights and dignity of the resident;

(3) For obtaining informed consent, including the right of the custodian and parent or guardian of the resident to be notified of any use of restraint ~~or seclusion use~~ or any change in policy or procedure regarding use;

(4) Regarding documentation requirements of each restraint episode ~~of seclusion or restraint~~ and the use of such data in quality improvement activities; and

(5) Regarding the debriefing of the resident and employees immediately after incidents of ~~seclusion or~~ restraint; and

f. Quality management activities must examine the following:

(1) Available data on the use of these practices and their outcomes, including the frequency of the use of restraint ~~and seclusion~~, settings, authorized employees, and programs;

(2) The accuracy and consistency with which restraint ~~and seclusion~~ data ~~are being~~is collected, as well as the extent to which ~~these data are~~restraint data is being used to plan behavioral interventions and employee training;

(3) Whether policies and procedures for using these practices are being implemented with fidelity;

(4) Whether procedures continue to protect residents; and

(5) Whether existing policies for restraint ~~and seclusion~~ remain properly aligned with applicable state and federal laws.

4. Restraint:

a. Personal restraint is the only form of restraint allowed.

b. If an emergency safety situation occurs and a personal restraint is determined necessary, the following actions are prohibited:

(1) Any maneuver or techniques that do not give adequate attention and care to protection of the resident's head;

(2) Any maneuver that places pressure or weight on the resident's chest, lungs, sternum, diaphragm, back, or abdomen causing chest compression;

(3) Any maneuver that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the resident's head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the resident's torso;

(4) Any type of choke hold;

(5) Any technique that uses pain inducement to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points for pain compliance; and

(6) Any technique that involves pushing on or into a resident's mouth, nose, or eyes, or covering the resident's face or body with anything, including soft objects, such as pillows, washcloths, blankets, and bedding.

5. ~~Seclusion:~~

~~a. A resident may be maintained in seclusion only by one of the following means:~~

~~(1) A room that does not use a key lock, pad lock, or other lock of similar design and remains unlocked;~~

~~(2) A room equipped with a lock that only operates with an employee present such as a push-button lock that only remains locked while it is being pushed; or~~

~~(3) A room or area where an employee is positioned to prevent the resident from leaving.~~

~~b. A resident placed in seclusion must be continuously observed by an employee.~~

~~c. A room used for seclusion must:~~

~~(1) Hold only one resident at a time;~~

~~(2) Have adequate ventilation;~~

~~(3) If there is a door, a shatter-proof observation window on or adjacent to the door, which allows for observation of all parts of the room and allows for the resident to see out;~~

~~(4) Be located within hearing or call to a living area or other area of activity;~~

~~(5) Allow for auditory contact with the resident at all times;~~

~~(6) Have at least sixty-four square feet [5.95 square meters] of floor space with a ceiling height of not less than eight feet [2.44 meters] and a width of at least eight feet [2.44 meters];~~

~~(7) Be an architectural or permanent part of the building structure and may not include a box or other compartment that represents a stand-alone unit within the facility; and~~

~~(8) Be free of any objects and materials that could represent a hazard to the resident or others.~~

~~6.~~ ~~Orders~~Authorization for the use of restraint ~~or seclusion~~:

a. ~~Orders~~Authorization for restraint ~~or seclusion~~ must be ~~ordered~~given by a tier ~~1~~2 mental health professional and the ~~ordering~~ tier ~~1~~2 mental health professional must be trained in the use of the facility emergency safety interventions.

b. The ~~order~~authorization must indicate the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with the clinical director.

c. If the ~~order~~authorization for restraint ~~or seclusion~~ is verbal, the verbal ~~order~~authorization must be received by a ~~nurse or~~ clinical ~~director~~team member, while the emergency safety intervention is being initiated by an employee or immediately after the emergency

safety situation ends. The tier ~~1~~2 mental health professional must verify the verbal ~~order~~authorization in a signed written form in the resident's record and be available to the resident's treatment team for consultation, in person or through electronic means, throughout the period of the emergency safety intervention.

d. Each ~~order~~authorization for restraint ~~or seclusion~~:

