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1784 FAIRVIEW ROAD, GLENMOORE, PENNSYLVANIA 19343 U.S.A.
TEL.: (610) 469-9256 FAX: (610) 469-9758

March 12, 1998

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Robert L. Gioffre
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675
FAX 717-787-0414

Re: Chapter 3800
Child Residential & Day Treatment Facilities

Dear Mr. Gioffre:

We are a Community Home for Individuals with Mental Retardation, ages 4 to 21, currently under the 6400 regulations. As a group of facilities for which the proposed 3800 regulations apply, we are grateful for the opportunity to comment and offer alternative suggestions.

Find included comments and suggestions for these sections:

3800.57 (a) to (f)
3800.58 (g)
3800.59 (h)
3800.128
3800.129
3800.141 (a)
3800.142
3800.144 (a)
3800.145
3800.164 (a)
3800.171 (4)
3800.184 (a)
3800.185 (a)

Thank you for consideration.

Sincerely,

Bernard Wolf
Director

CAMPHILL SPECIAL SCHOOL - BEAVER RUN
1784 FAIRVIEW ROAD, GLENMOORE, PA 19343 U.S.A.

Section 3800.57(a) to (f) Staff Training

Comment: The staff training requirements which are proposed here far exceed those currently required of Community Homes for Individuals with Mental Retardation. Staff training for these facilities are given at 6400.46. It is requested that these requirements be transposed to this section and that the status quo be maintained. Therefore, it is requested that this section be revised to incorporate the provisions of 6400.46

Revision: Section 3800.57)

(a) The home shall provide orientation for staff persons relevant to their responsibilities, the daily operation of the home and policies and procedures of the home before working with individuals or in their appointed positions.

(b) The home shall have a training syllabus describing the orientation specified in subsection (a).

(c) The chief executive officer shall have at least 24 hours of training relevant to human services or administration annually.

(d) Child care supervisors and child care workers who are employed for more than 40 hours per month shall have at least 24 hours of training relevant to human services annually.

(e) Child care supervisors and child care workers shall have training in the areas of mental retardation, the principles of normalization, rights and program planning and implementation, within 30 calendar days after the day of initial employment or within 12 months prior to initial employment.

(f) Child care supervisor and child care workers shall be trained before working with individuals in general fire safety, evacuation procedures, responsibilities during fire drills, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures if individuals or staff persons smoke at the home, the use of fire extinguishers, smoke detectors and fire alarms, and notification of the local fire department as soon as possible after a fire is discovered.

(g) Child care supervisors and child care workers shall be trained annually by a fire safety expert in the training areas specified in subsection (f).

(h) Child care supervisors and child care workers and at least one person in a vehicle while individuals are being transported by the home, shall be trained before working with individuals in first aid techniques.

(i) Child care supervisors and child care workers and drivers of and aides in vehicles shall be trained within 6 months after the day of initial employment and annually thereafter, by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid, Heimlich techniques and cardio-pulmonary resuscitation.

*****

Section 3800.57 (g) Staff Training

Comment: This section calls for annual training in first aid, Heimlich techniques, and CPR. The Red Cross First Aid Training is valid for three years. It is requested that this section be revised to validate the Red Cross training for the full three years.

Revision: Section 3800.57(g) ***Each staff person who will have direct contact with children, shall complete training in first aid, Heimlich techniques and cardiopulmonary resuscitation at least every year. However, for those staff persons completing the authorized Red Cross first aid training, this training shall be valid for three years.***

*****

Section 3800.103(h) Bathrooms

Comment: This section prohibits commonly used bar soap. Commonly used bar soap is an accepted feature of family living; that is homes in which families or live-in staff are actually living. It should be allowed in actual home settings.

Revision: "Section 3800.103(h) Bathrooms ***In facilities with live-in staff, bar soap or liquid soap must be available at each sink, at all times. In facilities without live-in staff bar soap may only be used if there is a separate bar clearly labeled for each child."***

*****

Section 3800.128 Wood and Coal burning stoves

Comment: Wood and coal burning stoves are a perfectly acceptable alternative to other forms of fuels. Community Homes for Individuals with Mental Retardation are currently allowed such stoves under Section 6400.108 provided certain safety features are met. It is requested that the provisions of 6400.108 be transposed to this section and that this section read as follows:

Revision: Section 3800.128

(a) ***The use of wood and coal burning stoves is permitted only if the stove is inspected and approved for safe installation by a fire safety expert. Written documentation of the inspection and approval shall be kept.***

(b) ***Wood and coal burning stoves, including chimneys and flues, shall be cleaned at least every year if used more frequently than once per week during the winter season. Written documentation of the cleaning shall be kept.***

*****

Section 3800.129 Fireplaces

Comment: Fireplaces are a perfectly acceptable source of heat and atmosphere in homes. Currently Community Homes for Individuals with Mental Retardation are allowed fireplaces provided basic safety conditions are met. The provisions of 6400.109 should be here incorporated.

Revision: Section 3800.129

(a) ***A fireplace shall be securely screened or equipped with protective guards while in use.***

(b) ***A fireplace chimney and flue shall be cleaned at least once a year if used more frequently than once per week during the winter season. Written documentation of the cleaning shall be kept.***

*****

Section 3800.141(a) Child Health & Safety Assessment

Comments: This provision requires the assessment within 24 hours of admission. No provision is given for completing the assessment prior to admission. For planned admissions it must be allowable to complete the assessment prior to admission.

Revision: "Section 3800.141(a) A child shall have a written health and safety assessment completed prior to admission or within 24 hours of admission."

*****

Section 3800.142 Health & Safety Plan

Comment: In this requirement no provision is given to write the plan prior to admission. For planned admissions it must be allowable to complete the written plan prior to admission.

Revision: Section.142 "If the health and safety assessment in Section 3800.141 (relating to health and safety assessment) identifies a health or safety risk, a written plan to protect the child shall be developed prior to admission or within 48 hours after admission, and implemented within 48 hours after admission.

*****

Section 3800.144(a) Dental Care

Comment: Currently, the regulations for Community Homes for Individuals with Mental Retardation distinguish between children 17 years of age or younger and children 18 years of age or older at 6400.142. Children 17 years of age or younger do require semi-annual dental exams but children 18 years of age or older require annual exams. It is requested that this distinction be continued in these regulations. Additionally, certain children with mental retardation require a general anesthesia in order to perform a routine dental exam. A general anesthesia is both costly and intrusive with accompanying medical risks. It is requested that such children, regardless of age, receive a dental exam only once a year.

Revision: Section 3800.144(a) A child who is 3 years of age to 17 years of age shall have a dental examination performed by a licensed dentist and teeth cleaning performed by a licensed dental technician at least semi-annually. A child who is 18 years or older shall have a dental examination performed by a licensed dentist and teeth cleaning by a licensed dental technician at least annually. Any child who requires a general anesthesia to receive a dental exam or teeth cleaning shall be required to do so only annually.

Section 3800.145 Tobacco Prohibited

Comment: This is a good provision. However, certain aspects need clarification. Presumably, "in the facility" means outside the building. "on the premises" is unclear. We allow staff to smoke outside the buildings and away from the proximity of the children. Also for staff who do smoke outside or away from the facility, no provision is given for storing their tobacco products. This is especially a need for live-in staff. In order to support this provision and clarify the above, the following revision is proposed:

Revision: 3800.145 ***Use and possession of tobacco products by children is prohibited inside the facility, on the grounds of the facility and during transportation provided by the facility. Use of tobacco products by staff persons is prohibited inside the facility and during transportation provided by the facility. Each facility shall have a written policy governing use of tobacco products by staff persons on the grounds of the facility (outside the buildings) and safe storage of tobacco products by staff persons when inside the facility and during transportation provided by the facility.***

*****

Section 3800.164(a) Withholding or Forcing of Food Prohibited

Comment: It is recognized that every child is entitled to 3 regularly scheduled meals and that withholding regularly scheduled meals is a form of abuse. Many children have behavior problems which respond to carefully constructed behavior management plans. Extra non-essential foods such as snakes and desserts are great motivators for positive behavior. Withholding such extra non-essential foods for negative behavior is an acceptable component of a behavior management plan. It is requested that the withholding of snacks and desserts be permissible provided such procedures are written up as a behavior management plan and included in the ISP.

Revision: Section 3800.164(a) ***A facility may not withhold food or drink, including snack and dessert, as punishment. Snack and dessert may be withheld if specified in a behavior management plan which is incorporated in the ISP.***

*****

Section 3800.171(4) Safe Transportation

Comment: It is acknowledged that the age 21 generally indicates a level of capacity and responsibility which enables one to drive vehicles with children. However, younger drivers with prior driving experience and a good driving record could be better drivers than a new driver who is 21. Also the size of the vehicle and the occupancy are factors. In family-based or family-sized facilities a driver may only be transporting a few children, say 1 to 4. In larger facilities, a driver may be transporting many children, say 10 or more. This is a factor to determine the age of a responsible and safe driver. It is requested that this section be revised to allow younger drivers with experience to also drive, but that the younger drivers be limited in the size of vehicle that they can driver to an 8 passenger vehicle (based on a family-style station wagon.)

Revision: 3800.174(4) ***The driver of a vehicle with a capacity of 8 passengers or less shall be eighteen years of age or older. Drivers under 21 years of age shall have at least six months of driving experience. The driver of a vehicle with capacity of 9 passengers or more shall be 21 years of age or older.***

*****

Section 3800.184(a) Medication Log

Comment: This section names six components for the medication log. All these items are important information. Not all of them are necessary to have available for administration of medication on a daily basis. Those that are not necessary for administration should be readily available in the child's record. Inclusion of all these items of information on the medication log make the log bulky and impractical to use. Items (a), (2), and (5) should be included in the log. Items (3), (4), and (6) need not be in the log but in the child's record.

Revision: 3800.184(a) ***A medication log shall be kept to include the following for each child:***

(1) ***A list of prescription medications;***
(2) ***The prescribed dosage;***
(3) ***Specific administration instructions, if applicable.***

The following information shall be kept in the child's record:

(1) ***Possible side effects;***
(2) ***Contraindicated medications;***
(3) ***The name of the prescribing physician.***

*****

Section 3800.188(a) Medications Administration Training

Comment: This provision seems to call for completion of the full Department-approved medications administration course every two years. This exceeds the requirements of 6400.168 governing Community Homes for Individuals with Mental Retardation. 6400.168 requires completion of the course only once, but then an annual Medications Course Practicum must also be passed. It is requested that the provisions of 6400.168 be incorporated and that this section be re-written as follows:

Revision: Section 3800.188(a ***A staff person who has completed and passed a Department approved medications administration course is permitted to administer oral, topical and eye and ear drop prescription medications and epinephrine injections for insect bites. Such a staff person shall then complete and pass the Medications Administration Course Practicum annually.***

*****

Dept. of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, Pa. 17105-2675

Dear Mr. Gioffre,

I am a parent of a child with disabilities. I am greatly concerned that the regulatory changes your office is proposing does not adequately insure my child's right to good services.

I firmly believe that I have a right to be involved in the planning and delivery of any and all services that are for my child. These regulations do not insure that. They even go so far as to discourage that. You need to rewrite any and all sections that have to do with parent involvement to make sure that all service providers treat me as a partner and with respect.

As an African American I know only too well how discriminatory and insensitive to cultural differences some service providers can be. These regulations do nothing to insure that services will be culturally competent. That needs to be addressed.

There are many things in these regulations that fall short of what a good system should have. Please give us more time to develop a set of recommendations for you.

Thank-you for your consideration.

Sincerely,

Sherry Bradshaw

Boys Club & Girls Club

of Lancaster, Inc.

serving youth since 1939

607 Rockland Street, P.O. Box 104, Lancaster, PA 17608
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March 12, 1998

Department of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

After careful review of the proposed amendments to DPW regulations our agency is submitting for your consideration concerns that would significantly change the way we do business. The areas indicated would cause a 15 to 20% increase in cost to implement or perhaps deny service to the seriously problematic clients we successfully serve at this time.

3800.16 Unusual Incidents

(a) An unusual incident is a death of a child; an action taken by a child to commit suicide that requires in patient treatment; an injury, trauma or illness of a child requiring inpatient or outpatient treatment at a hospital; a violation of a child's rights, such as discrimination (race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age or sex.); intimate sexual contact between children, consensual or otherwise; an assault on a staff person by a child that requires medical treatment for the staff person; outbreak of a serious communicable disease as defined in 28 Pa Code 27.2 (relating to reportable diseases); an incident requiring the services of the fire or police departments that places children at risk; and any condition which results in closure of the facility.

Rationale:

Children often express suicidal ideations, or make gestures that can be addressed in counseling with contact made to the funding agency. To generate an unusual incident report to DPW investigators for every incident would be cost prohibitive. Children leaving a facility for 30 minutes or more without approval should be referred to the proper authorities, the funding agency, and a call to the parents. Very often they are returned by police, parents or return on their own. Again there would be an enormous cost to have an investigation for each incident. Any incident of abuse or misuse of a child's funds or property requires an internal investigation with documentation of findings provided to the funding agency. This would be time consuming to DPW investigators

Rationale:

Children do have a right to refuse food and can not be forced to eat. Additionally, there are situations where children would prefer to eat foods brought in by family members that do not Meet Department of Agriculture standards. This behavior is not acceptable, because of nutritional concerns.

3800.201 (b)

A behavior intervention procedure, with the exception of exclusion as specified in 3800.212 (relating to exclusion), may be used only to prevent a child from injuring himself or others.

Rationale:

Children are becoming more and more aggressive and the assaults are not limited to staff, but include peers. Behavior intervention is often used to help an out of control situation began to de-escalate. Once the need to strike out is gone de-escalation can continue with dialogue. The proposed amendment would adversely affect the types of children we currently accept into program, thus forcing otherwise appropriate clients into secure placement. Also, we would be faced with a higher turnover of staff, due to fewer options when dealing with crisis situations.

We appreciate the opportunity to review and respond to the proposed Department of Public Welfare regulations. As its our pleasure to provide a service that makes a difference in the lives of children we trust our recommendations will be carefully considered as revisions are made.

Sincerely,

Cecelia A. Stewart, MSW
Director, Fulton Shelter

MAR-14-98

P.03

Bethany
CHILDREN'S HOME
Light • Life • Hope for Children

1865 Bethany Road • Womelsdorf, PA 19567-9214 • Phone (610) 589-4501 • Fax (610) 589-5771

The Department of Public Welfare
Robert L. Gioffre
PO Box 2675
Harrisburg, PA 17105-2675

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March 3, 1998

Dear Mr. Gioffre,

I am writing this letter in response to the proposed 3800 regulations as published in the Pennsylvania Bulletin, Vol. 28, dated February 14, 1998.

I have followed the process of rewriting the 3810 regs. and encompassing a wide variety of programs and services for quite some time. I can certainly appreciate the time and effort that such an undertaking requires. However, I do feel that bringing a broad array of service types under one set of regulations can come at the expense of some programs by overly restricting long-standing and successful practices. I believe that this is the case with Bethany Children's Home and these new proposed regulations.

My comments regarding the specific regulations are as follows:

3800.16 Unusual incidents

The new definition for what is an unusual incident is much too broad. It will now include many situations that are not at all unusual for any facility serving children. For example, does an action taken by a child to commit suicide allow staff any discretion in determining whether the attempt was genuine or attention-getting behavior? Outpatient treatment at a hospital is certainly not an unusual situation. Most of the medical services available to children in placement are only available at our local hospitals. Requiring Unusual Incident Reports for any injury or illness requiring outpatient treatment at a hospital would involve excessive paperwork completion. Who is to determine whether a child's rights were violated? A child leaving the premises for more than 30 minutes is not very unusual. The statement about abuse or misuse of a child's funds or property does not identify abuse or misuse by whom? Does this include abuse or misuse by another resident of the facility? Finally, an incident requiring police Departments seems to include police coming to the facility to follow-up on child run away reports. Is that too an unusual incident? That practice is absolutely routine at Bethany.

It is believed that requiring Unusual Incident Reports (both initial and after the facility's investigation) under these new circumstances will greatly increase staff time in completing paperwork. All such incidents are currently documented in a child's file and reported to the County agency. Requiring the completion of Unusual Incident Reports is

redundant and will take staff time away from providing services to children. The use of unusual incident reports certainly has an important purpose. I believe that the definition of an unusual incident has been expanded to include many situations that are not unusual at all.

3800.32 Specific rights

I would ask clarification on subsection (k) regarding a child's right to be free from excessive medication. Whose opinion that the medication is excessive is to be considered?

3800.56 Supervision

In subsection (d), why do children with adjudicated delinquency provide an automatic exclusion to not needing hourly observational checks throughout sleeping hours? What about children who are placed for family issues and not for reasons that involve their delinquency? Children with serious delinquency issues are not considered for placement in our residential program. This provision creates great difficulty for us in trying to normalize the placement of children who are adjudicated delinquent. We have children with delinquency adjudications in most of our group homes. Requiring hourly bed checks is invasive and unnecessary for the children that are placed at Bethany. It will also be a significant financial burden in needing to hire nine or ten additional child care workers to provide such a service.

3800.103 Bathrooms

What is the expectation for "clearly labeling" bar soap?

3800.106 Water areas

We take exception to the requirement that all water areas need to be fenced. Is there an assumption that all water areas are a safety issue? If any water area is identified as problematic for safety, then corrective measures should be taken. However, requiring such measures for all water areas, regardless of the lack of identified problems seems excessive and unnecessary. It also seems to then require that a lifeguard must be present when kids are fishing?

3800.129 Fireplaces

We have met all previous requirements with regard to the use of fireplaces without any incidents. We believe that the existing regulations are sufficient for safe use of fireplaces at our facility. Additionally, the use of fireplaces in our cottages follows our philosophy of a home-like atmosphere. This regulation removes another important part of our approach to normalizing the experiences while addressing the therapeutic needs of children placed at Bethany. I can not begin to convey the positive impact or importance of cottage groups sitting around a fireplace, discussing issues or just talking about the day's events. I ask that you seriously consider allowing the use of fireplaces with adequate supervision, having the fireplaces screened and chimneys cleaned on an annual basis.

3800.132 Fire drills

Subsection (e) regarding fire drills during sleeping hours is believed to be an excessive and unnecessary interruption of sleep for children in our facility.

3800.143 Child physical examination

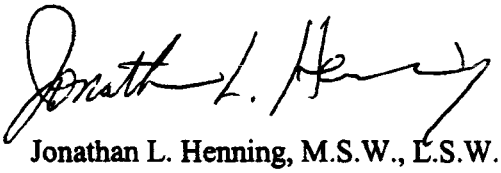
Regarding subsection (e) (2) unclothed physical examination- shouldn't it be up to the doctor to make the determination whether an unclothed exam is warranted? Many of the children being placed in our facility have sexual abuse in their histories. For these children, an unclothed physical exam can be a very traumatic and unnecessary procedure.

3800.212 Exclusion

Placing subjective time limits or use limits on "time out" is very impractical and just does not make sense. Wouldn't a child's behavior be a better determination as to being appropriate to rejoin the group? Having to bring an acting out child back into a group situation simply because time has expired will not have a positive impact on the child being excluded nor on the rest of the children in the group.

We believe the above-mentioned regulations, as written, severely compromise our ability to provide a "normalizing" therapeutic experience to the children placed at Bethany Children's Home. We ask that you carefully consider the impact that these regulations will have on the provision of services to children placed in a residential facility like Bethany. I thank you for your time and interest and appreciate your willingness to consider these comments.

Sincerely,



Jonathan L. Henning, M.S.W., L.S.W.
Assistant Executive Director

Cc: Jeanne DeAngelis, PCCS

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MAR 10 1998

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98 MAR 12 PM 2:56 3/3/98

Dept. of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, Pa. 17105-2675

Dear Mr. Gioffre,

I am writing to you to express my concern over the proposed 3800 regulations. I am extremely upset that the need for culturally competent services is completely ignored as well as the right of parents to bc partners in the service and treatment process.

I beleive this is a huge waste of my tax dollars if it is enacted as written.

People who are going to provide good services for children are going to regardless of any set of regulations. Those aren't the people I worry about. I worry about the people who want to make a huge profit because of the disabilities of some of our children. Those are the people who will benefit most from these regulations. With these regulations, almost anyonc can set up shop and get a liscense.

Please, give us more time to respond and give you input. Then, please, rewrite these so that they do insure that our children are getting good services.

Thank-you for your consideration.

Sincerely,

Stanley Bell

115

BEACON LIGHT
BEHAVIORAL
HEALTH SYSTEMS

800 East Main Street
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March 20, 1998

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Mr. Robert Gioffre
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre,

This letter is in response to the Saturday, February 14, 1998 publication of PART IV of the Department of Public Welfare's Child Residential and Day Treatment Facilities proposed regulations. These comments are presented to be considered in the review under public comment.

We would like to express our support of the effort to revise the regulations put forth in this publication. We believe the proposed regulations represent the best interest of the children of the Commonwealth and are a reflection of best practice as it is interpreted at this point in time. We commend the staff of the Department of Public Welfare for their thoughtful consideration of these regulations.

These comments are put forth based on more than twenty-five years of treatment of children in a variety of residential settings. Beacon Light Behavioral Health Systems operates ICF/MR, CRR, RTF, and C & Y residential programs, as well as provides day treatment services. Our agency is JCAHO Accredited and works to meet best practice standards for our industry. We provide services under the corporate names of *Children's Home of Bradford*, *Children's Center for Treatment and Education*, and *Ramsbottom Center*.

Please consider the follow comments on the regulations:

The comments under "*Fiscal Impacts*" in PA Bulletin, Vol. 28, No. 7, February 14, 1998, p 957 - *"2. Physical site"* do not consider the cost of renovation of group homes for children with more than four (4) clients sleeping on the second floor under the current NFPA guidelines (See discussion below on 3800.122). If renovations are necessary to create a second means of exit from the building, the cost could be considerable. Within our agency, one of our eight group homes does not meet this standard and renovation costs would exceed $20,000. These facilities are in compliance with all current requirements for life safety as required by the Commonwealth.

A. Our major concern centers on the vague or general language that describes many of the major provisions of the regulations. This language leaves much to the interpretation of the

reviewer, which, in the past, has led to various interpretations across the Commonwealth. The following section is typical of our concern:

3800.16 - Unusual incidents - PA Bulletin, Vol. 28, No. 7, February 14, 1998, p 962 - This reporting provision is essential to identify potential problem areas within an agency, and we support this requirement, however, the language clarification is required so as to balance the need for the Department to know of potential problems with the time that is necessary to meet notification requirements, particularly for minor or false alarm situations that will not yield the Department the information it requires.

To illustrate,

1.) "an injury, trauma or illness of a child requiring in-patient or out-patient treatment at a hospital" includes nearly every trip to a hospital. In our rural area, often children are taken to the emergency room when physicians are not available in their office to have minor conditions diagnosed or treated (at the physician's request). This may be prompted by a fever, the onset of the flu or a minor sprain of a finger or ankle that needs to be checked out to assure the appropriate care of the client. In normal situations, parents and county caseworkers are called in these situations, but the more lengthy process of reporting to the regional office is not done. The original 3680.21 (4) regulations were more specific with regard to intent and represented a clearer understanding of what was reportable than the current language.

2.) "an assault on a staff person by a child that requires medical treatment for the staff person." There are two issues in this statement, the definition of "assault" and "medical treatment." If we are only dealing with assaults that require "medical treatment," we have failed to identify those assaults that, because of appropriate staff intervention or circumstances, avoided medical treatment. As the current language is written, we are required to report if a staff person seeks out the agency nurse for cleaning of an abrasion, but not if a major assault did not require medical treatment. The regulatory language should require the reporting of all overt assaults on staff (or other clients) by a client. If the reporting of staff medical treatment resulting from assaults is important to the department, then the report should be made on those incidents that require *in-patient or out-patient treatment at a hospital* consistent with the language for injury of a child.

It is our concern that because of a lack of more specific language, the requirement to report minor cases may cause staff to not seek timely treatment for the client or themselves because of the required "paperwork." This is not the intent of the Department, nor is it best practice, and the

language should be reviewed to be more descriptive of the Department's intent.

3.) In a similar vein, the language that requires reporting of "an incident requiring the services of the fire or police departments," should be made client-specific to reduce the mandate to report non-client care issues. Is it the intent of the department to know every time a service department representative is involved with the agency? False Alarms due to mechanical failure, request of police assistance to resolve employee theft of agency property, etc. are not believed to be the intent of this language, and could be clarified with more specific language such as "*any incident involving clients or their families that require the services of....*"

B. A second concern with the regulations is that at points they exceed existing standards of best practice without documenting a justifiable need to do so.

3800.122 - Exits - PA Bulletin, Vol. 28, No. 7, February 14, 1998, p 966. This section requires two exits from each floor if more than four (4) children sleep above the ground floor. This requirement is more restrictive than the (most recent) 1995 National Fire Protection Act (NFPA) or the current PA. Labor and Industry requirements for group home facilities. The NFPA standards are used by JCAHO to establish standards for fire safety.

1.) Our first consideration of this language is the safety it assures the client. The necessity of the more restrictive language than national fire safety standards may be justified based on prior experience, but lacking that experience (i.e. fire related deaths due to lack of a second exit), the question that the regulations fail to answer is "Are the more restrictive standards necessary to protect children?," or "Do not the current standards protect children adequately?" These questions need to be answered based on hard information, by fire safety experts, rather than the department's need to move to the highest level of standards as a matter of principle. To make an arbitrary move to this level adds increased cost to programs with no demonstrated safety return.

2.) The second consideration that must be answered is how the Department intends to deal with existing facilities that do not meet this higher standard. Will compliance be required within a specified time frame, and what is that time frame, or will facilities be grandfathered in or limited to only new facility approvals?

The proposed language, if adopted, will cause some agencies to make structural changes to their facilities that will result in major capital expenditures that are not reflected in the statement of fiscal impact accompanying this publication.

C. A third area of concern deals with the lack of specific information regarding Department approved training programs and the assurance of their availability.

3800.188 (a) - Medications administration training - PA Bulletin, Vol. 28, No. 7, February 14, 1998, p 969. This section references to "Department approved medications administration course." In the past, our agency has not been able to secure adequate placements in the medication administration course offered for MR facilities. Instructor training of multiple staff persons per agency is essential to assure instructors for the variety of settings and times training must take place in an agency of our size. The periodic training provided by the Department in the past has not been able to keep up with this demand. The Department must assure that adequate training opportunities will be available for the duration of the effective term of these regulations in order for this requirement to be meaningful. Otherwise, training alternatives should be referenced in the regulations so that there are no questions as to acceptable options.

The fiscal impact of providing this training should also be a consideration under "*Fiscal Impact.*" There is cost associated with having staff attend training programs. The average cost to sent staff to CASSP training seminars over the past year for two days amounted to $184.80 per person. Currently, our agency has six persons trained in medication administration to meet training demands. Based on CASSP training, cost for six trainers annually could cost in excess of $1,100 annually for our agency.

3800.205 (a) - Staff Training - PA Bulletin, Vol. 28, No. 7, February 14, 1998, p 970. This section references to "...a Department approved training program..." for behavior intervention. Our concern in this area is for the scope and failure to identify training programs. While the open nature of this statement allows the Department down the road flexibility, it also opens the door for various interpretations about what is Department approved. The language is also singular in nature. A mechanism must be in place to define the range of approved courses that are not currently in place. Currently, our agency utilizes two different nationally recognized approaches, depending on the population being served--MR/ADD or MH. At times, individual treatment plans will reflect another recommended method for exceptionally resistive and self-abusive children in certain settings. The professional staff identify procedures to be used, based on the presenting problems identified by the child and the setting in which the services are delivered. There is no single method that will answer the safety needs of all of our children. The regulations need to be more specific about the Department's understanding of the behavior intervention needs of individual groups of children. The current language leads the reader to think that there will be only one approved method of intervention. JCAHO has studied this issue at some length over recent years and has established a set of standards for restraint in the 1997-98 guidelines that we would recommend to the Department for consideration (see attached).

Again, the fiscal impact of providing this additional required training should also be a consideration under "*Fiscal Impact.*" While our agency is already committed to providing this training to a large degree, there is not provision in our budget for having trainers recertified or refresher trainings each year. The Department needs to identify the approved training programs, and their requirements for recertification should be reviewed for cost purposes. If there is a cost associated with this training, it should be identified under "*Fiscal Impact.*"

I am pleased to have had the opportunity to offer comment on the proposed regulations and again would like to commend the Department on its effort in this regard. Thank you for your consideration of our information.

Sincerely,

Thomas E. Urban
President and CEO

TEU:cg

(27)

Appalachian Youth Service
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March 9, 1998

Mr. Robert L. Gioffre
PA Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

ORIGINAL: 1927
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Sandusky
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Dear Mr. Gioffre:

In response to the February 14, 1998 publication of the proposed 3800 regulations, please review the following. Once again a tip of my hat to you and your team for your creativity, consideration, and compromise during the development process of this draft. Regardless of our issues with the regulations, the provider community is very appreciative of the welcomed involvement and opportunity to comment and assist in the evolution of the document.

My opinion remains that the development of one set of regulations to govern program services ranging from Independent Living, group homes, and secure programs, serving clients with diverse needs ranging from children that are in their own apartments meeting all of their own needs with minimum support, to clients that need assistance with basic hygiene, to violent offenders, is an impossible task! The extreme nature of the programs and the diverse needs of the clients cannot logically or safely be regulated by one all encompassing set of regulations. In general, I believe that the draft 3800 regulations are too loose for non-self-reliant clients and too restrictive for normal range clients. The attempt to fit Day Treatment programs into the residential regulations will ultimately result in curtailed services and unnecessary increased costs for Day Treatment service providers. Day Treatment programs have had the opportunity to develop unrestricted by programmatic regulations for the past 20 years, and the models are as numerous as the colors in the rainbow.

General comments:

1. The current 3810 regulations have served the dependent and delinquent programs well for the past 12 years protecting the health and safety of the children in residential care.

2. Day Treatment programs' activities are very different from residential programs and do not belong with residential regulations. Day Treatment regulations should be developed that match the nature and requirements of the program.

3. The 3800 regulations will limit community based services to certain children.

4. The 3800 regulations will increase the cost of residential care for dependent delinquent children between 10 and 20 percent and not materially increase either the health or safety of the children in care.

Specific comments being made are based on normal ability range dependent and delinquent children living in community based residential group homes. Many of the comments concerning the various sections of the regulations would not be made if the sections were applied only to lower functioning children or children in a secure setting.

3800.16 Unusual Incidents.

The expansion of the unusual incident reports to include "outpatient treatment at a hospital; a child who leaves the premises of the facility for 30 minutes or more without the approval of staff persons".

If programs are required to report all outpatient treatments without limitations including routine, non-serious colds, sprains, and splinters, the expansion will result in unusual incident reports being completed on a daily basis by most programs. The requirement will result in increased costs with direct care staff being diverted from productive work with children for no productive reason.

Recommendation: Retain original Unusual Incident reporting procedures from existing 3810 regulations.

3800.17 Incident Record.

The requirement to maintain an incident record on "a child who leaves the premises of the facility for less than 30 minutes without the approval of staff; and injuries, traumas and illnesses of children that do not require inpatient hospitalization which occur at the facility." If a program is required to develop and maintain an incident report on every cold, ache, and reported pain that are not serious, the process will be costly and divert direct care staff from more productive duties. This change to Incident Records and Unusual Incident reports is a perfect example of the need for different requirements to meet the needs of widely varying clients.

3800.54 Child Care Supervisor.

(d) The child care supervisor shall have one of the following

(1) A bachelor's degree from an accredited college or university and 1 year work experience with children.

(2) An associate's degree or 60 credit hours from an accredited college or university and 3 years experience with children.

This regulation does not consider the absolute value of direct child care experience. The difficult direct care work involving delinquent and dependent children in a 24 hour setting has little appeal for bachelor or master level college graduates. Having been a director of residential programs for almost 15 years, I can attest to my appreciation for direct care staff that have worked with children for five or more years. This regulation will force many programs to artificially modify flow charts and more importantly eliminate the incentive of non-college graduates to work in residential programs due to the lack of advancement potential.

Recommendation: To recognize the value of direct care work experience and to allow one year of direct care experience to equal two years of education.

3800.57 Staff Training

(b) Prior to working alone with children and within 60 calendar days after the date of hire, each full-time staff person who will have direct contact with children and the director, shall have at least 30 hours of training to include at least the following areas.

This regulation is unnecessary for programs that deal with normal range children in a community based setting. The regulation will be impossible for small community based programs to comply with. Small programs are unable to maintain a pool of staff to act as replacement workers, or hire a specific training specialist.

Recommendation: The current requirement of the 3810 regulations has worked well for the past 12 years.

3800.145 Tobacco Prohibited.

Use or possession of tobacco products by children and staff persons is prohibited in the facility, on the premises of the facility, and during transportation provided by the facility.

I agree that staff must not use tobacco products in sight or smell of children, but to prohibit staff from carrying or storing tobacco in their personal vehicles is impractical. The total prohibition of tobacco products on agency property will ultimately prove to be a fire hazard as staff will continue to use tobacco, but clandestinely in an uncontrolled manner.

Facilities must be allowed to make their own policies on smoking as long as the children cannot sense or be effected by the use.

3800.188 Medications Administration Training

(a) A staff person who has **completed and passed a Department approved medications administration course** within the past 2 years.....

3800.205 Staff Training

(a) If behavior intervention procedures are used, each staff person who administers a behavior intervention procedure **shall have completed and passed a Department approved training program** within the past year in the use of behavior intervention procedures.

3800.291 Criteria.

A child shall **complete a Department approved training program** and demonstrate competency in the following areas to be eligible for transitional living:

The reference to a **Department approved training program** referred to in the above three sections is vague. Without the specifics of the requirements, it is impossible to evaluate the appropriateness of the regulation and the relative cost impact to the delivery of services. When the 3810 regulations became effective on June 7, 1986, the Department indicated that an interpretation manual would be developed in quick order to assure uniform application of the regulations to all providers across the regions. The interpretation manual was issued April 26, 1995, nine years later. The interpretations in the manual differed markedly from the practical interpretation.

Recommendation: Provide specific information concerning the **Department approved training program** or change the language to just training.

3800.143 Child Physical Examination.

(a) A child shall have a physical examination within 15 days after admission and thereafter....

This regulation would prove to be especially cumbersome and restrictive to Day Treatment programs. Some Day Treatment programs may only have a child for 5 days to reduce truancy. Day Treatment programs should not have requirements above or already required of the home school district of the child.

Recommendation: Physical requirements should remain the responsibility of the home school district, drop the requirement.

3800.56 Supervision

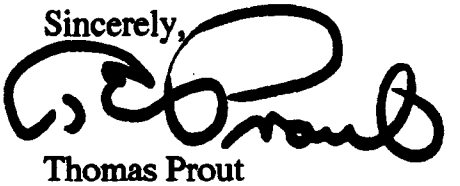
(d) The requirements in subsections (a)-(c) regarding supervision of children during sleeping hours do not apply if the facility serves 12 or fewer children, there are no children in an adjudicated delinquency status at the facility, and one of the following is met:

The regulation makes reference to "in an adjudicated delinquency status". This reference has no relevance to community based, non-secure programs. Children placed in a community based program, either dependent or delinquent, are deemed appropriate for a non-secure program. Whether a child is adjudicated delinquent or deemed a dependent is as much a function of age, budget, and county philosophy as the actual offenses of the child. AYS operates a sex-offender program - a significant number of the children served by the program are dependent not delinquent. The status of Delinquency is not a measure of threat to the community.

Recommendation: Drop the reference to "adjudicated delinquency status" from the regulation.

Once again thank you for the opportunity to be involved in the regulation review process. If I can be of further assistance, please call.

Sincerely,



Thomas Prout
Executive Director

Children's Home
OF YORK

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March 11, 1998

Department of Public Welfare
Mr. Robert L. Gioffre
PO Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

Thank you for the opportunity to respond to the proposed amendments to the Department of Public Welfare [55 PA. CODE CHS. 3680, 310, 370, 3800, 3810, 5310 and 6400] for Child Residential and Day Treatment Facilities as stated in Pennsylvania Bulletin, Volume 28, Number 7, dated February 14, 1998.

§3800.16 Unusual Incidents

Section (a) mandates reporting for an injury, trauma or illness of a child requiring inpatient or outpatient treatment at a hospital. This would include, as we understand it, treatment for sprains, jammed fingers from playing basketball, treatment for minor cuts and other non-serious injuries. With active children, often using poor judgment, these injuries take place with some degree of regularity and would be burdensome and an inappropriate use of staff time to report. It is recommended that this sentence by changed to read, "an injury, trauma, or illness of a child requiring any inpatient treatment at a hospital or outpatient treatment for non-routine and serious illnesses or injuries."

Section (a) also contains the requirement to report a child who leaves the premises of a facility for 30 minutes or more. In open facilities, including group home and emergency shelter care, a child may run away and either return or be found by staff or the police. While this doesn't happen very often, it seems that 30 minutes is a very short period of time, and suggest that while appropriate notification be made immediately to referring agencies, parents and police departments, reporting as an unusual incident should be required after four hours or more of unapproved absence from the facility.

3800.57 Staff Training

(b) The 60 calendar day requirement for completing 30 hours of training is just too short. It is suggested that 60 days by extended to at least 90 days after the date of hire, and that until the training is completed staff should not work alone with children. This will help insure quality training rather than some expedient but poor quality substitution. In our situation, Therapeutic Crisis Intervention, as developed by Cornell University, is a 28-hour training module. It makes no sense to do this training over and over again for three or four new staff members. When you add this to all the other trainings that are required, it becomes very time consuming and expensive to conduct them very frequently for very small groups. By spreading the time frames, the groups can be larger and more productive.

§3800.141 Child Health and Safety Assessment

We feel it should be the responsibility of the referring county agency to provide the Child Health and Safety Assessment. This material is necessary for an agency to decide if the referral is appropriate for the services they provide. For example, incidents of violence or aggressive behavior and predisposition for self-injury or suicide would be determining factors as to whether or not the services an agency provides are appropriate for a child.

§3800.145 Tobacco Prohibited

While we are in total agreement that children and staff should not use or possess tobacco products in the facilities, or during transportation, most agencies have a few tobacco addicted staff members, and asking staff to leave the premises of the facility would present a hardship for staff, especially in bad weather, and a coverage problem. It is recommended that current staff be allowed a six month grace period to be able to smoke on the premises, but not in the facility, to give them the opportunity to break the tobacco addiction. New staff would have to be screened for tobacco addiction and be advised that no one with a smoking or other tobacco addiction can be hired. I am not sure if this is a legal alternative. In addition, I don't think communities would appreciate staff smoking in front of their home when they were required the leave the premises of a group home. It would also be very difficult for agencies who have large campuses. Workers would have to take their cars or walk quite a distance to be "off premises." We have also been advised by the Society of Human Resource Management that this would effect minority employees disproportionately since statistics indicate a higher level of smokers in this group.

§3800.188 Medications Administration Training

Before this section goes into effect, "the department" should have already approved a substantial number of medication administration courses and not have after the fact implementation. Most small children and youth facilities do not have the staff indicated in Section (a) available to give daily medications, especially in group home facilities.

§3800.202 Appropriate Use of Behavior Intervention Procedures

Section (b) mandates that a behavior intervention procedure may be used only to prevent the child from injuring himself or herself. This is unworkable and dangerous since it does not include a child who is injuring others or damaging property. This section should be modified to read "may be used only to prevent a child from injuring himself, others or damaging property."

§3800.211 Manual Restraints

Small facilities, such as group homes,would not be able to comply with section (e) because it would either tie up all staff on coverage or not leave enough staff to adequately supervise the rest of the children. Many larger, more violent children require at least a two person restraint, and with the addition of the observer, three or more staff would be occupied with one child. For many facilities this is not doable. It is recommended that (e) be rewritten to require the staff person or persons involved in the restraint to fill out the required documentation of the physical and emotional condition of the child at the conclusion of the restraint period.

Thank you for your consideration of these very important regulatory issues.

Sincerely,

Richard Harris

Richard Harris, ACSW
Executive Director

RH:su

CHILDREN & YOUTH SERVICES
OF LYCOMING COUNTY

March 11, 1998

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Sandusky
Legal (2)

Mr. Robert L. Gioffre
Department of Public Welfare
PO Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

Lycoming Children and Youth Services operates a thirteen (13) bed Shelter Care facility and a Day Treatment Program which serves sixty-four (64) clients. These Programs will directly be affected by the proposed Chapter 3800 Child Residential and Day Treatment Facilities regulations.

Our Agency has reviewed the proposed regulations and is in general agreement with the proposed changes. Our Agency has serious concerns regarding four sections of the regulations.

The following are our concerns and recommendations regarding the four sections:

A) **Sections 3800.54(d) and 3800.55(g)** Our Agency would recommend that existing staff at facilities presently licensed by the Office of Children, Youth and Families be grandfathered into compliance of the proposed regulations. All staff at our Agency are hired in accordance with Civil Service. This change in regulations will have impact on the Civil Service Houseparent and Residential Director job titles. Our Agency would have two staff which do not meet the educational guidelines set in the proposed regulations, even though they have a combined work experience of thirty-three (33) years with our Agency.

B) **Section 3800.103(f)** This is the only subsection of the section 3800.103 that applies to Day Treatment Programs. Our Agency recommends that it also be excluded. Our Agency believes this to be an omission as it is inconsistent for it to remain when all other subsections have been excluded. Our Agency also believes it to pose no jeopardy to the health, welfare, safety or well-being of children if it is excluded.

200 East Street • Williamsport, Pa. • Telephone (717) 326-7895

C) **Section 3800.221** Emergency Shelter Care Programs or any facilities which only provide emergency care for up to thirty (30) days should complete an Emergency Service Plan (ESP) for children as set forth in the 3810 regulations. An ISP to be completed within thirty (30) days would be of no use for these facilities.

D) **Section 3800.312(8)** The present wording in the proposed regulations allows for interpretation that the program is solely responsible for the provision of the meal. The wording makes it questionable about allowing lunches to be brought in from home or the children's school providing the lunch. Our Agency would recommend the following wording. "A meal time shall be provided to the children at least every 5 hours they are at the facility." This section only applies to Day Treatment Programs and meals are provided in a variety of ways.

Thank you for consideration of these sections. I would be available if any questions should arise.

Sincerely,

Richard J. Saylor, Director
Lycoming Youth Campus Programs

RJS/rsb

CYFC

EDUCATION CONSORTIUM

Children, Youth and Family Council Education Consortium

ORIGINAL: 1927
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March 31, 1998

Bob Gioffre
Office of Children, Youth and Families
Department of Public Welfare
Harrisburg, PA 17105

Dear Bob,

I want to thank you for the opportunity to comment on the 3800 regulations. We have appreciated the open process the Department utilized to develop the regulations. The intensive group process and discussion with stakeholders has allowed for input from a variety of sources thereby enriching the development of the regulations. You had a daunting task and engaged in it in an inclusive, thoughtful manner. Thank you for involving us.

I would hope that the a plan for working with the legislature would be addressed. I echo Ray Webb's concern at the meeting March 3, that a plan should proactively be developed for consistent response to the questions that are arising. We also express concern that these regulations are not applicable to the Youth Development Centers, state run facilities housing many of the same children cared for in private non profit agencies. Consistency should be the key baseline for children served in Pennsylvania and we urge DPW to adopt these regulations for their facilities.

The Department of Public Welfare has consistently been unresponsive to the needs of children in substitute care and HealthChoices. Several points are made in this letter

related to the implementation of these regulations and coordination and linkage with HealthChoices. There has been no agreement or decision between OCYF, OMA, via DPW to resolve current problems getting physicals and dentals for children in substitute care. These regulations only set further into practice and unresolved situation. DPW should address this in a holistic manner rather than in a piece meal manner; without that resolution children will continue to fall through the cracks and providers continue to be out of compliance with OCYF and at odds with the HMOs.

As we had discussed at our meeting on the 3rd, we have a number of comments and questions about the proposed regulations. I have solicited input from our residential providers and combined the comments into the following areas of concern: initial costs for implementation, on-going costs of implementation, impact on program delivery, and questions.

Initial Cost Concerns

• 3800.17 Lead content. The initial cost for lead testing can be as much as $500/facility. For community based group home, this can be a prohibitive cost. We recommend that organizations work closely with the health department in their jurisdiction to establish the best way to remdiate the problem depending on the situation. This would include the option of sealing the surfaces besides removal if absolutely necessary. We recommend that the state pay for the testing of lead through the Department of Health.

• 3800.54 Child care supervisor: We are encouraged to see the increase in educational requirements for this position. However, we recommend that staff currently in this position who not meet the new requirements be grandparented into the position with the understanding that new staff will meet the requirements stated in this section.

• 3800.122 Exits. Group home settings may find this difficult to comply with due to local codes and requirements. DPW should consider alternatives to externally fixed fire escapes for these facilities.

Impact on Program Delivery

• We recommend that Drug and Alcohol programs be included in this set of regulations. As HealthChoices moves across the state and behavioral health and drug and alcohol treatment are carved out of managed care, these regulations should reflect this integration of services. Otherwise, it appears that the health and safety of children placed in drug and alcohol facilities will be measured with a different process.

• The definition section should include legal guardians in the family definition. This is particularly true for the number of children placed with extended family members in kinship settings.

• There should be a section about grievances for providers as a part of the general overview. The published draft does not allow for grievances or appeals by the providers.

• 3800.129 Fireplaces. Many older facilities have working fireplaces as a part of the physical structure. Agencies use these for special celebrations and use them to bring children together in a warm, homelike setting. To eliminate the use of fireplaces creates an unnecessary restriction on programs that are working to make the experience of children placed in an institutional setting as "normal" as possible. This section should read, "Fireplaces should be used only with staff present and with close supervision".

• 3800.143 Child Physical examination: (e) (2) Unclothed physical examinations will not be easily accomplished by many adolescents. Academy of Pediatric standards should be used which include appropriate draping of the patient. Section (6) is unnecessary and should be removed as medical professionals should be using universal precautions.

• 3800.242 Child Records: (b) Should allow for electronic signatures for computerized records.

On-going Costs

• 3800.143 Child Physical examination: (a) The fifteen day time frame is unrealistic given the implementation of HealthChoices. For children in substitute care, often knowing the child's HMO and Primary Care Physical (PCP) is often a scavenger hunt in a complex, un-user friendly system and inaccessible by the provider, only by the County Children and Youth Agency. Even if the provider knew the PCP and request it be changed to the PCP they use, the HMOs only capitate their PCPs once a month or twice a month, thus changing the PCP at this time only. This makes it impossible for the provider to comply with this regulation. It should read within the first 21 days of placement, this is difficult, but far more realistic. The best option would be for the Office of Medical Assistance to establish a fund for physicals for this population, allowing for physicians to access funding for OCYF regulation compliance physicals.

• 3800.144 Dental Care: See above. In addition, dental resources are severely limited. Currently there is <u>one</u> orthodontist in Montgomery County enrolled in Keystone Mercy Health Plan although health plan has 62% of the MA recipients in the Southeast. HealthChoices has greatly reduced an already limited dental resource and residential providers should not be responsible for being out of compliance due to problems with HealthChoices. Most providers are out of compliance with this component now. DPW should take this opportunity to review and address these problems before

implementation. We recommend that children in substitute care, enrolled in HealthChoices be permitted to see dentists on a fee for service basis to meet the regulatory requirements.