(1) Must be limited to no longer than the duration of the emergency safety situation;

(2) May not exceed ~~four hours for residents ages eighteen to twenty-one; two hours for residents ages nine to seventeen; or one hour for residents under age nine~~the amount of time necessary to begin verbal de-escalation techniques with the resident; and

(3) Must be signed by the ~~ordering~~ tier ~~1~~2 mental health professional no later than twelve hours from initiation of a verbal ~~order~~authorization.

e. Within one hour of the initiation of ~~the emergency safety intervention~~a restraint, a face-to-face assessment of the physical and psychological well-being of the resident must be completed, documenting:

(1) The resident's physical and psychological status;

(2) The resident's behavior;

(3) The appropriateness of the intervention measures; and

(4) Any complications resulting from the intervention.

f. Each ~~order~~authorization for restraint ~~or seclusion~~ must include:

(1) The name of the ~~ordering~~ tier ~~1~~2 mental health professional;

(2) The date and time the ~~order~~authorization was obtained; and

(3) The emergency safety intervention ~~ordered~~authorized, including the length of time authorized.

g. An employee shall document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must

include all of the following:

(1) Each ~~order~~authorization for restraint ~~or seclusion~~ as required in subdivision f;

(2) The time the emergency safety intervention began and ended;

(3) The time and results of the one-hour assessment required in subdivision e;

(4) The detailed emergency safety situation that required the restraint ~~or seclusion~~; and

(5) The name of each employee involved in the ~~emergency safety~~restraint intervention.

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

i. If a tier ~~1~~2 mental health professional ~~orders~~authorizes the use of restraint ~~or seclusion~~, that person shall:

(1) Consult with the resident's treatment team physician as soon as possible and inform the resident's treatment team physician of the emergency safety situation that required the restraint ~~or seclusion~~; and

(2) Document in the resident's record the date and time the resident's treatment team physician was consulted.

7. Monitoring of the resident in and immediately after restraint ~~or seclusion~~:

a. An on-call clinical team member trained in the use of emergency safety interventions shall be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint ~~or seclusion~~ throughout the duration of the emergency safety intervention.

b. If the emergency safety situation continues beyond the time limit of the ~~order~~authorization for the use of restraint ~~or seclusion~~, a nurse or other on-call clinical team member, immediately shall contact the ~~ordering~~ tier ~~1~~2 mental health professional, to receive further instructions.

c. Upon completion of the emergency safety intervention, the resident's well-being must be evaluated immediately after the restraint ~~or seclusion is removed or~~ has ended.

8. Notification of custodian and parent or guardian:

   a. The facility shall notify the custodian and parent or guardian of the resident who has been restrained ~~or placed in seclusion~~ as soon as possible after the initiation of each emergency safety intervention.

   b. The facility shall document in the resident's record that the custodian and parent or guardian has been notified of the emergency safety intervention, including the date and time of notification and the name of the employee providing the notification.

9. Postintervention debriefings:

   a. Within twenty-four hours after the use of restraint ~~or seclusion~~, employees involved in an emergency safety intervention and the resident shall have a face-to-face discussion. This discussion must include all employees involved in the intervention except when the presence of a particular employee may jeopardize the well-being of the resident. Other employees and the ~~resident's~~ custodian and parent or guardian may participate in the discussion when it is deemed appropriate by the facility. The facility shall conduct such discussion in a language understood by the ~~resident's~~ custodian and parent or guardian. The discussion must provide all parties the opportunity to discuss the circumstances resulting in the use of restraint ~~or seclusion~~ and strategies to be used by the facility, the resident, or others who could prevent the future use of restraint ~~or seclusion~~.

   b. Within twenty-four hours after the use of restraint ~~or seclusion~~, all employees involved in the emergency safety intervention, and appropriate supervisory and administrative leadership, shall conduct a debriefing session that includes, at a minimum, a review and discussion of:

      (1) The emergency safety situation that required the emergency safety intervention, including a discussion of the precipitating factors that led up to the emergency safety intervention;

      (2) Alternative techniques that might have prevented the use of the restraint ~~or seclusion~~;

      (3) The procedures, if any, employees are to implement to prevent any recurrence of the use of restraint ~~or seclusion~~; and

      (4) The outcome of the emergency safety intervention, including any injuries that may have resulted from the use of restraint ~~or seclusion~~.