• 3800.189 Self administration of medications: This should read that the child is age 6 and older and has been trained by medical personnel to self administer. This is critical in teaching children life skills management techniques.

• 3800.57 Staff Training: The providers support the staff training model and support the topics to be included in the initial training. However, the new training requirements will be a costly implementation effort as well as ongoing. In order for staff to be accountable and to be in compliance, agencies will have to provide training on a monthly basis. In addition, staff are generally not hired in groups, but individually. One on one training is costly. We recommend that this section read that if a staff member has had training in an area that is certified (CPR, First Aid, Crisis Management, Heimlich), and the certification is current (not just the last 12 months), they not be required to complete this training. Otherwise, this becomes a duplication of effort and very costly.

A large residential agency anticipates increased costs of $65,000/year. A smaller bed facility anticipates costs come close to $32,000/year. Another recommendation would read that for facilities with less than 8 children and there is not on-site supervision, this requirement holds true, as most smaller facilities may not have constant on-site supervision. While facilities that are larger and have direct supervision on the units, this kind of requirement may not be necessary. The state must include these increased costs into the rates of RTF providers and counties must include these costs into their rate calculations and increase them accordingly.

There has been no definition of medication administration training, the components of the training or when the expectations of competencies to be completed will be released. The state should offer this training at no cost, on a monthly basis, throughout the state in order for providers to meet the requirements of the regulation.

• 3800.211 Behavior Interventions, Manual Restraints: The state must be willing to pay for additional staff to implement this regulation. If a staff member must implement a restraint, then the additional staff member monitoring the restraint must be pulled away from program or the other children, leaving them unsupervised. We appreciate the state's concern about monitoring the use of restraints, however, the additional cost to an agency per unit of children will dramatically affect the cost for the providers. It means an additional staff person for each unit to anticipate the documentation role of this staff member.

Questions

3800.209 Chemical restraints: Subsection (d) (1) How long should staff do the hourly monitoring?

Again, we thank you for the opportunity to comment on the regulations and be included in the process. We look forward to continued participation.

Sincerely,

June M Cairns

June M. Cairns
Executive Director

cc Feather Houstoun
JoAnne Lawer
Bob Gioffre
Joan Reeves
Estelle Richman
Bob Schwartz
Ray Webb

Questions

3800.209 Chemical restraints: Subsection (d) (1) How long should staff do the hourly monitoring?

Again, we thank you for the opportunity to comment on the regulations and be included in the process. We look forward to continued participation.

Sincerely,

June M Cairns

June M. Cairns
Executive Director

cc Feather Houstoun
JoAnne Lawer
Bob Gioffre
Joan Reeves
Estelle Richman
Bob Schwartz
Ray Webb

Special Treatment Procedures

Certain clinical interventions are of particular interest from a risk-management standpoint. Clinicians using these interventions should ensure that their use is warranted and that individuals and their rights are always protected. Such treatment procedures include

- seclusion;
- restraint;
- electroconvulsive therapy and other forms of convulsive therapy;
- behavior-modification procedures that use painful stimuli;
- unusual medications and investigational and experimental drugs;
- maintenance use of drugs that have abuse potential, are known to involve a substantial risk, or are associated with undesirable side effects; and
- research projects that involve inconvenience or risk to the individual.

Standard

TX.6 *Designated special treatment procedures require clinical justification.*

Intent of TX.6

Special treatment procedures place individuals in a significantly more limited environment than the usual organizational setting. Because these interventions have the potential for neglect and abuse of the individual, health care providers document

- that such interventions are clinically justified;
- that less restrictive interventions were attempted first; and
- that the individual's condition was considered when using these interventions.

Scoring for TX.6

This standard is scored at TX.6.1 through TX.6.5.12.

Restraint and Seclusion

Creating a physical, social, and cultural environment limiting restraint and seclusion use to clinically appropriate and adequately justified situations or that actually reduces their use through preventive or alternative strategies helps organization staff focus on the individual's well-being. The leaders' role is to help create such an environment. This requires planning and, frequently, new or reallocated resources, thoughtful education, and performance improvement. The result is an organization approach to restraint and seclusion that protects the individual's health and safety while preserving his or her dignity, rights, and well-being.

Restraint or seclusion may be used in response to emergent, dangerous behavior; addictive disorders; as an adjunct to planned care; as a component of an approved protocol; or, in some cases, as part of standard practice. Because restraint or seclusion may be necessary for certain individuals, health care organizations and providers need to be aware of the associated risks of both use and nonuse. They also need to be able to use restraint or seclusion when essential to protect individuals from harming themselves, other individuals, or staff.

In its broadest context, *restraint* is any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body. In the context of these standards, restraint is considered involuntary use as either part of an approved protocol or as indicated by individual orders.

Seclusion refers to the involuntary confinement of a person alone in a room where the person is physically prevented from leaving.

Restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death. Due to the associated risks and consequences of use, organizations are increasingly exploring ways to decrease restraint and seclusion use through effective preventive strategies or the use of alternatives. For some organizations, a restraint- and seclusion-free environment is appropriate to their populations and clinical services, and can be achieved now or in the future. However, for many organizations, restraint or seclusion may continue to be necessary in clinically justified situations and in the foreseeable future, given the organization's populations and clinical services, the current state of knowledge, and available effective alternatives.

These standards for restraint and seclusion address processes and activities that

- identify areas of organization leadership and action that will limit restraint and seclusion use to clinically justified situations and may, when appropriate, seek to reduce restraint use through performance improvement;
- guide an organization's efforts to prevent the need to restrain or seclude individuals; and
- provide a framework focused on the individual to guide any actual restraint or seclusion use through clinical protocols or individual orders.

Standard(s)

- TX.6.1.1 through TX.6.1.1.7 address limiting restraint and seclusion;
- TX.6.1.2 addresses reducing restraint and seclusion as part of performance improvement;
- TX.6.1.3 addresses the policies and procedures associated with restraint and seclusion;
- TX.6.1.3.1 through TX.6.1.3.1.3 address restraint and seclusion as a component of an approved clinical protocol;
- TX.6.1.3.2 through TX.6.1.3.2.8 address restraint and seclusion initiated through individual orders; and
- TX.6.1.3.3 addresses clinical record documentation.

Note: *Standards TX.6.1 through TX.6.1.3.3 apply to any organization where restraint or seclusion is initiated by individual orders or approved protocols of care.*

The standards do not apply to restraint associated only with medical, dental, diagnostic, or surgical procedures and are based on standard practice for the procedure. Such standard practice may or may not be described in procedure or practice descriptions. For example, the standards do not apply to medical immobilization in the form of surgical positioning, IV arm boards, radiotherapy procedures, electroconvulsive therapy, and so on.

The standards do not apply when a restraint device is used to meet the assessed needs of an individual who requires adaptive support (for example, postural support, orthopedic appliances) or medical protective devices (for example, helmets, tabletop chairs, bed rails). Such use is always based on the assessed needs of the individual. Periodic reassessment ensures that the restraint continues to meet an identified individual need.

The standards do not apply to therapeutic holding or comforting of children or to a time-out when the person to whom it is applied is physically prevented from leaving for 15 minutes or less and when its use is consistent with the behavior-management standards.

The standards do not apply to forensic and correction restrictions used for security purposes. However, *restraint or seclusion use related to the clinical care of an individual under forensic or correction restrictions is surveyed under these standards.*

Standard

TX.6.1 Restraint or seclusion use within the organization is limited to those situations with adequate, appropriate clinical justification.

A 12345 NA

Intent of TX.6.1

Limiting the use of restraint or seclusion to clinically justified situations requires clear policies and procedures, well-trained staff, and the support of the organization's leaders and culture.

Clinical justification can be guided by clear criteria in practice guidelines, practice parameters, pathways of care, or other standardized care processes from relevant professional organizations. When not available, the qualified staff of an organization establishes criteria or otherwise guides justification for the population served and clinical services provided by the organization.

Examples of Implementation for TX.6.1

1. An intermediate care facility for mentally retarded residents appoints a performance-improvement team to review bed-rail use on all resident care units. The review is conducted to determine whether use is based on the assessed safety and protective needs of residents and whether the new Joint Commission standards will apply. The review reveals considerable variation in bed-rail use among and within units. In one unit, staff raises the bed rails at 9 p.m. for all residents. In another unit, bed rails are raised in the evening for all older adults. Because both of these practices are not based on the assessed needs of residents, the team decides that this type of bed rail use is restraint, so Joint Commission standards will apply. In the remaining units, staff conduct standardized resident assessments to determine the need for bed rails and note the outcomes in routine clinical record notes. In these instances, the Joint Commission standards will not apply because bed-rail use is clearly based on individual resident needs for this type of medical protective device.

   The facility then conducts a two-week, in-service program to set up standardized resident assessments to guide bed rail use. Based on the success of the bed-rail use review and staff-education process, the facility then decides to conduct a similar review of the use of lap belts and Posey vests.
2. A residential treatment program conducts a review of the organizationwide use of room restriction that reveals variation among the cottages. In all but one cottage, staff occasionally restrict residents to their rooms for up to fifteen minutes as a consequence of disruptive behavior. All residents are informed of this consequence when they are oriented to the rules of the cottage. Further, organization policy requires a team review whenever a resident is restricted three or more times in one week. Program staff concludes that this restriction is clinically justified.

   In the remaining cottage, residents are restricted to their sleeping rooms from 7:00 to 8:00 p.m. every evening. During this time of restriction, staff conduct meetings and catch up with their record keeping. Program staff decide that the routine time restrictions observed at this cottage are not clinically justified and eliminate the restriction. They establish a workgroup to address alternative times and mechanisms for staff meetings and record keeping.

Scoring for TX.6.1

Is restraint or seclusion use within the organization limited to clinically justified situations?

Score 1 Yes

Score 3 With a few minor exceptions

Score 5 No

Standards

TX.6.1.1 *Organization leaders support limited, justified use of restraint or seclusion through the following:*

A 1 2 3 4 5 NA

TX.6.1.1.1 Plans, policies, and priorities;

TX.6.1.1.2 *Human resource planning;*

TX.6.1.1.3 *Staff orientation and education that creates a culture emphasizing prevention and appropriate use and encouraging alternatives;*

TX.6.1.1.4 Education of the individual and, when appropriate, his or her family; A 1 2 3 4 5 NA

TX.6.1.1.5 Assessment processes that identify and, when appropriate, prevent potential behavioral risk factors; A 1 2 3 4 5 NA

TX.6.1.1.6 Design and delivery of care; and A 1 2 3 4 5 NA

TX.6.1.1.7 The development and promotion of preventive strategies and use of safe and effective alternatives. A 1 2 3 4 5 NA

Intent of TX.6.1.1 Through TX.6.1.1.7

Limiting the use of restraint or seclusion to those situations with appropriate and adequate clinical justification requires

- effective leadership to shape the culture of the organization;
- supportive plans, policies, and priorities;
- an understanding of the human-resource implications of limited use and choices related to reduced use;
- ongoing staff orientation and education;
- education of the individual and, when appropriate, his or her family; and
- the integration of restraint and seclusion into the organization's performance-improvement activities.

In particular, attention is directed toward

- refining behavioral health, medical, dental, surgical, and diagnostic assessment processes to identify earlier the potential risk of dangerous behavior and the prevention, when appropriate, of those behaviors;
- reviewing and, when necessary, redesigning care processes associated with restraint and seclusion use; and
- identifying, developing, and promoting preventive strategies and the use of safe and effective alternatives.

Example of Implementation for TX.6.1.1.2

A crisis stabilization unit of a community mental health center introduces the use of restraint and seclusion throughout the organization into the annual human-resource planning process. The unit reviews its use of restraint and seclusion in emergent situations. The leaders brainstorm several possibilities for limiting its use and then identify the staffing implications of each possibility in terms of staffing patterns, staff mix, and staff education.

Examples of Implementation for TX.6.1.1.3

1. Care staff need to be aware of their organization's plans, policies, and strategies for limiting the use of restraint and seclusion. A staff education program is created to provide the knowledge, skills, and behaviors needed to support this effort. The information in the program includes
   - the impact of restraint and seclusion on the individual and his or her rights and dignity;
   - clinical assessment strategies for identifying potential behavioral risk factors;

- care planning that incorporates strategies to prevent or manage risk factors;
- the alternatives to restraint and seclusion effective for different behaviors;
- the correct application and removal (as guided by manufacturer's directions) when restraint is used; and
- clinical strategies to identify and meet emergent needs of the individual during use of restraint or seclusion.

The leaders decide that the education program should include individuals who have experienced restraint or seclusion and activities that will give staff the opportunity to experience restraint and seclusion more personally. Orientation for new staff also includes this information, and periodic reviews are offered.

2. The orientation and training of child care staff at a residential treatment program stresses staff understanding of the cognitive and behavioral stages of development. Before assignment to group homes, child care staff must complete an in-service program that includes role-playing responses to proactive behaviors typical of the various development stages.

Example of Implementation for TX.6.1.1.4

A crisis stabilization unit is exploring ways to limit the use of restraint for aggressive or combative individuals. They decide that the individual and, when appropriate, family could play a significant role in carrying out alternatives that would limit use. Education, however, is needed to support the participation of the individual and his or her family; this education includes

- explaining the behaviors that might cause restraint to be incorporated into the plan of care based on assessed needs of the individual or on an emergent basis;
- explaining how the organization uses restraint as a component of care;
- explaining available alternatives to the use of restraint;
- identifying possible participation of the individual and his or her family in the care process that could limit or halt the use of restraint;
- discussing the preferences of the individual and his or her family, as well as insights on prevention and alternatives; and
- incorporating the individual's preferences, whenever possible.

Example of Implementation for TX.6.1.1.5

Early identification of the potential risk of behavior that could result in the use of restraint or seclusion is built into an adolescent residential treatment program's assessment process. Staff also identify environmental risk factors that may alleviate, precipitate, or escalate such behaviors or that have the potential to support positive behaviors. Although such an assessment may be unplanned and almost instantaneous when a person poses an immediate danger to self or others, it is incorporated into routine assessments.

In either case, early identification of the potential risk and alternatives as a routine component of assessment permits care providers and the adolescent to plan for, rather than react to, such behaviors. This assessment also helps develop care protocols that have clear criteria for applying and discontinuing restraint for these behaviors.

Example of Implementation for TX.6.1.1.6

As part of an organization's periodic risk-management assessment, treatment procedures that frequently include restraint and seclusion are reviewed. The review offers suggestions for process redesign to accommodate the use of alternatives and appropriately respond to potentially dangerous behaviors identified during assessment or emerging during care.

All treatment procedures including restraint are now guided by protocols that include criteria for behavioral risk factors. If the criteria are met, alternatives are ruled out, and restraint is considered clinically necessary, then use is initiated. Similarly, if the criteria are no longer met, the use of restraint is discontinued.

Scoring for TX.6.1.1
This standard is scored at TX.6.1.1.1 through TX.6.1.1.7.

Scoring for TX.6.1.1.1
Do plans, policies, and priorities support limited, justified use of restraint and seclusion?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Scoring for TX.6.1.1.2
This standard is scored at HR.2.

Scoring for TX.6.1.1.3
This standard is scored at HR.3.2 and HR.3.3.

Scoring for TX.6.1.1.4
Is education of the individual and, when appropriate, the family used to support limited, justified use of restraint and seclusion?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Scoring for TX.6.1.1.5
Do assessment processes identify and, when appropriate, prevent potential behavioral risk factors that may lead to the use of restraint or seclusion?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Scoring for TX.6.1.1.6
This standard is scored at LD.1.3.1.

Scoring for TX.6.1.1.7
Does the organization use preventive strategies and alternatives to restraint and seclusion to support its limited, justified use?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

A 1 2 3 4 5 NA

TX.6.1.2 Performance-improvement processes identify opportunities, when appropriate, to reduce restraint or seclusion use.

Intent of TX.6.1.2

Restraint and seclusion are high risk and problem prone. Thus they are a logical component of an organization's performance-improvement program. The measurement and assessment process for restraint and seclusion seeks to understand the root cause of their use and incorporates this understanding into the organization's plans and priorities to evaluate and, if appropriate, reduce their use. This understanding is advanced by assessing aggregate data on restraint and seclusion episodes from all units, for all shifts, and for all purposes for which restraint and seclusion are used. Particular attention is paid to instances of multiple episodes of use for one individual and the frequency of restraint use by type(s) of staff.

Examples of Implementation for TX.6.1.2

1. Staff at a large residential treatment program view restraint use as high risk and problem prone; thus, it is seen as a priority component of the organization's performance-improvement program. The measurement and assessment process is used to understand the root cause of restraint use and to incorporate this understanding into the organization's plan to consistently reduce its use. Staff use the assessment of aggregate data on restraint episodes for all shifts and for all purposes to help them develop an early triage process for individuals with certain behaviors. Staff are able to reduce restraint use by using techniques for de-escalation of behavior.

   Assessment of data reveals a high volume of multiple episodes of restraint experienced by some residents and variation of restraint use by staff category. In response, a "debriefing" policy in which staff who initiated the restraint and the affected resident would identify the triggers that led to its use and seek ways to minimize the possibility of restraint use reoccurring.
2. Staff in a residential treatment program note frequent aggressive behavior among teenage males. When the behavior escalates, restraint or seclusion is needed in about 25% of the incidents. During the routine debriefing of staff and residents after each incident, a pattern of phrases and words used by female staff when addressing adolescent males is noted. The adolescents perceive the language used as infantile and demeaning, although it is clearly not intended to convey that message.

   A plan is developed to review the program's rules and consequences of unacceptable behaviors with the residents and to train staff to use neutral or passive language when attempting to diffuse an incident or modify behavior. Subsequent monitoring reveals a 50% decrease in restraint or seclusion use.
3. A residential treatment program plans to build a new wing for partial- and day-hospitalization programs. Management works with the design firm to help create soft, warm, and quiet interiors by positioning the building on its site for maximum light and views of nearby woods. Interior space is designed to have a variety of small spaces that are pleasant and quiet. These interior spaces are part of a new program designed to reduce stress and agitation and to de-escalate emerging, potentially dangerous behaviors.

   Management visits other new facilities, holds discussions with staff and residents, and reviews literature to help it establish the space specifications for the new programs.
4. An intermediate care facility for mentally retarded individuals monitors emergency restraint and seclusion use and the total number of hours they were used. This monitoring is initiated after staff

met to discuss the variation in how restraint and seclusion are used throughout the organization. The data from the assessment reveals that emergency restraint and seclusion use is discontinued more quickly for some individuals. These individuals are usually those for whom restraint or seclusion is deemed clinically necessary near the end of the shift of the staff member who initiated the use. Therefore, the staff member who reassessed the individual and made the decision to continue or discontinue restraint or seclusion is *not* the staff member who originally initiated its use. Subsequent interviews with staff and individuals served lead to the conclusion that staff who did not initiate the original use of restraint conduct more objective, impartial reassessments of the need for continued use.

Consequently, the facility develops a policy that does not allow staff who initiate the original restraint use to perform reassessments. Although continued monitoring shows no decrease in the number of emergency restraint episodes, the total number of hours of use drops 30% because of increased early release at reassessment.

Scoring for TX.6.1.2

Does the organization use performance-improvement activities to support limited and, when appropriate, reduced restraint or seclusion use?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

TX.6.1.3 When restraint or seclusion is used, organization policy and procedures guide appropriate and safe use.

A 1 2 3 4 5 NA

Intent of TX.6.1.3

Several essential elements govern how an organization uses restraint and seclusion appropriately for the population and individuals served. These elements focus on the individual and are described in organization policy(ies) and procedure(s) and include appropriate details as to how the organization

- protects and preserves the individual's rights, dignity, and well-being during use;
- bases use on the individual's assessed needs;
- makes decisions about least restrictive methods;
- ensures safe application and removal by competent staff;
- monitors and reassesses the individual during use;
- provides for the individual's needs during use;
- limits individual orders to licensed independent practitioners;
- time-limits orders; and
- documents in the clinical record when restraint or seclusion clinical protocols are used or individual orders written.

These essential elements help ensure that any use of restraint or seclusion, even when initiated by a protocol, protects and preserves the individual and his or her rights, dignity, and well-being. Appropriate staff approve policies and procedures for restraint and seclusion.

Example of Implementation for TX.6.1.3

Consistent with their established procedure, clinical staff of a residential treatment program use the following debriefing questions to be addressed by the treatment team after an event that results in using restraint or seclusion:

- Is this a new or unusual behavior for the individual?
- Is the individual assessed or reassessed appropriately for medication?
- Does the treatment environment, including staff, contribute to the behavior that led to the use of restraint or seclusion?
- Is the individual debriefed? If so, what do the individual and staff learn as a result of the debriefing?

Scoring for TX.6.1.3

a. Does the organization have a policy(ies) and procedure(s) that include the essential elements listed in the intent?
b. Are the policy(ies) and procedure(s) approved by appropriate staff?

Score 1 a. Yes
b. 100%

Score 2 a. With a few minor exceptions

Score 3 a. Not consistently
b. 95% to 99%

Score 4 a. Rarely

Score 5 a. No
b. Less than 95%

Standards

A 1 2 3 4 5 NA **TX.6.1.3.1** Protocols that guide using restraint as an integral component of medical, dental, diagnostic, or surgical procedures or devices are consistent with organization policy.

A 1 2 3 4 5 NA **TX.6.1.3.1.1** The appropriate clinical staff approve the protocols.

A 1 2 3 4 5 NA **TX.6.1.3.1.2** Criteria are used to select individuals for care under the protocol.

A 1 2 3 4 5 NA **TX.6.1.3.1.3** Qualified staff are identified and permitted to apply the criteria.

Intent of TX.6.1.3.1 Through TX.6.1.3.1.3

Restraint use guided by a clinical care protocol is consistent with written policies for restraint as described in the intent of TX.6.1.3. Such protocols are based on professional practice standards and focus on the individual, reducing health and safety risks and protecting the individual's rights and dignity. The appropriate clinical staff approve the protocol.

Restraint use guided by a protocol is initiated and terminated by qualified staff through the application of criteria.

Scoring for TX.6.1.3.1

Is the use of restraint as part of a clinical protocol consistent with organization policy on restraint?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Scoring for TX.6.1.3.1.1

Are protocols approved by appropriate clinical staff?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Scoring for TX.6.1.3.1.2

Are criteria used to select individuals for care under the protocol?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Scoring for TX.6.1.3.1.3

Are qualified staff members who are permitted to apply the criteria identified?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

TX.6.1.3.2 ***Individual orders for restraint or seclusion are consistent with organization policy.***

Intent of TX.6.1.3.2

Individual orders are the most common source for initiating restraint or seclusion, especially in behavioral health settings. Who is authorized to order restraint or seclusion, how orders are conveyed, the details given in an order (for example, those related to time limits), and who is authorized to carry out the order are all essential aspects of processes to protect the individual served, other individuals, and staff.

Example of Implementation for TX.6.1.3.2

The organization establishes a policy using special treatment procedures that prohibits the use of restraint for children and adolescents. The policy is based on concern about trauma associated with the use of restraints, particularly for children who have a history as abuse victims.

Scoring for TX.6.1.3.2

This standard is not scored. Performance consistent with organization policy (as described in TX.6.1.3) is scored at TX.6.1.3.2.1 through TX.6.1.3.2.8 or at the standard noted.

Standard

A 1 2 3 4 5 NA

TX.6.1.3.2.1 Individuals' rights, dignity, and well-being are protected during restraint or seclusion use.

Intent of TX.6.1.3.2.1

Each individual has the right to respectful care that maintains his or her dignity. Restraint and seclusion have the potential to significantly restrict these rights and can have serious adverse effects on the individual's well-being. Thus, each episode of use considers how the intervention will affect the individual, including whether

- the application or initiation respects the individual;
- the environment is safe and clean;
- the individual is able to continue his or her care and participate in care processes; and
- modesty, visibility to others, and comfortable body temperature are maintained.

Scoring for TX.6.1.3.2.1

Are individuals' rights, dignity, and well-being protected during the use of restraint or seclusion, as described in the intent?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

A 1 2 3 4 5 NA

TX.6.1.3.2.2 Restraint or seclusion use is based on the assessed needs of the individual.

Intent of TX.6.1.3.2.2

Single episodes of use or continued use of restraint or seclusion is based on the individual's needs, as identified in the initial assessment process or by qualified staff in emergent situations that pose the risk of injury to self or others. Therefore, there is clinical justification for each episode of use, including emergency use when a licensed independent practitioner is not available.

Use is not based solely on previous history of use or history of dangerous behavior. Rather, use is based on the individual's needs in the immediate care environment and the interaction of the individual with staff and other individuals in that environment. The organization does not permit any other use, such as for punishment or staff convenience.

Use appropriate to the needs of the individual is ensured by

- the training and skill of those who decide to apply restraint or initiate seclusion for emergency reasons in the absence of a licensed independent practitioner;
- clinical oversight by a licensed independent practitioner;
- review and evaluation of multiple episodes of use or continuous use; and
- organization policy.

Scoring for TX.6.1.3.2.2

Is the use of restraint and seclusion based on the assessed needs of the individual?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

TX.6.1.3.2.3 The least restrictive, safe, and effective restraint or seclusion method is used.

A 1 2 3 4 5 NA

Intent of TX.6.1.3.2.3

The choice of restraint or seclusion method is guided by policy. The choice of the least restrictive, safe, and effective method for an individual is determined by the individual's assessed needs and the effective or ineffective methods previously used on the individual. In the absence of previous experience, policy describes typical circumstances under which the least restrictive methods should be tried first and explains how to use the methods. Once used, monitoring and reassessment of the individual ensures that less restrictive methods are used when possible and use is discontinued as soon as possible. The safety of both the individual and staff are considered in making these decisions.

Example of Implementation for TX.6.1.3.2.3

A fourteen-year-old resident of a residential treatment center engages in self-scratching whenever she becomes agitated. The staff, resident, and the resident's parents meet and agree that staff will try restraining just one arm whenever the resident engages in self-injurious behavior and work with her to master self-relaxation techniques.

Scoring for TX.6.1.3.2.3

Is the least restrictive, safe, and effective method used as identified in the intent?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

TX.6.1.3.2.4 Restraint or seclusion is used correctly by competent, trained staff.

A 1 2 3 4 5 NA

Intent of TX.6.1.3.2.4

Competent staff are essential to using restraint or seclusion safely and effectively and to protecting the individual during use. Appropriate use of restraint or seclusion is necessary if the individual's rights are to be respected and harm to the individual avoided. The organization identifies, educates, and determines the competency of those staff members who apply or remove restraint or who initiate or terminate seclusion. Frequently repeated in-service education, including an understanding of manufacturer's instructions for use of restraint devices, helps ensure safe use.

If possible, and as appropriate to the population and methods used, the insights of individuals who have experienced being placed in restraints are included to help staff better understand all aspects of their use.

Scoring for TX.6.1.3.2.4

Are restraint and seclusion used by competent staff as identified in the intent?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

A 1 2 3 4 5 NA

TX.6.1.3.2.5 Individuals in restraint or seclusion are monitored and reassessed appropriately.

Intent of TX.6.1.3.2.5

Individuals can experience harm, unintentional limitation of their rights and dignity, deterioration in well-being, and feelings of isolation when restraint or seclusion methods are used. Monitoring is essential to prevent or reduce such occurrences. Reassessment during monitoring permits the reduction or early termination of restraint or seclusion.

Organization policy defines the nature and extent of appropriate monitoring by observation and direct, face-to-face interaction with the individual, and defines the monitoring frequency as continuous or no less frequent than every 15 minutes.

Reassessment associated with monitoring is used primarily to determine the individual's well-being, and reassessment of time-limited orders is used mainly to determine the continuing need for restraint or seclusion.

Scoring for TX.6.1.3.2.5

Are appropriate monitoring and reassessment of individuals provided during the use of restraint or seclusion, as identified in the intent?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

A 1 2 3 4 5 NA

TX.6.1.3.2.6 The needs of the individual are met during restraint or seclusion use.

Intent of TX.6.1.3.2.6

The individual's physical and emotional needs are considered while the individual is in restraint or seclusion. The basic rights of human dignity and respect are maintained, and physical well-being is preserved through adequate exercise, nourishment, and personal care.

Scoring for TX.6.1.3.2.6

Are the individual's needs met during the use of restraint or seclusion as identified in the intent?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

TX 6 1 3 2 7 Restraint or seclusion use is ordered by a licensed independent practitioner.*

A 1 2 3 4 5 NA

* **Licensed independent practitioner** Any individual who is permitted by law and who is also permitted by the organization to provide care services without direction or supervision, within the scope of his or her license, and in accordance with individually granted clinical privileges.

Intent of TX.6.1.3.2.7

Licensed independent practitioners oversee how the assessed needs of individuals they are responsible for are met. This requires knowledge about and involvement in any use of restraint and seclusion.

Each licensed independent practitioner can best carry out his or her responsibility when he or she

- provides verbal or written orders for initial use or to reauthorize continuing emergency use;
- participates in daily reviews of restraint and seclusion use for the individuals in his or her care; and
- participates in measuring and assessing use for all individuals within the organization.

Some state laws, such as in Illinois, permit nursing staff to order restraint or seclusion. Organization policy identifies who (in accordance with state law) is authorized by the organization to give verbal or written orders for restraint or seclusion and who may receive, record, and initiate verbal orders. Organization policy also identifies the process for reviewing and reauthorizing emergency restraint or seclusion use.

The organization may authorize an individual who is not a licensed independent practitioner to order emergency restraint or seclusion use in response to an individual who poses an immediate danger to himself or herself or to others. When such emergency use is initiated, a licensed independent practitioner is called within one hour. Continued use depends on authorization by a licensed independent practitioner.

Scoring for TX.6.1.3.2.7

What percentage of restraint and seclusion episodes contain orders from an individual who is authorized by policy to order restraint and seclusion as identified in the standard and its intent?

Score 1 100%

Score 2 95% to 99%

Score 3 90% to 94%

Score 4 80% to 89%

Score 5 Less than 80%

Standard

TX 6 1 3 2 8 Orders for restraint or seclusion define specific time limits.

A 1 2 3 4 5 NA

Intent of TX.6.1.3.2.8

Time-limited orders. Written orders for restraint and seclusion are limited to

- 4 hours for adults;

- 2 hours for children and adolescents ages 9 to 17; or
- 1 hour for children under age 9.

Early release. Staff can use criteria to guide early restraint or seclusion termination. When restraint or seclusion is terminated early and the same behavior is still evident, the original order can be reapplied if alternatives remain ineffective.

Continuation of orders. After the original order expires, the individual receives a face-to-face reassessment by a licensed independent practitioner. The licensed independent practitioner writes a new order if restraint or seclusion is to be continued. Organization policy and the original order may permit a licensed, qualified, and authorized individual (such as a registered nurse) to perform the reassessment and make a decision to continue the original order for an additional

- 4 hours for adults up to a maximum of 24 hours;
- 2 hours for children and adolescents ages 9 to 17 up to a maximum of 24 hours; or
- 1 hour for children under age 9.

Continuation of orders cannot under any circumstances exceed 24 hours without a face-to-face reassessment by a licensed independent practitioner and a new order.

PRN orders. PRN orders, whether individual or as part of a protocol, are prohibited.

Scoring for TX.6.1.3.2.8

What percentage of restraint and seclusion episodes address specific time limits for the using restraint or seclusion as identified in the intent?

Score 1 100%

Score 2 95% to 99%

Score 3 90% to 94%

Score 4 80% to 89%

Score 5 Less than 80%

Standard

A 1 2 3 4 5 NA

TX.6.1.3.3 Documentation in clinical records reflects organization policy.

Intent of TX.6.1.3.3

The use of restraint or seclusion is recorded in the individual's clinical record. The purpose and focus of an entry(ies) is on the individual.

Each episode of use is recorded and includes

- clinical justification for use;
- orders for restraint or seclusion that meet the requirements described in organization policy; and
- measures taken to protect the rights, dignity, and well-being of the individual including monitoring, reassessment, and attention to needs.

Scoring for TX.6.1.3.3

What percentage of clinical records reflects the items identified in the intent?

Score 1 100%

Score 2 95% to 99%

Score 3 90% to 94%

Score 4 80% to 89%

Score 5 Less than 80%

Other Special Procedures

Standard

TX.6.2 Policies and procedures govern the use of electroconvulsive therapy and other forms of convulsive therapy.

A 1 2 3 4 5 NA

Intent of TX.6.2

The governing body, administration, and clinical staff establish policies and consistent processes to control the use of these special and high-risk interventions.

Before initiating electroconvulsive therapy for a child or adolescent, two qualified child psychiatrists must concur with the treatment. These psychiatrists must be trained or experienced in treating children and adolescents and not directly involved in treating the individual. Both must

- examine the individual;
- consult with the responsible psychiatrist; and
- document their concurrence with the treatment in the individual's record.

Example of Evidence of Performance for TX.6.2

- Governing body bylaws and clinical staff rules and regulations or policies and procedures

Scoring for TX.6.2

a. Do policies and procedures address the use of electroconvulsive and other forms of convulsive therapy, as described in the intent?
b. Are these policies and procedures implemented?

Score 1 a. Yes
b. 100% of those reviewed

Score 3 a. Not consistently
b. 95% to 99% of those reviewed

Score 5 a. No
b. Less than 95% of those reviewed

Standard

TX.6.2.1 Written consent for any use of electroconvulsive therapy or other forms of convulsive therapy is obtained from the individual or family and documented in the clinical record.

A 1 2 3 4 5 NA

Intent of TX.6.2.1

Because convulsive therapies raise societal and individual rights concerns, fully documented and fully informed consent is essential to protect individuals served, staff, and the organization. Steps are taken and documented to ensure that consent is fully informed and based on enough information to enable valid decision making by the individual or family. Individuals giving consent must be legally authorized and competent to do so, and provisions are made for withdrawal of consent.

These interventions are of particular concern when used to treat children and adolescents. Therefore, careful and detailed documentation is required in these instances.

Example of Implementation for TX.6.2.1

For children and adolescents, the family and/or legal guardian and, when appropriate, the individual served give written, dated, and signed informed consent for the use of electroconvulsive therapy or other forms of convulsive therapy.

Examples of Evidence of Performance for TX.6.2.1

- Performance-improvement program records
- Documentation of ongoing reviews
- Clinical records
- Risk-management records
- Organization policies and procedures

Scoring for TX.6.2.1

Is written consent obtained as described in the intent?

Score 1 100% of those reviewed

Score 3 95% to 99% of those reviewed

Score 5 Less than 95% of those reviewed

Standard

A 1 2 3 4 5 NA

TX 6 3 Policies and procedures govern the use of unusual medications and investigational and experimental drugs.

Intent of TX.6.3

Special risk-management concerns are raised by medications that carry an unusually high risk of side effects or undesirable reactions or for which clinical safety and efficacy have not been fully established. Current, comprehensive, written policies and procedures guide the use of such medications. Monitoring helps ensure adherence to all requirements of these policies and procedures.

Examples of Evidence of Performance for TX.6.3

- Complaints and grievances of the individuals being served
- Pharmacy, research, and rights plans, policies, memorandums, and compliance monitoring
- Clinical staff rules and regulations, memorandums, and policies

Scoring for TX.6.3

a. Are policies and procedures regarding the use of unusual, investigational, and experimental medications current, comprehensive, and communicated throughout the organization?

b. Are these policies and procedures implemented?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Standard

TX 6.3.1 Investigational drugs are used only under the principal investigator's supervision and with the approval of the physician members of the clinical staff or an appropriate clinical staff committee, the research review committee, and appropriate federal, state, and local agencies.

A 1 2 3 4 5 NA

Intent of TX.6.3.1

Recognizing sensitivity to the use of particular populations for experimentation and research, the organization uses a well-documented process of approval, supervision, and monitoring when using investigational drugs.

Examples of Evidence of Performance for TX.6.3.1

- Documentation of ongoing reviews
- Individual clinical records
- Performance-improvement program records
- Organization policies and procedures

Scoring for TX.6.3.1

Have investigational drugs been used under the principal investigator's supervision, with the approval of the clinical staff, and within applicable governmental guidelines?

Score 1 100% of the time

Score 2 95% to 99% of the time

Score 3 90% to 94% of the time

Score 4 80% to 89% of the time

Score 5 Less than 80% of the time

Standard

TX 6.4 Policies and procedures govern maintenance use of drugs that have abuse potential (usually considered to be Schedule II drugs), are known to involve substantial risk, or are associated with significant, undesirable side effects.

A 1 2 3 4 5 NA

Intent of TX.6.4

Clear direction and control in drug prescription and administration are instituted to allay public and professional concerns about the side effects of medications, adverse reactions to medications, and misuse of prescribing authority (misuse of prescribing drugs with abuse potential). If psychopharmacologic drugs are used, the organization's governing body, administration, and clinical staff establish written policies and procedures addressing

- multiple psychopharmacologic agents;
- high-dose pharmacotherapy; and
- prevention, identification, and management of tardive dyskinesia.

Example of Evidence of Performance for TX.6.4

- Governing body bylaws and clinical staff rules and regulations or policies and procedures

Scoring for TX.6.4

a. Do written policies and procedures address prescribing and administering Schedule II drugs and those with substantial risk or side effects?

b. Are these policies and procedures implemented?

Score 1 a. Yes
b. Yes

Score 2 b. With a few minor exceptions

Score 3 b. Not consistently

Score 4 b. Rarely

Score 5 a. No
b. No

Standard

A 1 2 3 4 5 NA

TX 6.4.1 The organization's list of selected medications includes prescribed and administered maintenance drugs that have abuse potential.

Intent of TX.6.4.1

A physician documents in the individual's clinical record both the need and rationale for prescribing and administering maintenance drugs with abuse potential. Such drugs have been identified as an appropriate selection of medications available for prescription or ordering as part of the list described in TX.3.1.

Examples of Evidence of Performance for TX.6.4.1

- Clinical records
- Performance-improvement documentation on medication administration
- Pharmacy policies and procedures

Scoring for TX.6.4.1

a. Are all prescribed and administered maintenance drugs with abuse potential included in the organization's list of selected medications available for prescription or ordering?
b. When drugs with abuse potential are prescribed and administered for maintenance use, does a physician document the clinical need and rationale for using the drug?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Behavior Management

Standard

A 1 2 3 4 5 NA

TX 6.5 Policies and procedures govern the use of behavior-management procedures for controlling maladaptive or problem behavior.

Intent of TX.6.5

The clinical leaders establish a clear, comprehensive framework for using behavior-management procedures.

Examples of Evidence of Performance for TX.6.5

- Individual clinical records
- Clinical staff policies and procedures

Scoring for TX.6.5

Have the clinical leaders established clear, comprehensive policies and procedures governing the use of behavior-management programs?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standards

TX.6.5.1 The organization requires a positive approach to behavior management and the progressive use of the least restrictive alternatives. A 1 2 3 4 5 NA

TX.6.5.2 The clinical leaders specify and approve the behavior-management procedures that can be used in the organization. A 1 2 3 4 5 NA

TX.6.5.3 Behavior-management programs identify and teach the individual appropriate expression of the target behavior or alternative adaptive behaviors. A 1 2 3 4 5 NA

TX.6.5.4 Procedures that may result in denying a nutritionally adequate diet are prohibited. A 1 2 3 4 5 NA

TX.6.5.5 Seclusion is prohibited, except in accordance with standards in this chapter. A 1 2 3 4 5 NA

TX.6.5.6 Corporal punishment is prohibited. A 1 2 3 4 5 NA

TX.6.5.7 Fear-eliciting procedures are prohibited. A 1 2 3 4 5 NA

TX.6.5.8 Other individuals served by the organization's services are prohibited from carrying out an individual's behavior-management program. A 1 2 3 4 5 NA

Intent of TX.6.5.1 Through TX.6.5.8

Behavior-management programs represent an important clinical intervention to address maladaptive or problem behaviors. However, these programs also present a potential for physical as well as psychological risk when used without adequate care. Least restrictive methods are always tried first, and if ineffective, only then are progressively more restrictive methods used. Policy specifies the aspects of behavior-management programs that clinical leaders should consider when reviewing individual behavior-management programs.

Example of Implementation for TX.6.5.1 Through TX.6.5.8

If hanging pictures on walls and similar activities are privileges to be earned for treatment purposes, a clinical staff member explains to individuals served the conditions under which the privileges may be granted.

Examples of Evidence of Performance for TX.6.5.1 Through TX.6.5.8

- Policies and procedures
- Individual clinical records

Scoring for TX.6.5.1

a. Do well-defined policies and procedures require a positive approach to behavior management and the progressive use of least restrictive alternatives?
b. Are these policies and procedures carried out?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Scoring for TX.6.5.2

Have the clinical staff specified behavior-management procedures approved for use in the organization?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Scoring for TX.6.5.3

a. Do policies and procedures guide the use of behavior-management programs to identify and teach the individual appropriate expression of the target behavior or alternative adaptive behaviors?
b. Are these policies and procedures carried out?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Scoring for TX.6.5.4

a. Do policies prohibit using procedures that may result in denial of a nutritionally adequate diet?
b. Are these policies followed?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Scoring for TX.6.5.5

a. Do policies prohibit using seclusion as part of behavior-management programs?
b. Are these policies followed?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Scoring for TX.6.5.6

a. Do policies clearly prohibit using corporal punishment to control maladaptive or problem behavior?
b. Are these policies followed?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Scoring for TX.6.5.7

a. Do policies clearly prohibit using fear-eliciting programs to control maladaptive or problem behavior?
b. Are these policies followed?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Scoring for TX.6.5.8

a. Do procedures prohibit other individuals served from carrying out aspects of an individual's behavior-management program?
b. Are these procedures followed?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Standard

A 1 2 3 4 5 NA

TX.6.5.9 An interdisciplinary behavior-management committee established by the clinical staff reviews, evaluates, and approves all behavior-management programs.

Intent of TX.6.5.9

Consistent with its responsibility for promoting the quality of care, the organization leaders identify behavior management as a clinical activity that warrants careful review and evaluation. An interdisciplinary committee performs the review and evaluation, and ensures that behavior-management programs are initiated only with its approval.

Examples of Evidence of Performance for TX.6.5.9

- Individual clinical records
- Committee records
- Organization policies and procedures

Scoring for TX.6.5.9

Are behavior-management programs reviewed, evaluated, and approved by an interdisciplinary committee?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

TX.6.5.10 Time-out is used in accordance with the individual's program plan and the organization's policies and procedures.

A 1 2 3 4 5 NA

Intent of TX.6.5.10

Time-out is identified as a clinical intervention. As such, it is used only when the interdisciplinary team has identified a specific need for it and has defined objectives and conditions for its use in the individual program plan.

Well-defined, written policies and procedures provide a clear framework for using time-outs. The organization's leaders may delegate responsibility for developing written time-out policies and procedures to the behavior-management committee.

Example of Implementation for TX.6.5.10

Time-out is used in accordance with organization policies and procedures, which include the following:

- Time-out procedures provide for appropriate monitoring of the individual's safety;
- Locks are not used on rooms in which individuals are restricted for time-out;
- The time-out period does not exceed 30 minutes; and
- Restraining devices used in time-out procedures are not used for periods longer than 30 minutes.

Examples of Evidence of Performance for TX.6.5.10

- Individual clinical records
- Organization policies and procedures
- Time-out policies and procedures

Scoring for TX.6.5.10

a. Do well-defined policies and procedures govern the use of time-out?
b. When time-out is used, is it fully addressed in the individual program plan?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

Score 3 a. Not consistently
b. Not consistently

Score 4 a. Rarely
b. Rarely

Score 5 a. No
b. No

Standard

TX.6.5.11 Aversive behavioral consequences are used only when withholding this intervention would be contrary to the individual's best interests and less restrictive alternatives have failed.

A 1 2 3 4 5 NA

Intent of TX.6.5.11

When behavior-management programs call for using aversive behavioral consequences, there is clear documentation in the clinical record that the program's target behavior is seriously detrimental to the individual's physical health or is a significant obstacle to normalization. Documentation of the failure of

positive-reinforcement techniques is also documented in the clinical record before aversive behavioral consequences are used.

Example of Evidence of Performance for TX.6.5.11

- Individual clinical records

Scoring for TX.6.5.11

Do applicable clinical records clearly document the necessity of using aversive behavioral consequences?

Score 1 Yes

Score 2 With a few minor exceptions

Score 3 Not consistently

Score 4 Rarely

Score 5 No

Standard

A 12345 NA

TX.6.5.12 Aversive behavioral consequences for maladaptive behavior are used in accordance with the individual's behavior-management plan and organization policies and procedures.

Intent of TX.6.5.12

Using aversive behavioral consequences as clinical interventions is appropriate only when the interdisciplinary team has identified a need and defined objectives and conditions for its use in the individual behavior-management plan. Well-defined, written policies and procedures provide a clear framework for using aversive behavioral consequences. The clinical staff may delegate responsibility for developing these policies and procedures to the behavior-management committee.

Example of Implementation for TX.6.5.12

When restraining devices or aversive behavioral consequences are used, the individual's clinical record documents

- antecedents of the target behavior;
- consequences of the target behavior;
- frequency and duration of the target behavior;
- severity of the target behavior; and
- efforts to reduce the target behavior by less restrictive alternatives.

Examples of Evidence of Performance for TX.6.5.12

- Individual clinical records
- Organization policies and procedures

Scoring for TX.6.5.12

a. Are policies and procedures governing the use of aversive behavioral consequences well-defined?
b. Is the use of aversive behavioral consequences fully addressed in individual behavior-management plans?