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

History: Effective October 1, 2019; amended effective October 1, 2021.
General Authority: NDCC 50-11-03
Law Implemented: NDCC 50-11-02

SECTION 17. Section 75-03-40-46 is repealed.

75-03-40-46. Use of special care unit.

[Repeal effective October 1, 2021]

~~1. For purposes of this section, "special care unit" means a separate secure area of the facility designated as a protective environment in which treatment and services are provided to residents. The special care unit is secured by means of a key lock that prevents residents from leaving at will. A special care unit is not seclusion, but rather a fully operational separate space located on the facility's grounds. A facility building locked for purposes of external security is not the special care unit, provided that residents may exit at will.~~

~~2. Conditions for use. A resident may not be placed in a special care unit unless the facility has first obtained department approval to operate the special care unit and the special care unit meets the requirements of this section.~~

~~3. If an emergency safety situation arises in the special care unit requiring the use of the emergency safety interventions of restraint or seclusion for a resident placed within the special care unit, then section 75-03-40-45 applies.~~

~~4. A facility's use of the special care unit must be part of a behavior management program and all of the following conditions must be met:~~

~~a. The resident has exhibited chronic or recent severely aggressive or destructive behaviors that have been determined to place the resident or others at serious threat of violence or injury to self or others and the lack of the special care unit prevents the clinical team from being able to treat the resident.~~

~~b. A tier 1 mental health professional knowledgeable about contemporary use of the special care unit treatment intervention gives written approval included in the resident's treatment record for~~

its use.

c. The goals, objectives, and approaches in the resident's treatment plan support the use of the special care unit, with goals and objectives directed at reducing or eliminating the need for use of the special care unit.

d. The custodian, or if there is no court appointed custodian, the parent or guardian of the resident gives informed consent in writing to the use of a special care unit or the intervention is ordered by a court or other lawful authority.

e. The resident has no known medical or mental health condition that would place the resident at risk or harm from being placed in a special care unit as evidenced by a statement from a tier 1 mental health professional.

f. The clinical team conducts at least a weekly assessment for the continued need.

5. Appropriately trained employees shall supervise the use of a special care unit directly, with evidence of training in their employee file training record.

6. A facility with a special care unit shall have written policies and procedures that include the following:

a. A resident may be placed in the special care unit only if there is a written informed consent document signed by the resident's custodian, or if there is no court appointed custodian the parent or guardian or by an order of a court or other lawful authority. A copy of the informed consent document, court order, or document from another lawful authority shall be filed in the resident's treatment record.

b. Custodian's, or if there is no court appointed custodian, the parent or guardian's written informed consent for placement of a resident in the special care unit must be effective for no more than forty-five days from the date of the informed consent and may be withdrawn sooner unless otherwise specified in a court order or by another lawful authority.

c. Custodian's, or if there is no court appointed custodian, the parent or guardian's written informed consent for continued use of the special care unit may be renewed for thirty-day periods except as otherwise specified in a court order or by another lawful authority. Each renewal of informed consent must be through a separate written informed consent document.

d. Except as otherwise specified in a court order or by another lawful authority, the custodian, or if there is no court appointed custodian, the parent or guardian may withdraw their written informed consent to the resident being placed in the special care unit at any time, orally or in writing. The resident must be transferred out of the special care unit promptly following withdrawal of the informed consent.

e. All employees supervising residents in the special care unit shall have the means to unlock the unit immediately.

f. The special care unit must be furnished in a manner that minimizes the use of items by a resident in a harmful way.

g. A facility shall provide in each special care unit one resident care worker with no assigned responsibilities other than direct supervision of the residents. During hours when residents are awake, there must be one resident care worker for every two residents. During sleeping hours, there must be one resident care worker for every four residents. There must be a minimum of two workers always present in the special care unit. Employees shall be present in the special care unit with residents and shall have the means to immediately summon additional clinical support as needed.

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