Score 1 a. Yes
b. Yes

Score 2 a. With a few minor exceptions
b. With a few minor exceptions

ORIGINAL: 1927
Org. in file

PROPOSED CHILD RESIDENTIAL AND DAY TREATMENT FACILITIES REGULATIONS
55 PA CODE CHAPTER 3800
1997 EXTERNAL GROUP INVOLVEMENT IN PROPOSED RULEMAKING

External Group	Individual Meetings/ Visits 2-3/97	Sent Draft for Written Comment 4/97	Invited to Work Group #1 4/97	Written Comments Submitted 5-6/97	Attended Work Group #1 5/97	Invited to Work Group #2 6/97	Attended Work Group #2 7/97	Individual Meetings 10/97
Center for Juvenile Justice	✓	✓	✓	✓	✓	✓	✓	
Tressler Lutheran		✓	✓	✓	✓	✓	✓	✓
Vision Quest		✓	✓	✓	✓	✓	✓	✓
Pa Coun of Children's Services	✓	✓	✓	✓	✓	✓	✓	✓
George Jr. Republic		✓	✓	✓	✓	✓	✓	✓
ARC	✓	✓	✓			✓		
PA Community Providers Assoc	✓	✓	✓	✓	✓	✓		
New Castle YDC	✓	✓	✓	✓	✓	✓		

External Group	Individual Meetings/ Visits 2-3/97	Sent Draft for Written Comment 4/97	Invited to Work Group #1 4/97	Written Comments Submitted 5-6/97	Attended Work Group #1 5/97	Invited to Work Group #2 6/97	Attended Work Group #2 7/97	Individual Meetings 10/97
Spectrum Family of Agencies		✓	✓	✓	✓	✓	✓	✓
Woods Services		✓	✓	✓	✓	✓	✓	
Children, Youth & Family Council of Delaware Valley	✓	✓	✓	✓		✓		✓
Alternative Rehab Communities		✓	✓	✓	✓	✓	✓	
Parents Involved Network		✓	✓	✓		✓	✓	✓
Youth Serv Alliance of PA		✓		✓		✓	✓	
Pressley Ridge		✓	✓	✓	✓	✓	✓	

External Group	Individual Meetings/ Visits 2-3/97	Sent Draft for Written Comment 4/97	Invited to Work Group #1 4/97	Written Comments Submitted 5-6/97	Attended Work Group #1 5/97	Invited to Work Group #2 6/97	Attended Work Group #2 7/97	Individual Meetings 10/97
Bureau of Safety & Lab Serv/Dept of Ag		✓		✓				
Abraxas	✓	✓	✓	✓	✓	✓	✓	✓
Bureau of Occup and Ind Safety/Dept of L & I		✓						
Juvenile Law Center		✓		✓		✓	✓	
Mel Blount Youth Homes		✓	✓			✓	✓	
Glen Mills		✓	✓		✓	✓	✓	
Silver Springs M. Luther School	✓	✓	✓		✓	✓	✓	✓

External Group	Individual Meetings/ Visits 2-3/97	Sent Draft for Written Comment 4/97	Invited to Work Group #1 4/97	Written Comments Submitted 5-5/97	Attended Work Group #1 5/97	Invited to Work Group #2 6/97	Attended Work Group #2 7/97	Individual Meetings 10/97
Juvenile Detention Center Admin. of PA	✓	✓	✓	✓	✓	✓	✓	
PA Children & Youth Adm	✓	✓	✓		✓	✓	✓	
Indiana Co CYS		✓	✓		✓	✓	✓	
Devereux		✓	✓	✓	✓	✓	✓	
Catholic Social Services		✓	✓	✓	✓	✓		✓
Specialized Treatment Services		✓	✓			✓	✓	
Children's Hospital of Pittsburgh		✓		✓				
Schaffner Youth Center		✓	✓	✓	✓	✓	✓	✓
Appalachn Youth Services		✓	✓	✓	✓	✓	✓	

External Group	Individual Meetings/ Visits 2-3/97	Sent Draft for Written Comment 4/97	Invited to Work Group #1 4/97	Written Comments Submitted 5-6/97	Attended Work Group #1 5/97	Invited to Work Group #2 6/97	Attended Work Group #2 7/97	Individual Meetings 10/97
Juvenile Court Judges Comm.	✓	✓	✓		✓	✓	✓	
Northwestn Youth Services	✓	✓	✓		✓	✓		
Phila Co DHS		✓	✓		✓	✓		
Gannondale		✓	✓			✓		
Youth Study Center		✓	✓			✓		
Kids Peace Natl Ctr	✓	✓	✓			✓		
Tioga Co CYS		✓	✓			✓		
Holy Family Institute	✓	✓	✓		✓	✓		
U. of Pitt Schl of Social Work		✓	✓			✓		
Chester Co CYS		✓	✓		✓	✓		

External Group	Individual Meetings/ Visits 2-3/97	Sent Draft for Written Comment 4/97	Invited to Work Group #1 4/97	Written Comments Submitted 5-5/97	Attended Work Group #1 5/97	Invited to Work Group #2 6/97	Attended Work Group #2 7/97	Individual Meetings 10/97
PA Partnerships for Children	✓-invited; stated not interested in the regs.							
PA Assoc of Resources for People with MR	✓	✓	✓		✓	✓	✓	
PA Assoc of Rehab Facilities, Inc	✓	✓	✓		✓	✓	✓	
Allegheny County CYS		✓	✓	✓	✓	✓	✓	
PA Protection and Advocacy	✓ invited, did not attend							

PROPOSED CHILD RESIDENTIAL AND DAY TREATMENT REGULATIONS
55 PA CODE CHAPTER 3800
EXTERNAL GROUPS INVITED/INVOLVED IN 1997 DEVELOPMENT OF PROPOSED REGULATIONS

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Phyllis Yester

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Elita Evans

Spectrum Family of Agencies
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Bob Bartelt

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Kevin Casey

ARC
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Becky Allen

(147)

April 14, 1998

Mr. Robert Gioffre
Office of Children, Youth and Families
PA Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

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Glen M. Faus, Executive Director
Jeannine S. Boyer, Director of Family Life Services
James J. Doughty, Director of Placement Services

Dear Mr. Gioffre:

COBYS Family Services expresses a sincere THANKS for the opportunity to respond to the proposed 3800 regulations for Child Residential and Day Treatment Facilities as published in the Pennsylvania Bulletin on February 14, 1998. After reviewing the proposed 3800 regulations COBYS offers the following comments:

The main issue is:

- 3800.2 (g) (1) states that this chapter does not apply to child residential and child day treatment facilities operated by the Department. However, under GENERAL 3800.1, Purpose, "The purpose of this chapter is to protect the health, safety and well-being of children receiving care in a child residential facility . . ." Regardless of state, county or privately operated programs **all** children desire the minimum licensing requirement as stated in the 3800 regulations.

Additional issues:

- Numerous references are made to Department "approved or certified curricula" and "immediately" throughout the proposed regulations. We feel that there needs to be more clarity what the department defines as "approved or certified curricula" and "immediately."

- COBYS recognizes the importance of an education and responsibility, however not to acknowledge years of experience in the grandfathering process would result in the lost of a wealth of knowledge.

- Staff training- as to clarity of "Direct contact with children", does this include staff who have contact with the children but who do not have direct responsibility for them? Also the requirement for 30 hours of training within the first 60 days. This would not be cost effective and place additional hours on program staffing.

We have also reviewed the response dated April 3, 1998 to you from M. Jeanne DeAngelis, Executive Director of PCCS, and concur with issues of GENERAL REQUIREMENTS 3800.16 (a) (d) and (f) Unusual Incidents and 3800.17 Incident record, CHILD RIGHTS 3800.32 (f) (h) Specific rights, FIRE SAFETY 3800.127 Portable Space Heaters, CHILD HEALTH 3800.141 (b) and (e), BEHAVIOR INTERVENTION PROCEDURES 3800.203-204, 3800.205 (a), 3800.211 (d) and (e) and 3800.213.

Again thank you for the opportunity to respond to the proposed 3800 regulations.

Please feel free to contact us if you have any further questions.

Sincerely,

James J. Doughty
Director of Placement Services

Clear Brook Inc.

98 MAR 12 PM 2:50

REVIEW COMMISSION

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February 25, 1998

Department of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, Pa. 17105-2675

Dear Mr. Gioffre,

I am writing in support of exclusion for drug and alcohol treatment facilities as pertains to your bulletin regarding the Department of Public Welfare's Child Residential and Day Treatment Facilities, Volume 28, Number 7, dated February 14, 1998.

I have been Drug and Alcohol Counselor at Clear Brook for the past 4 years and strongly support the continuation of site reviews by the Department of Health Division of Drug and Alcohol Program Licensure. They are thorough, fair, supportive and knowledgeable of treatment which is the cornerstone of our programs.

Thank you in considering maintaining exclusion of drug and alcohol programs and if I can be of any further assistance, please contact me at 717-864-3116.

Sincerely,

Stephen Emerick
Drug and Alcohol Counselor

DEPARTMENT OF HUMAN SERVICES
1401 Arch Street Philadelphia, PA 19102

JOAN M. REEVES
Commissioner

MAXINE H. TUCKER
Deputy Commissioner
Children and Youth Services

JOYCE L. BURRELL
Deputy Commissioner
Juvenile Justice Services

MARGARET B. HOLTZMAN
Superintendent
Aging Services

RUSSELL J. CARDAMONE, JR.
Deputy Commissioner
Administration and Management

CITY OF PHILADELPHIA

March 20, 1998

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Mr. Robert L. Gioffre
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

RE: Proposed Chapter 3800 Child Residential and Day Treatment Services, PA Bullentin, Vol. 28, No. 7, February 14, 1998.

This letter is an addendum to my response dated March 11, 1998 addressing the possible impact of Chapter 3800 on our secure detention center.

The majority of the proposed Chapter 3800 regulations as the replacement for Chapter 3760 regulations that govern licensure of the Youth Study Center should not impact significantly on our operations since most of those amendments which might have had a major effect have been exempted for secure detention facilities. These include:

- Section 3800.55 a-d which relates to staff/resident ratios
- Section 3800.56 (d) which relates to the supervision of residents during sleeping hours
- Section 3800.102 (c) which relates to child bedrooms
- Section 3800.103 (f) which relates to the placement of mirrors in the bathroom
- Section 3800.171 (l) which relates to the child care ratio during transportation
- Section 3800.206 which relates to seclusion
- Section 3800.210 which relates to the use of mechanical restraints
- Section 3800.143 (b) which relates to child physical examinations
- Section 3800.221-3800.225 which relates to the development of the individual service plan (ISP)

There are however, some proposed amendments which will impact directly on our operations. These include the additional requirements for detention facilities, Section 3800.283 which limit the number of residents allowed in a bedroom to one and the number of residents in a group or sleeping area to 12. When the Youth Study Center is overcrowded or exceeds the 105 limit, it may not be possible to comply with this standard. Our groups (units) would exceed (12) twelve resulting in non-compliance to this standard which could then result in provisional licensing of the YSC since we cannot control the intake of youths to the facility.

Additionally, this standard would also complicate staffing patterns by setting up dual requirements. We would have to meet the current staffing ratio of 6:1 as well as the unit/group limit of 12. This also potentially could result in an increase in Union grievances filed about the safety of staff working on units with more than 12 youth.

We note that this regulation uses the word "may" rather than the legally compelling term "shall" and that any regulation that might be difficult to meet has an appeal or waiver process available to the agency.

The reduction of training in both orientation and yearly requirements is a concern. Our juvenile population is coming to us with greater risk factors and limited supports. We believe that there is a need for **more** training and education of child care staff than less.

- Current regulations in 3760.56 state that an associate's degree in one of the Social Sciences is needed. Proposed amendments reduces this standard to a high school education or equivalency. However, a child care supervisor should have a bachelor's degree and 1 year work experience or an associate's degree and 3 years work experience with children.

  This impacts career ladders and promotions opportunities for operations staff. Staff need to be prepared through regular training to address the many problems presented by our juvenile population.

Additional concerns include:

- Visiting rights for parents were flexible in current regulations. Proposed regulations identify visitation specifically at least once every 2 weeks. Parents should be required to have more contact with a child than this. More visitation should be encouraged, not restrictive visitation.

- Current Title 55 Regulations are specific in terms of stating that no person including law enforcement officials shall be allowed firearms in living areas. The proposed 3800 regulations related to firearms allow law enforcement personnel to have their firearms on the facility grounds. It is recommended that this regulation **not** be changed for the safety of youth and staff in the facility.

- New proposed regulations do not allow use or even possession of tobacco products by children and staff persons in facilities. Possession of cigarettes by staff is not illegal, thus possession of tobacco products in the facility or during transportation of youth will present a challenge to enforcement and resulting disciplinary action.

Essentially the spirit of the proposed regulation amendments with the noted exceptions is consistent with our pursuit of ACA accreditation; establishment of the "cottage model"; a Behavior Management Program; and our receiving a Chapter 3760 license for seven consecutive years.

Once again, thank you for the opportunity to respond to the proposed regulations. I hope my comments, questions, and concerns can form the basis for additional work on the proposed regulations. I share the State's desire to streamline and consolidate regulatory requirements. However, I want to be sure that we don't lose sight of the children and families who may ultimately benefit or be harmed by regulatory change.

If you have any questions regarding my letter, I would ask you to direct them to Wesley Brown (215) 686-9666 who was a member of the larger work group.

Sincerely,

Joan M. Reeves

JOAN M. REEVES
COMMISSIONER

JMR/vbs

cc: Maxine H. Tucker, Deputy Commissioner
Joyce L. Burrell, Deputy Commissioner
Russell J. Cardamone, Deputy Commissioner
Anne Shenberger, Regional Director, OCYF

401 Arch Street Philadelphia, PA 19102

JOAN M. REEVES
Human Services Commissioner

MAXINE H. TUCKER
Deputy Commissioner
Children & Youth Division

JOYCE L. BURRELL
Deputy Commissioner
Juvenile Justice Services

RUSSELL J. CARDAMONE, JR.
Deputy Commissioner
Administration and Management

CITY OF PHILADELPHIA

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March 11, 1998

Mr. Robert L. Gioffre
Department of Public Welfare
P.O.Box 2675
Harrisburg, PA 17105-2675

Re: Proposed Rulemaking - Chapter 3800 Child Residential and Day Treatment Services, PA Bulletin, Vol. 28, No. 7, February 14, 1998.

Dear Mr. Gioffre:

Thank you for the opportunity to review DPW's proposed regulations pertaining to child residential facilities and day treatment services. I understand and appreciate the State's desire to consolidate the myriad regulations that may apply to similar programs and facilities; to reduce the confusion and costs associated with efforts to comply with these myriad regulations; to ensure that applicable regulations adequately address child health, safety and well-being; and, to streamline the license review process. I do not feel that these proposed rules do what I believe the State intended. I wish to be on-record as opposing the proposed rulemaking as it is currently written.

Generally speaking, while the proposed rules clearly represent a consolidation of regulations, I believe consolidation has been accomplished at the cost of lowering standards rather than raising them. I believe it is an erroneous assumption on the State's part that anything that exceeds minimum health, safety, and well-being should be addressed via contracts and voluntary accreditation.

I believe it is an erroneous assumption on your part that there will be cost savings. Cost savings for providers are illusory unless the counties lower their standards, something I believe is unlikely for Philadelphia County. These changes certainly won't result in a reduction in costs for counties who will need to implement or expand program monitoring functions at county expense since the licensing process will no longer be examining program issues.

I do not believe that minimum child well-being is adequately addressed when requirements for engaging parents in the planning and service delivery process are reduced. Minimal child well-

being is not adequately addressed when the proposed rules do not address permanency planning or provider participation in the process.

In addition to the issues identified below, I am particularly concerned about two components of current licensing regulations that are almost entirely eliminated under the proposed rulemaking :

- Chapter 3680.41: Program descriptions. (This is a subset of the section pertaining to Program Responsibilities (§§ 3680.41 - 48))
- Chapter 3680.62 : Service relationship with a county agency. (This is a subset of the section pertaining to fiscal and purchase of service agreements (§§ 3680.61 - 63))

The following represent more specific comments, questions, and concerns that are offered for clarification regarding the concerns with the proposed rulemaking and for future discussion purposes. They are not in any priority order.

- Shifting responsibility to the counties for setting above minimum standards would seem to contradict DPW's reluctance to support efforts by the counties to work collaboratively in the contracting process.

- Duplication and inconsistency on the part of the State may be reduced or eliminated through consolidation of regulations, but shifting responsibility to the counties poses a much higher risk of duplication and inconsistency in the individual setting of standards by each county.

- Projections of reduced costs do not take into account higher costs that may result from the State's implied requirement that counties set above minimal standards; reduced costs will only occur if minimal standards as proposed are accepted as sufficient.

  - Since the State is setting standards that are minimal, there will be costs involved in the development of the additional standards that the Counties believe are necessary to treat children and their families. There will be confusion in the provider system if these standards are not developed at least on a regional basis.
  - Since the regulations will address health and safety issues, will the provider inspections by the Regional Offices address only these issues and not program issues? If so, the counties will have to increase their monitoring and evaluation activities.
  - The proposed regulations may be sending a double message to the provider community when the State says reduced regulations will result in reduced operating costs when we know that these standards are not sufficient to do more than provide adequate warehousing for our children.

- The only training requirements are related to safety and well being not service.

- Training in childhood development should be required whether or not behavior intervention procedures are used.
- Training in behavior intervention procedures should be required for all staff and not just those staff likely to have to implement if minimum safety and well being is to be better assured.

- The proposed regulations do not address permanency planning or provider participation in the process.

- Reference to natural family is minimal and occurs as part of the development process for the ISP and children's rights section pertaining to bi-weekly visitation.

- Requirements found at *Chapter 3680.42. Individual Service Plan* (ISP) which make specific reference to identifying a schedule of the child's visits with parents are eliminated. The proposed rules state only that the child has a right to bi-weekly visitation.

  - The requirement for quarterly reporting to the placing agency has been eliminated for the ISP process.

- Requirements found at *Chapter 3680.44. Visiting and Communication*, which make reference to content of the visitation plan including, time and place (a convenient and natural setting) as well as communications regarding location or change in location and person responsible are eliminated. The proposed rules address the child's right to communicate subject to " ... reasonable facility policy and written instructions from the funding agency or court, ... ".

- Personnel Policies

  Under Chapter 3680, the provider is required to establish a basic written personnel policy covering salaries, work hours, vacation and sick leave, overtime and employee benefits. This requirement is eliminated under Chapter 3800.

  A personnel policy is a fundamental element of internal control in most organizations. The vast majority of agencies providing residential services already have such a policy in place so it is unclear as to what cost savings would be realized. An exception could be made for small day care facilities where it may be impractical to formulate a policy for so few staff.

- Budget Requirement

  Under Chapter 3680, the provider is required to adopt an annual budget which encompasses all of their services. This requirement is eliminated under Chapter 3800.

Budgeting is the process of developing a monetary plan of operation for a specific period of time. At a minimum, it would contain information about the types and amounts of proposed expenditures, the purposes for which they are to be made and the proposed means of financing them.

The initial step of sound financial planning is the development of a budget. It would be difficult for any organization, even the smallest day care center, to operate efficiently without implementing a budget especially when resources are limited.

- Audit Requirement

Under Chapter 3680, the provider is required to have an annual audit performed by an independent public accountant. This requirement is eliminated under Chapter 3800.

As virtually all residential care providers are sub-recipients of Federal funds, they are subject to the provisions of OMB Circular A-133 entitled Audits of States, Local Governments and Non-Profit Organizations. This being the case, any agency receiving $300,000 or more annually in Federal funds is required to have an annual audit performed. In addition, the PA Department of Public Welfare has expanded the audit requirement to include agencies receiving $300,000 or more in combined State and Federal funds.

Instead of totally eliminating the requirement, an audit requirement in accordance with Federal and State thresholds could be included. This would not cause any increase in costs to providers.

- Insurance Requirement

Under Chapter 3680, the provider is required to maintain insurance protection for its clients, funds and properties including fire, theft, health, accident and workmen's compensation. This requirement is eliminated under Chapter 3800.

It is unclear as to why a license would be granted to an organization providing direct services to children that does not maintain insurance coverage. Not only the provider but the county and State would be at risk.

- Conflict Of Interest

Under Chapter 3680, the provider cannot use government funds for a related party transaction without a prior written determination of DPW that the transaction is at a competitive cost or under terms more favorable to the agency. This requirement is eliminated under Chapter 3800.

As virtually all residential care providers are sub-recipients of Federal funds, they are subject to the provisions of OMB Circular A-110 entitled Uniform Administrative

Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals and Other Non-Profit Organizations. This being the case, they must comply with the procurement standards contained therein which state that all procurement transactions shall be conducted in a manner to provide, to the maximum extent practical, open and free competition and the recipient shall be alert to organizational conflicts of interest. It also states that no employee, officer or agent shall participate in the selection, award or administration of a contract supported by Federal funds if a real or apparent conflict of interest would be involved.

In the past, the requirement for prior State approval for related party transactions has proved to be an excellent safeguard which helped to ensure that relatives of agency employees are not engaged to provide goods or services when more competitive prices can be found in the marketplace.

Once again, thank you for the opportunity to respond to the proposed rulemaking. I hope my comments, questions, and concerns can form the basis for additional work on the proposed regulations. I share the State's desire to streamline and consolidate regulatory requirements. However, I want to be sure that we don't lose sight of the children and families who may ultimately benefit or be harmed by regulatory change.

If you have any questions regarding my letter, I would ask you to direct them to Wesley Brown (215-686-9666) who was a member of the larger work group.

Sincerely

Joan M. Reeves

Joan M. Reeves
Commissioner

JMR/wmb
cc: Maxine H. Tucker, Deputy Commissioner
Joyce L. Burrell, Deputy Commissioner
Russell J. Cardamone, Deputy Commissioner
Anne Shenberger, Regional Director, OCYF

G:\POL_PLAN\REGULATE\3800DRFT.LET

CHOR Youth & Family Services, Inc

(Affiliated with The Children's Home of Reading)
1010 Center Avenue, Reading, PA 19601
Phone (610) 478-8266
Fax (610) 478-8094

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April 15, 1998

Division of Program Planning and Development

APR 1 5 1998

Received:
Refer to: [redacted]

Mr. Robert Gioffre
Office of Children, Youth and Families
Department of Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

The Children's Home of Reading would like to express its concern regarding the proposed Chapter 3800 regulations as they pertain to adolescent centered drug and alcohol services. The lack of applicability (3800.2) of the chapter to adolescent drug and alcohol residential facilities creates a serious dilemma of forced choice between DPW/OCYF and DOH/DDAPL licensure. This exclusion also raises basic health and safety concerns for children served in residential treatment facilities licensed only by the Department of Health.

It is our belief that it is in the best interest of children and youth who need residential drug and alcohol services that the proposed 3800 regulations be expanded to include these programs.

Sincerely,

Michael A. Viskovich
Clinical Director

MAV:lh

(139)

PROFESSIONAL SERVICES FOR CHILDREN, YOUTH, AND FAMILIES

EXECUTIVE DIRECTOR:

Glenn J. Hillegass

CONCERN.

April 13, 1998

Mr. Robert L. Gioffre
Department of Public Welfare
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Mr. Gioffre:

I thank you for the opportunity to comment on the proposed Department of Public Welfare's Child Residential and Day Treatment Facilities regulations published in the Pennsylvania Bulletin, February 14, 1998.

I am aware you will be receiving comments to these proposed regs from numerous sources, many of which CONCERN has been involved with, during this review period.

Our primary areas requiring further review are:

3800.16 - Unusual Incidents

The new regulations are requiring completion of an Unusual Incident Report when a client is taken into the hospital for outpatient treatment. This will mean a report has to be completed for any minor sprains or strains due to program recreational activities that may require emergency room visits. (This is not a requirement with the present regulations.) This change will greatly increase the number of reports being sent to the Department for their review, which, I would think, would stretch the Departments resources.

3800.211 - Manual Restraints

e) A staff person who is not applying the restraint shall complete observation and documentation of the physical and emotional condition of the child at least every ten minutes the manual restraint is applied.

Safe physical management should never be applied by only one staff person. Therefore, during a restraint, at a minimum, two staff persons should be involved in the restraint; and by this new defined regulation, a staff person should be observing and documenting the physical and emotional condition of the child during the restraint. This will require increased staff

patterns to deal with the delinquent population in our CTUB Units, and I would imagine that it will require higher staffing ratios in other programs.

Overall, I think the proposed regulations are pretty much on target, but I also believe additional resources will be necessary for agencies to comply with the changes.

Thank you for your time in this matter.

Respectfully submitted,

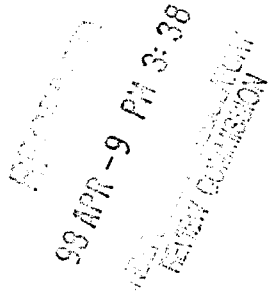
Kevin E. Stichter, MSCJ
Director of Delinquency Services

KES:SJH

cc: Glenn Hillegass

COUNTY COMMISSIONERS
Richard R. Stevenson, Chairman
Cloyd E. Brenneman
Olivia M. Lazor

Albert E. Acker Building
8425 Sharon-Mercer Road
Mercer, PA 16137
Telephone (412) 662-2703
or (412) 962-1999
After hours/Emergency (412) 662-3112



COUNTY OF MERCER

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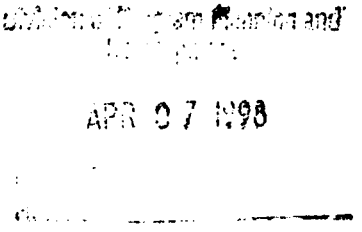


April 2, 1998

Robert L. Gioffre
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

Mercer County Children and Youth Services is requesting the Department of Public Welfare consider the following exceptions to the proposed rulemaking published in the Pennsylvania Bulletin dated February 14, 1998, Volume 28, No. 7, Part IV (Child Residential and Day Treatment Facilities).

3800.16 Unusual Incidents
The reporting of minor injuries that do not require in-patient medical treatment as unusual incidents is inappropriate. The only foreseeable outcome being increased paperwork in the form of an unusual record or a waiver. The benefit being unknown to the child and certainly would not effect the child's health and/or safety. After reviewing this proposed rulemaking with several facilities, I have concluded the only outcome to be an increase in placement costs to counties if facilities were to meet the proposed mandate. Facilities are adequately documenting medical treatment and MCCYS has always been notified of all treatment a child has received in a timely manner, i.e. if not immediately, then within 24 hours.

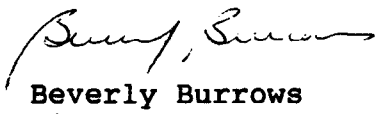
3800.56(d) Supervision
The proposed rulemaking differentiates between the delinquent and dependent status of a child versus the needs of an individual child in a specific population. This rulemaking discounts facilities serving both dependent and delinquent children which maintain live-in staff. Thus, this rulemaking has no validity in serving the best interests of children and only

serves to increase placement costs to counties if extra staff had to be hired or programs restructured.

The proposed amendments do not represent the intended goal as stated on page 953 to eliminate or reduce duplication inconsistencies or strengthen health and safety requirements on behalf of children.

Thus, I am requesting your support of these objections to the current language in the proposed regulations and ensure the appropriate adjustments are made. Your attention to this matter is greatly appreciated.

Sincerely,



Beverly Burrows
Director

BB:bak

cc: County Commissioners Association
Chuck Songer

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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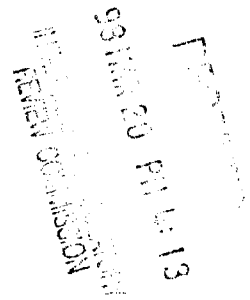
DATE: March 20, 1998



SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien ROB.
Senior Assistant Counsel

Attached are public comments received March 19, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

DATE: March 16, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien RO'B.
Senior Assistant Counsel

Attached are public comments received March 12 and 16, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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DATE: March 18, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien ROB.
Senior Assistant Counsel

Attached are public comments received March 18, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

ORIGINAL: 1927
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Form letter 4

DATE: March 12, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien ROB.
Senior Assistant Counsel

Attached are public comments received March 11, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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DATE: March 10, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien RO'B.
Senior Assistant Counsel

Attached are public comments received March 9, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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DATE: March 6, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien RO'B.
Senior Assistant Counsel

Attached is a public comment received March 5, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

DATE: March 3, 1998

ORIGINAL: 1927
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Legal (2)

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien ROB.
Senior Assistant Counsel

Attached is a public comment received March 2, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

ORIGINAL: 1927
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DATE: February 23, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien 120 '13.
Senior Assistant Counsel

Attached is a public comment received February 17, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

JUVENILE COURT
ANTHONY A. GUARNA
CHIEF JUVENILE PROBATION OFFICER
610-630-2252
FAX NO. 610-630-1749

COUNTY OF MONTGOMERY
JUVENILE PROBATION DEPARTMENT
530 PORT INDIAN ROAD
NORRISTOWN, PENNSYLVANIA 19403-3500

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March 26, 1998

Mr. Robert L. Gioffre
Department of Public Welfare
P.O.Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

I have just received a copy of the remarks of Pat. J. Farrone, Executive Director of George Junior Republic which was sent to you March 20, 1998. Please be advised that I am in complete agreement with Mr. Farrone's remarks.

It seems to me that DPW regulations should assist and not hinder the operations of the private providers. I do hope you will take in consideration and change the regulations accordingly. I did write to you sometime ago to express my feelings of the regulations.

Very truly yours,

Anthony A. Guarna
Chief Juvenile Probation Officer

AAG/rft

COMMISSIONERS
MARIO MELE
RICHARD S. BUCKMAN
JOSEPH M. HOEFFEL III

EXECUTIVE DIRECTOR
WALTER J. JUNEWICZ, A.C.S.W.
TELEPHONE: 610-278-5882
TDD: 610-631-1211

COUNTY OF MONTGOMERY

OFFICE OF CHILDREN AND YOUTH
LOGAN SQUARE, 1880 MARKLEY STREET
NORRISTOWN, PENNSYLVANIA
19401-2904
TELEPHONE: 610-278-5800
FAX: 610-278-5898

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April 8, 1998

PA Department of Public Welfare
Attn: Mr. Robert L. Gioffre
P. O. Box 2675
Harrisburg, PA 17105-2675

Re: Proposed Chapter
3800 Regulations

Dear Mr. Gioffre:

We appreciate the opportunity to comment on DPW's proposed Child Residential and Day Treatment Facilities Regulations as published in the Pennsylvania Bulletin dated February 14, 1998, Part IV.

1) As MHMR specialized treatment facilities would be covered by the regulations, so should specialized treatment D/A facilities.

2) We oppose the reduction in standard for direct child care staff to have a high school diploma or GED certificate. The DPW rationale that this reduction eliminates previous cumbersome administrative problems created by the 50% provision (50% to have 2 years of college and 2 years experience) is not satisfactory. The method to simplify the previous complex requirement is not to simply reduce the standard. At a minimum, we would propose that client child care staff have a high school diploma and two years of college or two years experience working with children.

3) Training requirements on the proposed regulations appear very limited to health and safety issues and should provide for training in family dynamics (problematical family relationships are often transferred and played out with child care staff) and child development. Little or no reference is made to the family

unit from which the youth came from and would return to upon discharge.

4) We oppose any change in the staff-child ratios. For youth who are six (6) and older, the proposed one (1) child care worker per eight (8) youth during awake hours and one (1) per sixteen (16) during sleeping hours is not adequate to preserve a safety standard. This would be the case, for example, when a child care worker might be diverted to restrain a youth, intercede in an altercation, or address some other emergency situation.

5) The regulations provide for minimal health and safety standards and abrogates the state from program, fiscal, and personnel standards considering:

   a) There is no requirement for personnel policy, a basic organizational mechanism to address hiring requirements, employee infractions and related disciplinary actions, promotions, discharges, etc.

   b) A requirement for prior State DPW approval for related party transactions should be included in the regulations as required under OMB Circular A-133 which practically all providers must adhere to as sub-recipients of federal funds.

   c) A basic requirement for providers to maintain insurance (property, workmen's compensation, fire, etc.) for licensure should remain part of regulations.

   d) We propose that audit requirements in accordance with federal and state requirements be included in the regulations.

   e) Providers should be required to have current written descriptions of their programs so user agencies can determine the suitability of same for youth.

6) We believe that shifting accountability for program and fiscal standards to counties increases potential for duplication and serious inconsistencies among counties and service providers. Additionally, since the proposed regulations only essentially establish minimal health and safety standards, increased costs may result as counties would require above minimal standards through their contracts.

7) The proposed regulations stipulate that a child can be seen within 24 hours only by a "staff person who has been trained by medical personnel." This could be a non-medical, high school educated person. Thus, child may not be seen by any licensed medical provide for 15 days (time of complete physical exam). The initial assessment is not supervised by a licensed medical provider nor requires a

supervising signature. The language of "A written health and safety assessment" does not state that an actual exam is required, only assumed. This is too bare bones, if not dangerous.

We appreciate the opportunity to comment on these draft regulations and trust revisions will be made in the best interests of all concerned.

Sincerely,

Walter J. Dunewicz
Executive Director

WJJ/rb

CC: Charles R. Songer Jr., Executive Director, PCYA

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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FORM LETTER #1 9
FORM LETTER #2 6
FORM LETTER #3 15
FORM LETTER #4 3
FORM LETTER #5 21

DATE: April 2, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien ROB.
Senior Assistant Counsel

Attached are public comments received March 30, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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DATE: March 30, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien
Senior Assistant Counsel

Attached are public comments received March 27, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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DATE: March 26, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien RO'B.
Senior Assistant Counsel

Attached are public comments received March 25, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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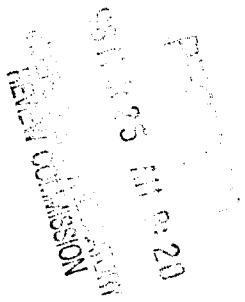

DATE: March 23, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien ROB.
Senior Assistant Counsel

Attached are public comments received March 20, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

Feather O. Houstoun
Secretary

Telephone 717-787-2600/3600
FAX 717-772-2062

MAR 16 1998

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Mr. Richard Sandusky
Director of Regulatory Analysis
Independent Regulatory Review Commission
333 Market Street
Harrisburg, Pennsylvania 17101

Dear Mr. Sandusky:

On February 4, 1998 we delivered a proposed regulation to you regarding Child Residential and Day Treatment regulations (55 Pa. Code Ch. 3800) (#14-442). Notice of proposed rulemaking was published at 7 Pa. B. 953 on February 14, 1998. The notice of proposed rulemaking provided for a 30 day public comment period to end on March 16, 1998. The public comment period on the proposed regulations is being extended by 30 days, until April 15, 1998.

The extension in the public comment period is being made because this is the first in a series of proposed licensing regulatory reform initiatives, and the department wants to allow adequate opportunity for interested stakeholders to review and comment on this comprehensive regulatory proposal.

Public notice of this extended comment deadline will appear in the *Pennsylvania Bulletin* on March 14, 1998. Notice of the extension will be mailed to all persons who received notice of the proposed rulemaking from the department.

Sincerely,

Feather O. Houstoun

Feather O. Houstoun

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGRICULTURE
BUREAU OF FOOD SAFETY AND LABORATORY SERVICES

March 3, 1998

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Robert L. Gioffre
Pennsylvania Department of Public Welfare
P. O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

On February 17, 1998 I received from Jo Ann R. Lawer, Esquire, a copy of the **Pennsylvania Bulletin** which contained the proposed Child Residential and Day Treatment Regulations.

I have reviewed this document and offer the following comments for your consideration.

Section 3800.31. Notification of rights.
(b). If it is a very small child, the child may not be able to sign the statement as listed in this section.

Section 3800.86. Lighting.
*** * * *** shall be lighted to avoid accidents. What is the lighting intensity? Should you specify a certain level of illumination in footcandles?

Section 3800.89. Temperature.
(b). Indoor temperatures may not be less than 58°F during sleeping hours. Isn't this a bit low for young children, especially when sleeping?

Section 3800.104. Kitchen areas.
(b). Add the words **"and sanitized"** after the word "rinsed".

Section 3800.151. Staff health statement.
The requirement of a statement signed and dated by a licensed physician et al within twelve (12) months prior to working with children or food service and every two (2) years thereafter is passe'. The statement about the condition of the person is good on the day of the examination only. The person could become infected and be a "carrier" of some communicable disease, but would not be tested for at least two years. It gives a false sense of security.

Section 3800.302. Exceptions for outdoor and mobile programs.
(b)(3). Why would you eliminate the concern for an infestation of insects and rodents? I know it is a rustic setting, but you should be sure the cabin or tepee is free of these vermin.

2301 NORTH CAMERON STREET
HARRISBURG, PA 17110-9408
717-787-4315
FAX 717-787-1873

(b)(4). Even a rustic living area must practice proper sanitation, have adequate ventilation, and be lighted to prevent accidents.

(b)(5). Water that conforms to the standards of the Pennsylvania Safe Drinking Water Act must be available.

Section 3800.307. Additional requirements for outdoor and mobile programs.
(a)(3). There shall be an opportunity * * * *and wash their hands and brush their teeth once a day. Because hands are the number one cause of transmitting disease organisms from person to person or from person to food to person, hands must be washed more often than once a day. Also, there is no mention about the number of or availability of toilet facilities at these programs.

Thank you for giving me the opportunity to comment on your proposed rulemaking. If you have any questions on my comments, feel free to contact me at (717) 772-8353.

Sincerely,

Kenneth W. Hohe

Kenneth W. Hohe, MSEH
Food Sanitarian Program Manager
Division of Food Safety

cc: Jo Ann R. Lawer
File

CRAY YOUTH AND FAMILY SERVICES, INC.

321 NORTH JEFFERSON ST. • NEW CASTLE, PA 16101
(724) 654-5507

137

98 APR 15 PM 1:53

REVIEW COMMISSION

April 13, 1998

Mr. Bob Gioffre
Office of Children Youth and Families
PA Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

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Division of Program Planning and Development

APR 14 1998

Received:
Refer to:

Dear Mr. Gioffre:

I am the Director of Cray Youth and Family Services in New Castle, PA. I am writing to provide you with some input on the proposed regulation governing child residential facilities.

I wanted to bring to your attention my concern on the wording used in section 3800.121, **Unobstructed egress**. My concern is specifically with 3800.121 (b), which states "Doors used for egress routes and from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of children from the building." My concern is with the word *immediate* and what your interpretation of this section specifically means.

Cray operates an emergency youth shelter program which is equipped with 15 second delay hardware on the doors. The doors automatically disarm in the event of a fire. These devices were very expensive to install and add security to the program without an adverse affect on the children's safety. I would like to see clarification on the above section to allow for the use of this hardware. I believe the word *immediate* should be eliminated.

I would also like to see the development of an interpretive manual for agencies to aid them in more clearly understanding how the governing bodies are going to interpret and apply the new regulations.

Thank you for taking these concerns under consideration.

Sincerely,

David Copper
Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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~~Notebook~~

DATE: April 14, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien RO'B.
Senior Assistant Counsel

Attached are public comments received April 10 and 13, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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Form letter 4

DATE: April 15, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien RO'B.
Senior Assistant Counsel

Attached are public comments received April 14, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

98 APR -9 PM 3:37

REVIEW COMMISSION

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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DATE: April 9, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien
Senior Assistant Counsel

Attached are public comments received April 6, 7 and 8, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LEGAL COUNSEL

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DATE: April 7, 1998

SUBJECT: Public Comment - #14-442
Child Residential and Day Treatment Facilities Regulations

TO: Richard Sandusky
Director, Regulatory Analysis
Independent Regulatory Review Commission

FROM: Ruth O'Brien ROB.
Senior Assistant Counsel

Attached are public comments received April 6, 1998 regarding the proposed Child Residential and Day Treatment Facilities Regulations.

Attachment

cc: Scott Johnson
Niles Schore
Sharon Schwartz
Michael Rish

(140)

Arizona
California
Connecticut
District of Columbia
Florida
Georgia
Maryland
Massachusetts
New Jersey
New York
Pennsylvania
Tennessee
Texas

Devereux

BENETOCENTER
Mapleton Programs

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April 14, 1998

Mr. Robert L. Gioffre
Department of Public Welfare
6th and Commonwealth Avenue
Health and Welfare Annex
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

Thank you for the opportunity to provide comments on the proposed regulations governing Child Residential and Day Treatment Facilities published in the February 14, 1998 Pennsylvania Bulletin.

The Devereux Beneto Center is comprised of four major program components; the Mapleton Programs, the Brandywine Programs, the Devereux Day School, and the Philadelphia Programs. The Center provides mental health treatment services to over 400 children, adolescents and their families throughout Southeastern Pennsylvania. Our campus-based programs, Brandywine and Mapleton provide residential services to approximately 250 clients, and currently operate under the 3810 regulations.

We have reviewed the proposed regulations and offer the following comments for your review:

3800.2 Applicability
Further consideration should be given to include drug and alcohol treatment centers. Through the growth of managed behavioral healthcare, these services have become increasingly integrated with the mental health services. Regulations governing the delivery of these services should reflect this integration. The goal of protecting the health, safety and well-being of children receiving care in a residential facility should be of equal importance in a drug and alcohol treatment center.

3800.3 Definitions
Under the definition for "child", subsection (iii), we are concerned with the phrase "with a plan to move to an adult setting by age 21..." What if a transfer to an adult setting is not planned, but the plan is to move the client back to the community? Must this person be discharged prior to age 21?

Under the definition of "relative", we request that "legal guardian" be included in the definition.

3800.16 Unusual Incidents
We would appreciate clarification on the following:

- What is the definition of facility/premises? Does it include the grounds of the facility or are these two different definitions?
- Who determines whether an action taken by a child is a suicide attempt? A physician, nurse, or psychologist?
- What is the definition for outbreak of a serious communicable disease?
- What is the definition for intimate sexual contact between children?
- Further information is needed concerning injury, trauma, or illness of a child requiring inpatient or outpatient treatment at a hospital. Please define this as an unusual incident.
- Clarification is needed regarding a child who leaves the premises of the facility for thirty minutes or more without the approval of staff. Clients may be missing for over one hour and return; we recommend increasing the time to 24 hours.
- What is the definition of abuse or misuse of a child's funds or property?
- Section d; we recommend 72 hours rather than 24 hours to complete a written unusual incident report.

3800.32 Specific Rights
Please define "excessive" medication in subsection (k).

3800.55 Child Care Worker
Subsection (h) places an age requirement of 21 or older on Child Care Workers in order to be counted in the ratio. We recommend the age limit be lowered to 18 as we have employed many individuals 18-20 years of age who have demonstrated excellent ability, skill and knowledge in carrying out their responsibilities; and have also exhibited the professional maturity necessary to maintain consistent job performance.

3800.102 Child Bedrooms
We recommend individual sleeping rooms remain at least 74 square feet of floor space including space occupied by floor space, consistent with current 3810 regulations.

3800.201 Appropriate Use of Behavior Intervention Procedures
Subsection (b) excludes the potential risk to others that a client may pose. This should be expanded to include the use of behavioral interventions to protect others from harm.

3800.205 Staff Training
(a) If behavior intervention procedures are used, each staff person who administers a behavior intervention procedure shall have completed and passed a *Department approved training program* within the past year in the use of behavior intervention procedures.

Devereux CP/I is a comprehensive crisis prevention and intervention training program for direct-care providers. The program emphasizes safe, therapeutic, proactive strategies and a least-restrictive approach. The training program was developed for and approved by The Devereux Foundation, and has been implemented throughout the organization for more than 12 years. In addition, Devereux CP/I has been available as training services to outside providers within the commonwealth for the past seven years.

The content that must be included in the approved training program, as specified in the proposed amendments (i.e. 3800.205.b.1-7), is indeed included in the Devereux CP/I training program.

We recommend that the Department consider and review the crisis intervention training programs currently implemented at each facility rather than designating one state-approved training program in crisis intervention for all facilities, in accordance with the specified content areas, and grant approval of those programs meeting those specified requirements.

3800.29 Chemical Restraints
Section (e) A Pro Re Nata (PRN) order for controlling acute episodic behavior is prohibited.

This severely limits the management of our clients. We recommend the current regulations which state a PRN order could be written and be valid for 30 days. Psychoactive medication orders are reviewed and rewritten every 30 days and do not differentiate for PRN orders.

3800.211 Manual Restraints
The staff person who is not applying the restraint will complete observation and documentation of the physical and emotional condition of the child at least every 10 minutes. Although the documentation and observation are extremely important, a staff person who is not involved in the restraint may not be available to make this observation. We recommend a modification to this regulation to allow for the staff involved in the restraint to complete the documentation upon completion of the restraint.

Thank you, again, for the opportunity to comment on the proposed draft 3800 regulations. If you have any questions, or need further clarification of these comments, please contact me directly at (610) 296-6923.

Sincerely,

Mark J. Snow
Administrator, Mapleton Programs
Devereux Beneto Center

cc: Richard Warden, Executive Director

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

APR 16 1998

SUBJECT: Additional Comments on Proposed Regulations 3800

TO: Robert L Gioffre
Office of Children, Youth and Families

Office of Children, Youth and Families Planning and Program Development
APR 15
Received:
Refer to: _____

FROM: Jerry Kopelman
Director, Bureau of Policy and
Program Development

Please refer to our memo of March 13, 1998. We are providing additional comments from Office of Mental Health and Substance Abuse Services Executive Staff.

1. In comment #10 of our memo of 3/13/98 we recommend, in §3800.143(a), that the physical examination be performed prior to admission. We would like to also recommend that provision be made to allow for placement without a physical examination in emergency situations. For emergency situations, the physical examination should be performed within 48 hours of placement. Such a provision would provide for an emergency placement over a weekend or similar situation.

2. We recommend that a subsection be added to permit waiver of standards to accommodate exceptional circumstances. Pursuant to DPW review and approval, waivers can accommodate worthy program exceptions such as the use of locked facilities for unique voluntary placements. Such placements would be determined by the specific clinical needs of individuals to be served.

If you have any questions or need further information please contact Robert Jones at 2-7926.

cc: Ms. Kroh
Mr. Feine

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

OFFICE OF
POLICY DEVELOPMENT

TEL: (717) 772-8318
FAX: (717) 787-1229

September 23, 1998

Mr. Richard M. Sandusky
Director of Regulatory Analysis
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, Pennsylvania 17101

Original: 1927
Copies: Wilmarth
Sandusky
Legal

Dear Mr. Sandusky:

As you discussed with Ms. Karen Kroh, attached for your informal review and comment are drafts of the preamble and the final regulations for 55 Pa. Code Ch. 3800 titled "Child Residential and Day Treatment Facilities", regulation #14-442.

In addition to the draft preamble and regulations, we are enclosing the following background information to aid in your review:

- A summary of public comments received during the 60-day public comment period.
- Comments and responses to the House Aging and Youth Committee.
- A summary of the scope of the regulations and numbers and types of facilities covered.
- A regulation work plan.
- A summary of external stakeholder involvement in the regulatory process.
- A one page summary of consumer protections contained in the new regulations.

If you have any questions on any of the enclosed documents, please contact Ms. Karen E. Kroh, Licensing Manager, Office of Policy Development at 783-2207. Ms. Kroh will contact you shortly to offer to meet with you informally to present and discuss this regulations packet. We would appreciate receiving your informal comments on the regulations packet by October 20, 1998.

We have carefully considered all the comments from the Independent Regulatory Review Commission, the legislature, and external stakeholders in the preparation of the final draft regulations. We have worked closely with provider, consumer, and advocacy groups during the past 22 months to prepare final regulations that protect the health, safety and welfare needs of children served in these facilities, while balancing the concerns of all interested parties.

Thank you for your assistance in reviewing these regulations prior to the formal review period.

Sincerely,

Peg Dierkers

Peg Dierkers, Director

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General

BY: _____
(Deputy Attorney General)

_____
Date of Approval

☐ Check if applicable
Copy not approved. Objections attached.

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

Department of Public Welfare
(Agency)

LEGAL COUNSEL: _____

DOCUMENT/FISCAL NOTE NO. #14-442

DATE OF ADOPTION: _____

BY: _____

TITLE: Secretary of Public Welfare
(Executive Officer, Chairman or Secretary)

Copy below is hereby approved as to form and legality. Executive or Independent Agencies.

BY: _____

_____
Date of Approval

(Deputy General Counsel)
(Chief Counsel, Independent Agency)
(Strike inapplicable title)

☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

DRAFT

Department of Public Welfare
Office of Children, Youth and Families
[55 PA Code Chapter 3800]
Child Residential and Day Treatment Facilities

DRAFT

TITLE 55 ---- PUBLIC WELFARE
DEPARTMENT OF PUBLIC WELFARE
[55 PA. CODE CHS. 3130, 3680, 3710, 3800, 3810, 5310, AND 6400]
Child Residential and Day Treatment Facilities

PREAMBLE - September 21, 1998

Statutory Authority:

The Department of Public Welfare (Department), by this order, adopts the amendment set forth in Annex A under the authority of Articles IX and X of the Public Welfare Code (62 P.S. §§901-922 and 1001-1080).

Notice of proposed rulemaking was published at 28 Pa.B 953 (February 14, 1998).

Background:

The purpose of this amendment is to establish requirements to protect the health, safety and well-being of children who receive services in residential or day treatment facilities within the Commonwealth. This regulation strengthens health and safety requirements based on current information and research and reduces duplication and inconsistencies within multiple chapters of licensing regulations.

This regulatory reform initiative is the first of many regulatory reform initiatives of the Cross-System Licensing Project. The purpose of the Licensing Project is to improve existing human service licensing functions within state government by strengthening health and safety protections and reducing duplication and inefficiency within the licensing process. The Departments of Public Welfare, Health and Aging are working jointly with external stakeholders to improve, strengthen and streamline the licensing function for all human service disciplines including child welfare, child care, personal care, mental health, mental retardation, drug and alcohol and aging. While the licensing project includes many initiatives, such as the development of new human service licensing legislation, automation, inferential inspection systems, and training of licensing staff, the regulatory reform initiative is one of the most critical of the project's activities.

This regulatory amendment is the first of ten regulatory amendments planned by the licensing project to be completed over the next four years. In February 1998, the project presented a regulatory consolidation proposal to external stakeholders to consolidate and combine at least 28 chapters of existing licensing regulations into ten chapters. All of these regulations are intended to protect the health, safety and well-being of consumers receiving services by the regulated facilities and agencies.

The consolidation of multiples chapters of regulations is being done in an effort to reduce multiple, and often conflicting and duplicative, sets of regulations that now apply to a single corporation or business. Many human service providers operate different types of human service facilities and therefore must meet several sets of regulations. This is very difficult and requires administrative and staff time and attention to devote to regulatory

compliance. Moreover, from a health and safety perspective, there is little value to having multiple sets of regulations where the risks to the consumers is similar. By eliminating some of the burden for compliance with multiple sets of differing regulations, it is anticipated that facilities will be able to improve their ability to comply with regulations and spend more time and effort in providing direct services to consumers. The primary intent of regulation consolidation is to improve services and protections to consumers by refocusing provider effort from regulatory compliance to the provision of consumer services.

Scope:

These regulations apply to a diverse variety of child residential and part-day program types currently operating within Pennsylvania. The regulations apply equally to profit and non-profit facilities, including service providers who do and do not receive public funds.

The regulations apply to facilities currently governed by 55 Pa Code Ch.3810 regulations titled "Residential Child Care Facilities", including but not limited to facilities and programs such as group homes generally serving no more than 12 children in a small, home-like setting; residential treatment facilities serving children with mental illness or serious emotional disturbance in a short-term specialized mental health treatment environment; and non-secure residential facilities serving both dependent and delinquent children in various sizes and types of physical structures and diverse program models ranging from the more traditional residential settings to alternative programs and settings such as boot camps, outdoor wilderness programs, mobile programs, and transitional living located in large settings. There are about 450 residential facilities licensed under 55 Pa. Code Ch. 3810 regulations.

The regulations will also apply to non-state operated, secure residential facilities currently licensed under 55 Pa Code Ch.3680 regulations titled "Administration and Operation of a Children and Youth Social Service Agency" and previously governed by requirements for "Training Schools" (formerly uncodified Title 6500) in which the building itself is kept locked and/or there is secure fencing around the perimeter of the building. There are fewer than 20 such secure residential facilities currently licensed in the Commonwealth. The regulations also govern 21 secure detention facilities currently licensed in accordance with 55 Pa. Code Ch. 3760 regulations titled "Secure Detention Facilities", where children are held temporarily awaiting court disposition, in which the facility is locked or the perimeter is fenced.

Also included within the scope of these regulations are maternity homes, which are currently licensed in accordance with 55 Pa. Code Ch.3710 regulations titled "Maternity Homes" serving an average of 5 expectant or new mothers who are under 18 years of age. There are only 11 maternity homes currently licensed in the Commonwealth. The Department has been transitioning licensure of these maternity homes from 55 Pa. Code Ch. 3710 titled "Maternity Homes" to 55 Pa. Code Ch. 3810 regulations titled "Residential Child Care Facilities". The Ch. 3810 regulations are more appropriate for this population.

These regulations also will apply to community residential mental retardation facilities serving exclusively children. There are approximately 30 such facilities currently licensed under 55 Pa. Code Ch. 6400 regulations titled "Community Homes for Individuals with Mental Retardation". These facilities provide specialized care for children with mental retardation.

The regulations will also apply to approximately 45 community mental health residential facilities serving exclusively children currently licensed under 55 Pa. Code Ch. 5310 regulations titled "Community Residential Rehabilitation Facilities". The mental health children's facilities are residential care facilities providing community care for children with mental illness.

In addition to the various types of residential programs that the regulations govern, the regulations also apply to approximately 75 child part-day service facilities currently licensed under 55 Pa Code Ch.3680 regulations titled "Administration and Operation of a Children and Youth Social Service Agency". These are full-day and extended-day alternative education and service programs for children who are transitioning from a more intense residential program back to their families or who need special services for the child to remain at home and avoid more intensive residential placement.

The development and adoption of a single set of regulations to apply to a variety of program models and settings is being done to reduce duplication and inconsistency among chapters of regulations that are intended to care for children who are exposed to similar health and safety risks.

These regulations do not apply to Department-operated facilities that provide secure and non-secure care to children who are adjudicated delinquent. While Department Youth Development Centers and Youth Forestry Camps do not receive a license to operate, it is the Department's intent to apply the regulations to the maximum extent possible in the operation of these facilities. With the implementation of these regulations, the Department will begin to apply the same regulations, measurement tools, and inspection frequency that apply to nonpublic facilities to the state operated facilities.

Regulatory Formulation Process:

A work plan describing the process and time frames for the regulatory development and promulgation of these regulations was developed in January 1997. The plan provided for ongoing and active consultation and involvement with many external advocacy, consumer and provider organizations. Throughout the two year regulatory formulation process, the plan called for external stakeholder participation in many and varied forums such as formal and informal meetings, discussing issues, and submitting written comment.

In February 1997, March 1997, October 1997, March 1998 and June 1998 individual meetings were held with several statewide provider, advocacy, and consumer organizations. The meetings were convened to give briefings on the scope and content of the new regulations and to obtain input on major issues of particular concern to the different organizations.

To allow for dialogue and to obtain specific feedback from those most directly effected by the regulations, a regulation work group was formed and met for several days during May 1997, July 1997 and August 1998. Work group members included over 55 individuals representing consumers, families, advocates, providers of service, county government, other professionals in the field of child residential and day treatment services and regional licensing inspectors. Provider participants represented a cross-section of geographic areas, program types, and sizes of facilities. In addition to work group participation, written drafts of the regulations were sent to work group members on several occasions for written review and

comment.

In accordance with statutory requirements, the regulations were also published as proposed rulemaking in the Pennsylvania Bulletin on February 14, 1998 with a 60 day public comment period. The Department received 145 letters submitting recommendations for improvement to the regulations.

Throughout the regulatory process and the various public comment forums, including the proposed rulemaking public comment period, many valuable comments and suggestions were received from the many external stakeholders who participated in the process. The Department values the comments and ideas submitted and has incorporated many of the suggested changes in the final regulations. The Department appreciates the time and expertise external stakeholders have given to make the final regulatory document an effective regulatory tool for protecting the children served in these facilities. Without the active participation of the external groups and individuals, this regulatory document would not be a useful, accurate and thorough product.

Format:

These regulations apply to a variety of types of facilities with diverse program approaches to the care and supervision of children and the facilities operated in varied types of physical site settings. The final regulations are formatted so that the first 75% of the requirements are universal requirements for all facility types (§§ 3800.1-245). The last 25% of the regulations include exceptions or additions that apply for special facility types such as facilities serving 9 or more children, secure care, secure detention, outdoor and mobile programs, transitional living, and day treatment §§3800.251-312).

Need for Regulation:

These regulations are needed to protect children who receive care and services in residential or day treatment settings away from their homes and families. Children, who are not under the direct care and supervision of responsible parents or family members are exposed to health and safety risks and do not have the abilities or resources necessary to protect themselves while receiving care and services away from their homes and families. The new regulations will protect the health, safety, and well-being of these children until such time as the parents reassume parenting responsibility.

These regulations cover some types of facilities, such as secure care, day treatment, transitional living, outdoor programs, and mobile programs, for which no facility-based requirements now exist. These regulations are needed to protect the health, safety and well-being of the children. Current regulations for several facility types, including maternity homes and community residential rehabilitation facilities, were promulgated over 17 years ago and do not address current issues and research related to health and safety risks. These regulations will ensure that children receive care in a safe and healthy manner in the various facility types covered by this chapter.

Affected Individuals and Organizations:

Child residential and day treatment facilities as defined in the scope of the regulations are directly affected and must comply with these regulations in order to operate. The children receiving care and services in licensed facilities are directly affected by these regulations since they are the consumers the regulations are aimed at protecting. Families of the children receiving care and services are affected in their interest to assure healthy, safe and quality care for their children. Purchasers of service and placement agencies such as Pennsylvania County Government and other state entities, are affected by the regulations in that they purchase and monitor the quality of the services. Juvenile courts are affected in that they use these facilities as a resource when making placement decisions regarding children who are adjudicated dependent or delinquent.

Paperwork Requirements:

Paperwork requirements have been reduced from the existing child residential regulations. Paperwork reductions include the elimination of requirements for some policies and procedures, independent audits, hiring practices, personnel records, job descriptions, and staff discipline procedures from the current regulations governing administration and operation of children and youth facilities (55 Pa. Code Ch. 3680). While these regulations may support best practice for facility operation, they are not considered to be directly related to the health, safety and well-being protection of children. Providers or funding sources may choose to continue to maintain current practices in these areas.

Where Departmental forms are required such as the reportable incident form, the Department will share a draft of the form with external stakeholders for review and comment prior to implementation.

Summary of Public Comment and Changes:

Written comments, suggestions and objections regarding the proposed amendments were requested within a 30-day period following publication of proposed rulemaking. In response to requests from several external stakeholders, the Department extended the public comment period by an additional 30 days. A total of 145 letters were received by the Department within the 60-day public comment period, in response to the proposed rulemaking. Following is a summary of the major comments received and the Department's response to those comments. A summary of all major changes from proposed rulemaking is also included.

General-Consolidation

Many comments were received both in support of and in opposition to the consolidation of eight chapters of regulations into one. The Independent Regulatory Review Commission (IRRC) recommended that separate regulations for day treatment and secure detention be developed. Those who supported the consolidation did so due to the ease of regulatory burden for providers who now operate under various duplicative and conflicting regulations. Those who opposed the consolidation raised concern about the need to address differences for day treatment and secure detention facilities and concern that the result of the consolidation was lessened requirements from existing regulations.

Response
While the regulations include the requirements for several service types in one chapter, unique program differences are retained. The regulations include special requirements for programs such as secure care, detention, day treatment, outdoor programs, mobile programs, and transitional living. As the Department discussed this issue further with external stakeholders, the commentators in opposition to the consolidation explained that their concerns were largely based on content issues that they believed were not addressed for specific program types, rather than objections based on Pennsylvania Code format and style issues.

While the Department is proceeding with the consolidation effort, concerns expressed by those in opposition were reviewed and considered. In response to concerns about the differences in day treatment and secure detention facilities, significant time was devoted to additional research, visits to facilities, and discussions related to secure detention and day treatment both at individual meetings with commentators during the spring of 1998, and at the regulation work group meeting in August 1998. As a result of public comment and subsequent discussions with commentators, many new exceptions and additional requirements were added for day treatment and secure detention facilities.

In response to concerns about lessening of requirements, the Department believes that the new regulations are not reduced protections for children. Rather they include many new and strengthened protections than those that exist in current regulations. Improved and strengthened areas of the regulations include: new facility specific requirements for many service types such as secure care, transitional living, day treatment, and outdoor and mobile programs; reportable incident requirements; medication administration; restrictive procedures; fire safety; physical plant; program planning; child health; staffing; and staff training.

The Department believes that by consolidating regulations, increased safeguards to consumers are provided. Many of the providers of service regulated by these regulations operate various types of day and residential programs for children. For example, of the 21 licensed secure detention facilities, nine operate non-secure care within the same building as secure detention, one is a private corporation that operates many other types of facilities under the scope of these regulations, and two new applications for secure detention to be operated by multi-facility, private companies are being processed. The regulatory consolidation allows providers of various service types to focus less time on regulatory compliance with multiple sets of regulations, and more time on direct services for children.

In addition, many of the children served in programs covered by these regulations move regularly within these various service types (for example, it is not uncommon for a child to move from a secure detention facility, to a secure facility, and then back home with their family to receive day treatment services). Currently, varied and sometimes conflicting requirements apply that are confusing for both the child and the child's family, as well as the provider, to understand and comply with many different requirements. By having one set of consistent requirements applicable for all types of children's facilities, the Department believes that the interests and needs of the child are best met. The consolidation supports equal and consistent protections for children and continuity of care and services for children who receive various services. The need for health, safety, and well-being protections for children served in these facilities is similar regardless of any disability or treatment need, while program and treatment needs of the child should be met on an individualized basis based upon each child's unique

needs.

General-Program and quality of care
The IRRC and several commentators raised concern about reduction in program standards, placement issues, and the difficulty of adopting universal program standards for children with many different needs.

Response
In response to these concerns, the Department reevaluated the existing regulations to determine where, if any, reductions in program standards occurred. As suggested by commentators, the Department found the reductions largely in the areas of service description, admissions, and placement. Based on public comment the Department has made additions to the final regulations to address these areas (§3800.221-223). In response to the concerns about the prevention of inappropriate placement of children in facilities that cannot meet the child's needs, application of these three new sections will assure that a child is placed in an appropriate facility that can meet the child's needs. The Department also added several new sections to the content of the individual program plan at §3800.226 in response to public comments. After these amendments were made and the regulations were reexamined with the existing regulations, the Department believes the regulations do not reduce program protections to children, but instead include many additional and updated requirements to protect the health, safety and well-being of the children in care.

The approach used in the regulations is to provide similar, comprehensive health and safety protections for all children, while maintaining, and even requiring, individual program planning for each child based on his-her own needs. The regulations require individualized health and safety assessments for each child upon admission (§3800.141), detailed individual health assessments and screenings for each child (§3800.143-146), individual service plans based upon the needs of the child with content of the plan expanded from all chapters of existing regulations (§3800.226), and individual restrictive procedure plans for each child that now exist only in regulations for community mental retardation facilities (§3800.203). These requirements, coupled with the new additions of admission, service description, placement (§3800.221-223) and increased program plan content (§3800.226) that were added from proposed rulemaking to final regulations include a comprehensive package of service protections based upon each child's needs.

In addition, while these licensing regulations are the minimum requirements necessary to operate a child residential or day treatment facility in Pennsylvania, they are just one piece, of a total quality of care system. Other protections continue to apply such as the Mental Health Procedures Act and regulations (55 Pa. Code Ch. 5100) addressing consent issues and program planning, county children and youth program regulations (55 Pa. Code Ch. 3130) governing family service planning, placement, and case management, and the mental retardation system include long-term planning for children. These licensing regulations apply in tandem with many other existing applicable laws, regulations, monitoring systems, and training programs.

General-Cost
Some commentators suggest that the regulations will create a significant financial burden on providers of service, particularly related to staff training, reportable incident reporting, and

physical site changes.

Response
While there are some additional requirements in the staffing and physical site areas, many providers are already meeting higher standards than currently required. The cost impact of meeting any new regulations is outweighed by the potential benefits to children. Reference the Fiscal Impact section of this preamble for further fiscal analysis and discussion.

§3800.1. Purpose
One commentator suggested that the purpose section of the regulations reference the Child and Adolescent Service System Program (CASSP) as a foundation for the regulations.

Response
The Department fully supports the principles of CASSP in the provision of services for children, and these regulations reflect CASSP principles. CASSP principles advance family involvement, child-centered programming, multi-system service planning, cultural competence, least restrictive settings, and community-based services, and these regulations include tangible requirements that support CASSP principles.

§3800.3 (1). Exemptions-Department-operated facilities
Five commentators suggested that facilities operated by the Department be required to meet these regulations. The IRRC requested clarification as to why the Department's facilities should not meet the same standards as private facilities, and whether these regulations apply to state-owned buildings that are operated by a private corporation.

Response
These regulations do apply to state-owned buildings if the facility is operated by a private company. The exemption applies only for facilities that are directly operated by the Department of Public Welfare.

The Department believes that the same standards should be applied to Department-operated facilities as well as private facilities in order to provide equal protection to children. The Department will manage, supervise, and monitor the Department-operated facilities to achieve and maintain compliance with the new regulations.

In addition to the application of the regulations, the Department's facilities have rigorous and extensive reportable incident procedures. The Department intends to maintain this rigorous reporting system that provides for routine and immediate follow-up whenever there are unusual occurrences. Also, the Department plans to continue its peer review system in which a comprehensive monitoring tool is applied every two years to each Department-operated facility, using juvenile probation officers and other state facility staff to conduct the reviews. These intensive peer reviews are conducted every two years and address regulatory compliance, as well as compliance with internal Departmental policies and procedures.

With these protections, the Department is confident that children served in facilities that are operated by the Department will be provided equal protection to children served in private facilities.

§3800.3 (9). Exemptions-Drug and alcohol facilities
Seventeen comments were received about drug and alcohol facilities not being covered by this chapter. Eight commentators suggested that children's drug and alcohol facilities should be included in the scope of the regulations, while nine commentators supported the proposed exemption for drug and alcohol facilities.

Response
The Department of Health in accordance with 28 Pa. Code Chs. 709 and 711 currently licenses, and will continue to license, child residential drug and alcohol facilities. Due to the requirements of the Commonwealth Documents Law (45 P.S. §1202), expansion of the scope of these regulations to include facilities not previously covered in the proposed rulemaking, may not be considered. Further discussion of this issue and the appropriate licensure for children's drug and alcohol facilities will likely occur in the future in a separate regulatory forum.

Based on public comment, one change is being made to further clarify the exemption. Concern was expressed that the regulations as proposed would no longer allow dual licensure between the Departments of Health and Public Welfare if both types of programs were provided in one setting. This is clearly allowed and there is no intent to change current practice. Therefore, the exemption was clarified to exempt programs in which the residents' sole need is the treatment of drug and alcohol dependence. The Department of Health has reviewed and concurred with this amended language.

§3800.4. Inspections and certificates of compliance
The IRRC suggested that this section be moved from the applicability section and placed in a separate section.

Response
This change was made.

§3800.5. Definition of child
Two commentators suggested that "through counsel" be deleted.

Response
This change was made.

§3800.5. Definition of child
The Department clarified the definition to be consistent with the Juvenile Act (42 Pa. C.S. §6302).

§3800.5. Definition of ISP
The IRRC suggested a more complete definition of individual service plan.

Response
This change was made.

§3800.5. Definition of relative
Three commentators suggested adding "legal guardian". One commentator suggested adding "or other extended family member as defined and designated by the child and family".

Response
The terms "child's guardian or custodian" was added in order to accurately reflect the meaning of "relative" as used in §3800.3 (11) (relating to exceptions).

§3800.5. Definition of secure care
Based on informal discussions with stakeholders, and a review of existing secure detention facilities, the Department clarified that secure care can be in a portion of a building. A facility can provide both secure care and non-secure care within the same building. The special requirements for secure care apply for the secure portion of the building.

§3800.5. Definition of secure detention
A comment was received suggesting clarification that detention was limited to delinquent or alleged delinquent children.

Response
This change was made.

§3800.Definitions-New
The IRRC suggested adding definitions for child care supervisor, child care worker, day treatment center, pressure point techniques, and serious communicable disease. No public comments were received relating to defining these terms.

Response
The term child day treatment center is clearly defined at §3800.3. All staffing positions, including supervisor and worker positions, are clearly explained by the responsibilities specified at §3800.54 © and 55 (f). Further definition of pressure point techniques has been added at §3800.208 (a), which is the correct location of a definition used only in one or a few specific sections of the chapter. Serious communicable disease is clarified as one which may be spread through causal contact, where these terms are used, including §3800.151-152.

§3800.14 Fire safety approval
The Department revised this section to reference applicable state law and regulation, rather than specifically address current fire and panic law and regulation. This change was made so that the regulations would remain current in the event of an amendment in the state fire and panic law or regulations.

§3800.15(b) Child abuse.
The Department added a new subsection to reference requirements of the Child Protective Service Law requiring a plan of supervision if there is an allegation of child abuse involving facility staff persons.

§3800.16(a) Reportable incidents
Sixty-three comments were received on the definition of reportable incident. The IRRC also submitted comments on this subsection. One commentator suggested changing the proposed term "unusual" to reportable. Six commentators stated the definition was too broad and would require increased paperwork. Eight commentators requested clarification of "action taken by a child to commit suicide", with three of those suggesting the addition of the term "physical" action. Seventeen commentators and the IRRC suggested a more narrow definition and

clarification of "injury, trauma or illness". Two commentators requested clarification of "intimate sexual contact". One commentator suggested adding civil rights as examples of child's rights. Two commentators suggested deletion of assault on staff persons. Eleven commentators and the IRRC either raised questions about, or objected to, the 30 minute time frame for child absences. One commentator requested deletion of abuse or misuse of child funds or property. Two commentators and the IRRC requested further limitation on reporting of incidents requiring the services of a fire Department.

Response
The majority of the requested changes were made. The term unusual was changed to reportable as suggested to more accurately reflect the meaning of this subsection.

The Department agrees with the commentators that the proposed definition of reportable incident was too broad and burdensome. Further, the Department agrees that by requiring more reports than are necessary, more important incidents that need to be quickly and carefully investigated, may go unnoticed and unattended to in a paperwork backlog, thus placing children at risk.

The Department added the word "physical" to further clarify suicide action as suggested.

The Department narrowed the definition of injury, illness or trauma by requiring reporting of all inpatient hospital care, but only outpatient hospital care for serious injuries or traumas. Illnesses, sprains, cuts and other less serious treatment received on an outpatient basis, are no longer included as reportable. The regulation work group, which included advocates, providers and other professionals, supported this revised definition.

As requested by commentators, an assault by a staff person was removed from the definition as it relates to non-secure care, but it continues to apply for secure care as specified at §3800.274(2). Since this relates largely to staff safety, this was removed from the definition. It was retained in secure care however, to indicate potential staff supervision issues that are more likely to occur with the secure care population.

The Department revised and narrowed the circumstances under which child absences must be reported to include those where a child is absent for more than four hours or for more than 30 minutes if the child may be in immediate jeopardy.

In response to specific concerns, the Department did remove abuse or misuse of a child's "property", while retaining "funds".

The Department did not change the terms covering intimate sexual contact, violation of rights, of fire Department services. Regarding the comment about the fire Department services, this regulation has been in effect for over ten years for community mental retardation facilities and the Department has found no unreasonable reporting. Reporting only incidents where a fire has caused actual damage or injury is not sufficient. Even when a child pulls a false alarm, or when a fire Department arrives in time to avert any major property damage, children are placed at risk and such incident should be reported. Frequent false fire alarms could indicate serious staff supervision issues at the facility, as well as create the risk of failure to evacuate in the event of a real fire.

§3800.16© Reportable incidents
The IRRC and one commentator requested clarification of the proposed subsection regarding the meaning of immediately and who must do the reporting.

Response
The Department agrees that this was confusing and has deleted this requirement. This was intended to refer to internal facility reporting procedures leading up to the 12 or 24 hour reporting requirement in © and (d). However, in accordance with (b) the facility must write its own internal reporting procedures which may reasonably vary from facility to facility. It is not necessary for the Department to dictate internal reporting procedures, as long as appropriate offices are notified within 12 or 24 hours.

§3800.16 (d). Reportable incidents
Several comments were received suggesting an oral report for more serious incidents.

Response
The Department agrees and has made this change to require oral reporting within 12 hours for a fire requiring relocation of the children, an unexpected death of a child, and a missing child if police have been notified for assistance.

§3800.16(f). Reportable incidents
One commentator suggested a specific time frame for submission of final reports and three questioned the necessity and cost of submitting a final report.

Response
No change was made. Because initial reports of reportable incidents must be filed very quickly, there are often additional internal and external investigations and follow-up corrective action that need to occur. A final report is necessary for the Department and the funding agency to be informed of the resolution of the incident. It would be unreasonable to specify a time frame for the final report since investigation and follow-up for each incident may vary greatly.

§3800.16(h). Reportable incident
One commentator suggested adding "individual" to modify court order. Two commentators request immediate notification of the child's parent and attorney in the event of a reportable incident.

Response
The word "individual" was added as suggested. The child's parent must be notified immediately as specified in this subsection. The child's attorney was not added as this is not appropriate for routine reporting procedures for all children.

§3800.17. Incident record
Eleven comments were received on this section. Some commentators suggested that medication errors, suicidal gestures and child absences be eliminated. Others suggested adding use of restrictive procedures.

Response
The Department eliminated medication errors, since recording of medication errors is required

in §3800.185(a). The Department clarified reporting of child absences, injuries, traumas and illnesses, in accordance with the changes made in §3800.16(a). The use of restrictive procedures was not added since separate, very comprehensive reporting of each restrictive procedure use is required in §3800.213. Suicidal gestures was not eliminated since these are incidents of warnings of problems and must be logged and monitored to avoid serious injury or death.

§3800.18. Child funds
One commentator suggested adding a section under child rights to protect a child's funds.

Response
The Department agrees this was an oversight in the proposed regulations and has added a new section covering protection of child funds. This section is based on current regulations found at 55 Pa. Code §6400.22 relating to community mental retardation facilities.

§3800.19. Consent to treatment
Three commentators requested clarification relating to consent to treatment.

Response
Since there are many differing laws and regulations applicable to the children served in these facilities, it is very difficult to develop specific standards applicable for all children. Reference to applicable law is a responsible approach. In response to specific questions regarding consent for mental health treatment, the Department added a reference to 55 Pa. Code Ch. 5100 relating to Mental Health Procedures.

§3800.20. Confidentiality
Two commentators and the IRRC requested additional requirements clarifying confidentiality requirements.

Response
The Department agrees this issue was not addressed in the proposed regulations and has added a new section on confidentiality. The section requires compliance with applicable laws and regulations as well as specifies requirement for specific circumstances where there is no other statutory or regulatory protection. As suggested by the IRRC, the new requirements are based on 55 Pa. Code §3680.35 and §3760.92 relating to confidentiality.

§3800.31. Notification of rights and grievances
Several commentators suggested that additional protections for children and families be added including the right to lodge grievances without fear of retaliation, communication in an easily understood manner, communication in the primary language or mode of communication of the child and parent, providing copies of rights and grievance procedures to the child and parent, notification of consent to treatment protections, and posting of rights and grievance procedures. One commentator suggested that reference to "parent, guardian or custodian" be changed to include the parent as a necessary rather than an optional person to involve through the regulations. It was suggested that the grievance procedure requirements (§3800.34 as proposed) be relocated to the section relating to notification of rights and grievance procedures.

Response
All of these changes were made.

§3800.32(f). Specific rights-visits
The IRRC and several commentators submitted comments regarding visits to the child. Some suggested that two weeks visits were minimal and that more frequent visits should be required or encouraged. One commentator suggested that visits every two weeks are difficult to arrange for mobile programs. One commentator suggested that visits should be individualized and required as specified in the individual service plan (ISP) rather than as a child right. Three commentators suggested that at time visits are clinically inappropriate. One commentator raised concerns about the child's right to refuse visits. Commentators also suggested visits that are mutually convenient for the child's family and the facility. The IRRC questioned how the two week minimum was established.

Response
The Department carefully considered the many varying views on the issue of child visits and discussed this issue with interested groups. The Department added the requirement that visits must be at a mutually convenient time and location. The Department clarified that visits are a right and not just an opportunity. While more frequent visits are encouraged, the two week minimum is required to assure that family ties are not broken during the time the child is receiving services away from his/her family. In response to IRRC's question, the two week minimum requirement for child visits is based on the current regulations regarding child visits at 55 Pa. Code §3680.44(2)(I) and is recommended by the Department as the frequency of time necessary for the child and family to be in contact so that family ties and bonds are not broken; more frequent visits with the child's family are encouraged.

§3800.32(g). Specific rights-mail
The IRRC and several commentators requested changes to the right regarding mail and the circumstances the child's mail may be opened in the presence of staff persons.

Response
In response to public comment, the Department revised the entire subsection on the child's rights to receive and send mail. The Department clarified the circumstances under which a child's mail may be opened in the presence of staff persons, including when there is suspicion that contraband or other materials or information that may place the child at risk may be enclosed.

§3800.32. Specific rights-Additional
Commentators suggested the addition of several rights including communication and visits with attorneys and clergy, behavioral health treatment, appropriate clothing, protection from inappropriate discipline, privacy, and the right to practice no religion.

Response
The Department added rights relating to communication with clergy and attorneys, behavioral health, clothing, religion, and discipline. The right to privacy in bathrooms is included in §3800.103(e).

§3800.33. Prohibition against deprivation of rights

A suggestion was received to add that rights may not be used as a reward or sanction.

Response
This change was made. In addition, the Department clarified that family visits may not be used as a reward or sanction.

§3800.34. Rights-general
One commentator recommended the addition of a requirement for each facility to have an independent ombudsman.

Response
This change was not made. Although an independent ombudsman for each facility may be a good standard for the oversight of the child's interests, this is not an appropriate minimum requirement for licensure regulations.

§3800.54(a)-(b). Child care supervisor-number present
The IRRC and two commentators recommended that a supervisor be on-site at all times for all sizes of facilities. One commentator suggested that a supervisor does not need to be present while children are sleeping. Another commentator suggested that there should be no requirement for presence of a supervisor at all, since technology such as beepers can be used to contact a supervisor if needed.

Response
The Department strengthened the proposed regulation to change the conditions and the minimum number of children present requiring the presence of a supervisor. A supervisor must be on-site at all times 16 or more children are present in the facility. Requiring a supervisor present at all times regardless of the size of the facility, is not necessary for the protection of the children and would be cost prohibitive for county government and providers of service.

§3800.54(d). Child care supervisor-qualifications
Twelve comments were received on the qualifications for child care supervisor. Four commentators did not support any lowering of the qualifications. Seven commentators suggested adding an option of additional years of experience in lieu of college credit hours.

Response
In response to the concern requesting lowering of qualifications by adding an option that would require experience but no college credits, the Department prepared a draft of the final regulations including this option (5 years work experience). However, when the draft was shared with the Regulations Work Group in August 1998, the majority of the work group members did not support the experience option for supervisor positions. The final regulations therefore reflect no change from the proposed rulemaking in regard to supervisor qualifications.

§3800.55(a)-(d). Child care worker-ratios
One comment was received suggesting a reduction of the ratio of staff to children to 1 staff to 6 children for facilities with 24 or more children. One commentator suggested that rations are too low during sleeping hours. One commentator suggested that overnight staffing is not necessary.

Response
This change was not made since it does not reflect the consensus of the Regulations Work Group representing various external stakeholders and it is not necessary for the protection of children in all types of facilities. Facilities or funding agencies are always permitted, and are encouraged, to exceed the minimum licensure requirements whenever appropriate to best meet the needs of the children. The staffing ratios in these regulations are not less stringent, and in some cases are more stringent, than existing licensure regulations.

§3800.55(h). Child care worker-age
Eight commentators requested the minimum age for child care workers to be 18 as opposed to 21 years of age, citing various program and hiring pool concerns.

Response
While the Department carefully considered this suggestion, no change was made. Since many of the children in the facilities covered by this chapter are older teens and sometimes 20 years of age, the maturity in staff persons that generally comes with age, is a critical requirement for the protection and supervision of children in child residential and day treatment facilities. In response to concern about currently employed staff persons who may be 18, 19 or 20 years of age, the Department has included a grandparent clause in §3800.56(b) to permit these young staff persons to continue to work at the facility.

§3800.55(g). Child care worker-qualifications
The IRRC requested consideration of why child care workers are not required to have college training or work experience. Six commentators do not support lowering of qualifications for child care workers.

Response
No change was made. The qualifications of a high school degree or GED certificate were discussed and supported in large part by the Regulations Work Group. Overall, these worker qualifications are not reduced from the current regulations. 55 Pa. Code CH. 3810 (Residential Child Care Facilities) require 50% of the workers to have at least two years of college or experience, while the other 50% of the workers have no minimum qualifications at all. 55 Pa. Code Ch. 6400 (Community Residential Homes for Individuals with Mental Retardation) and Ch. 5310 (Community Residential Rehabilitation Services for the Mentally Ill) have no minimum staff qualifications for workers. Hiring and retention of employees in child care worker positions continue to be a major challenge for human service providers. To limit the pool of potential employees in an already stressed and thin employment pool is not responsible and could result in reduced protection to children if qualified staff could not be recruited.

§3800.56. Exceptions for staff qualifications
Sixteen commentators requested that the new staff qualifications not be applied to currently employed staff persons.

Response
The Department made this change.

§3800.57(a). Supervision-checks
Two commentators suggested that checking on children every hour is excessive. One

commentators suggested checks on children every ten minutes as opposed to every hour.

Response
No change was made. A minimum of hourly checks of children is necessary to protect the health and safety of the children.

§3800.57(d). Supervision-sleeping hours
Eights commentators requested that the exceptions for child supervision during sleeping hours not be limited to those facilities serving no children who are adjudicated delinquent.

Response
The Department made this change. Because many facilities serve both dependent and delinquent children, and the mix of the types and needs of children changes frequently, the Department agrees it is not reasonable to limit this exception as proposed.

§3800.58(a). Staff training-orientation
Several questions were raised about who would require training.

Response
In response, the Department further clarified this requirement by adding "regular and significant" before "direct contact with children".

§3800.58(b). Staff training-training hours
The IRRC suggested that both part-time and full-time staff persons should be required have the same amount of training hours, since both staff persons may be alone with the children and would perform the same duties. Five commentators asked for an extension of time for completion of the 30 hours of training, while one commentator asked for a reduction in the time period. Three commentators recommended the number of training hours be reduced from 30 to 24 hours consistent with the current 55 Pa. Code Ch. 6400 regulations for community mental retardation facilities.

Response
The Department agrees with IRRC and the commentators requesting an extension of time to complete the training and has made a change to require 30 hours of training for both full-time and part-time staff, within 120 days of the person's date of hire. The Department has also changed the requirement for annual training in (d) to apply to both full-time and part-time staff. The Department did not reduce the number of training hours because the majority of the Regulations Work Group members and public commentators supported the 30 hour requirement and the training requirements are considered a major health and safety protection for the children.

§3800.58(a). Staff training-training content
Suggestions were received to add the following training content areas: CASSP principles, universal precautions, behavior management, special education regulations, family dynamics and relationships, use of psycho tropic drugs, and cultural diversity. The IRRC also asked if the Department will approve specific training courses used by providers.

Response

The Department has added two additional training content areas that relate directly to child health and safety including universal precautions and behavior management. Training on administration of medications is addressed in §3800.187-188. The Department will not be approving specific training courses for training areas identified in this subsection, since there are many acceptable training alternatives available and appropriate for a facility's particular needs and audiences.

§3800.58(e). Staff training-first aid
Several commentators and the IRRC requested clarification that a formal certification that is valid for more than one year be acceptable for the length of the certification. The IRRC asked if the Department will approve this training.

Response
The Department has made this additional clarification regarding formal certification. The Department will not approved this training, but the training must be completed by a certified individual as specified in (f).

§3800.81. Physical accommodations and equipment
One commentator requested a change since this would appear to permit facilities to refuse service to children with a disability.

Response
This clearly was not the Department's intent and the language was rewritten with involvement of the interested commentator.

§3800.89(b). Temperature
Two commentators and a member of the House Aging and Youth Committee suggested that the indoor temperature during sleeping hours was too low.

Response
The Department increased the temperature from 58 degrees to 62 degrees during sleeping hours. Sleeping temperatures will be applied in coordination of the requirements in 102(2) relating to appropriate bedding in order to assure comfort while the child is sleeping.

§3800.102. Child bedrooms
The IRRC asked what was meant by an average ceiling height. One comment was received in support of the square footage requirements. One commentator requested room size of 74 rather than 70 square feet. One commentator asked that bunk beds allow enough space for the child to lay comfortably rather than to sit up in bed. One commentator requested the addition specifying circumstances during which children should be placed in private rooms.

Response
In response to the IRRC's question, the Department refers to average ceiling height to allow for measurement of rooms with eves, gables, or slanted ceilings. Other changes to the child bedroom requirements were not made as these did not represent the mainstream of public comment on this section.

§3800.103. Bathrooms

One commentator suggested that bar soap should be permitted in family settings. One commentator asked about the requirement to provide and label individual toiletry items.

Response
Use of bar soap by multiple users is prohibited since bar soap is a receptacle for transmission of bacteria and germs. The Department clarified subsections (g) and (h) so that individual items required for each child include a towel, washcloth, comb, hairbrush and toothbrush. Other non-personal toiletry items such as toothpaste and shampoo may be shared by children.

§3800.106. Swimming
The IRRC and seven commentators objected to the requirement to fence ponds and lakes on the premises due to the cost impact. Several comments also suggested that a life guard should only be required if children are swimming, and not while boating or fishing.

Response
In consideration of cost implications, the Department has eliminated these two requirements. The Department cautions providers of service to institute the precautions necessary to protect child safety if water areas are located near areas accessible by the children and during water activities while children are not swimming.

§3800.121. Unobstructed egress
Four commentators requested allowance for delayed locking devices on doors.

Response
In accordance with regulations of the Department of Labor and Industry, this change could not be made. Title 34 Pa. Code Chs. 49-60 relating to Fire and Panic Regulations do not permit use of delayed locking devices on doors used for egress, except for C-5 occupancies. The Department of Labor and Industry Industrial Board will entertain requests for variances of this requirement if appropriate fire safety safeguards and protections are in place. For further information on delayed locking devices on doors in non-C-5 occupancies, contact the Bureau of Occupational and Industrial Safety, Department of Labor and Industry.

The Department clarified that if fire safety approval is not required in accordance with state law, means of egress shall not be locked.

§3800.129. Fireplaces
Five commentators and the IRRC suggested that use of fireplaces should be permitted with specific precautions in place.

Response
The Department made this change.

§3800.132(j). Fire drills
The Department clarified that elevators shall not be used during a fire drill or an actual fire, due to possible power failure and the possibility of elevator shafts acting as chimneys to funnel flames and smoke. Since fire drills are used to practice actual evacuation routes and actions in the event of a real fire, elevators cannot be used in drills.

§3800.141. Child health and safety assessment
Three commentators suggested requiring compliance with the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). One commentator suggested adding special diets to the assessment. Three commentators suggested adding hospitalizations, medical diagnoses, medical problems, and mother's pregnancy issues to the assessment.

Response
EPSDT is a Medical Assistance benefit which is available to children who are eligible for Medical Assistance. While many children receiving services in these facilities are eligible for Medical Assistance, not all children are eligible. Therefore, it would not be appropriate for these regulations to specify a particular program or benefit to which all children are not entitled. Rather, the Department has identified the components of the EPSDT screen as required elements of the child health assessment in order to assure equal access to appropriate health assessments to all children, regardless of Medical Assistance eligibility status.

The Department has added special dietary needs, hospitalizations, medical diagnoses, medical problems, and mother's pregnancy issues to the assessment.

§3800.143. Child health examination-general
Three commentators supported the unclothed physical examination, while three commentators objected to an unclothed exam as being intrusive and intimidating. Several commentators requested clear requirements for written documentation of pre-admission examinations. Several commentators suggested adding a history of mental health development, blood lead level assessments, and sickle cell screening.

Response
The requirement for an unclothed physical examination was not changed. All of the other requested changes were made. In response to discussion with commentators following the comment period, the Department also added a requirement for recommendations for follow-up health services, examinations and treatment in (e) (15). The Department changed the term "physical" examination to "health" examination to more accurately reflect the comprehensive nature of the examination process including more than a physical examination.

§3800.143. Child health examination-behavioral health
Two commentators requested addition of a behavioral health exam as part of each child's exam.

Response
The Department did not make this change since all children receiving services in these facilities do not require a behavioral health examination. In accordance with (e) (15) the physician must recommend any follow-up examinations, such as behavioral health, and in accordance with §3800.148 such services must be provided. The Department did add a reference to behavioral health to §3800.143 (e)(15) and §3800.148 to emphasize the requirement to include behavioral health services where appropriate for the individual child. This will assure that children receive appropriate behavioral health services based upon their own needs, rather than force a blanket requirement for all children that is not always necessary or appropriate.

§3800.144. Dental care
Suggestions were received to require dental care at as early an age as necessary, require protective sealants where indicated by the examination, and require an initial exam with 30 days following admission if there is no record of a prior exam within the past 6 months.

Response
These changes were made.

§3800.145-146. Vision and hearing care
The IRRC requested clarification that American Academy of Pediatrics guidelines recommend vision and hearing screenings at appropriate intervals. Several commentators requested special sections on hearing and vision care.

Response
The Department added new comprehensive sections on both hearing and vision care.

§3800.147. Use of tobacco.
Many comments were received on this proposed regulation. Most commentators were in favor of restricting child smoking but recommended that staff persons be permitted to smoke outside the facility and out of sight and secondary smoke access of the children.

Response
The Department agrees with the commentators and has revised this regulation to prohibit possession and use of tobacco products by children, prohibit possession and use of tobacco by staff persons inside the facility, allow staff use of tobacco outside the facility if fire safety precautions are taken and use of tobacco is out of sight of the children.

§3800.148. Health services
Commentators suggested adding diagnostic services, follow-up examinations and treatment, hearing, vision, blood lead level, and psychiatric services as examples of medically necessary services.

Response
These items were added to the list of examples of health services that may be planned of prescribed for a child.

§3800.149. Emergency medical plan
One commentator requested that parents receive copies of emergency plans and notification of implementation of such plans.

Response
This change was made.

§3800.163. Food groups and alternative diets
One commentator suggested adding a requirement to provide dietary alternatives for children with special health needs, religious beliefs regarding dietary restrictions, or vegetarian preferences.

Response
This change was made.

§3800.164. Withholding or forcing of food prohibited
The IRRC and six commentators requested that withholding of snacks and desserts as punishment be permitted as it can be an effective tool in managing a child's behavior.

Response
While the Department does not encourage use of snacks or desserts as a behavior management tool, the regulations have been changed so this is not a regulatory prohibition.

§3800.171(4). Safe transportation
Five commentators suggested that the age of drivers be lowered from 21 to 18 years of age.

Response
This change was not made. Staff persons at all levels, including drivers, must be of a maturity level and age to handle the important responsibilities of child care. Drivers in particular require maturity and driving experience that is generally achieved with age.

§3800.181(d). Storage of medication
A question was asked about what needs to be stored separately.

Response
The Department clarified this subsection to state that prescription and over-the-counter medications must be stored separately, as was intended by the proposed rulemaking.

§3800.184. Medication log
One commentator suggested that items (3), (4) and (5) be removed from the medication log and placed in the child's record. One commentator suggested blood test monitoring for certain psycho tropic medications. The IRRC suggested that the log be updated at the same time a medication is administered.

Response
The Department made the clarification suggested by the IRRC. Side effects, contraindicated medications and special administration instructions are critical items that must be readily available at the time a medication is administered and therefore cannot be kept in the child's record. Blood test monitoring should be ordered by the prescribing physician and would be required to be provided in accordance with §3800.148 relating to health services.

§3800.185. Medications errors
The IRRC requested an explanation of what constitutes a medication error and the procedures to be followed after a medication error. One question was received from a commentator asking what constitutes a medication error.

Response
The Department added the definition of a medication error and added that follow-up action taken after a medication error must be documented. Since the specific procedures to be taken after an error vary according to the type of medication, type of error, and individual child's

needs, it is not practical to specify standard follow-up procedures in the regulations. The Department will monitor, thorough licensing inspections, to assess whether the follow-up action taken is appropriate.

§3800.186. Adverse reaction
The IRRC and one commentator requested that parents be notified in the event of an adverse medication reaction. The IRRC also asked where and for how long this information must be kept.

Response
Notification to parents was added. Clarification was added that the information must be kept in the child's record. Section 3800.244 specifies how long record information must be kept.

§3800.188. Medications administration training
Ten commentators raised concern and requested more information about the availability and cost on the medications administration course. One commentator requested that the Department should have many courses already approved by the time of regulations implementation. One commentator objected to Departmental approval of the course. One commentator suggested that the two year retraining requirement is not necessary. The IRRC questioned the qualification of existing in-house provider training programs, requested public notice about the criteria used to determine approval of a training program, and asked whether staff persons would be permitted a phase-in period to meet the training requirement.

Response
The Department is very pleased that, throughout the regulatory process, so many providers and other stakeholders have supported the strengthened protections for children in the area of medication administration. The new and improved regulations regarding medications administration and the medications training programs will be a vast improvement over existing protections. The Department notes that there were no objections with the concept of medications administration training and that the concerns and questions centered around the approval and implementation of the training programs.

In August 1998 the Department developed and distributed a draft bulletin to outline the criteria and procedures for Departmental approval of the training programs. The draft bulletin was sent to a representative work group of external stakeholders, including statewide provider organizations, for review, comment, and discussion at a meeting in September 1998. The final bulletin will be published in the Pennsylvania Bulletin as a Statement of Policy. A list of approved training programs will be published and updated regularly and transmitted to all licensed facilities through a Departmental bulletin.

The Department will review the following training information and materials in order to approve a training program: the training sequence to be used, the time schedule for the training, method and resources used to evaluate effectiveness of the training, location of training, number of students to be accommodated in each class, outline of training curriculum, teaching methods and strategies, course testing provisions, validation of successful completion, trainer qualifications, and sample training materials.

The bulletin also identifies core training content areas to include: reporting and observing skills,

types of medication and side effects, staff responsibilities, handling emergencies, facility policies, communication, managing special instructions, administration rights of children, and regulatory compliance.

Existing in-house training programs are encouraged to submit proposals for approval of their programs to the Department. Training programs will be considered in accordance with the criteria specified in the bulletin.

Due to the serious nature and specific procedures and methods acceptable in the medical field relating to medications administration, the Department does not believe it is appropriate to permit medication administration without Departmental approval of each training program. The Department has met with the State Board of Nursing who also believes that Departmental approval and monitoring of the training programs is essential to assure the child's safety.

The Department believes that a two year retraining requirement is critical to assure staff are trained in up-to-date practice issues and to keep their skills and knowledge current.

The Department has considered the IRRC's and commentators concerns about a phase-in period and assurance of a sufficient supply of training before implementing this section of the regulations. The Department has decided to adopt an effective date of twelve months after the publication of the regulations as final rules, for sections §3800.187-188, to permit adequate time for the development and implementation of medication administration programs. Within nine months of this publication, all staff persons who administer medications must meet the criteria specified in §3800.187-188.

The Department revised the source for the Standards for Diabetes Education Programs from the National Diabetes Advisory Board to the Pennsylvania Department of Health, since the National Diabetes Advisory Board no longer exists. The Department of Health standards are based on the former standards of the National Diabetes Advisory Board. The Department of Health publishes a list of approved diabetes patient education programs for public use. This list is available through the Department of Public Welfare regional offices.

§3800.189. Self-administration of medications
Three commentators and the IRRC suggested the elimination of the proposed requirement to limit self-administration to children who are 13 years of age or older.

Response
The Department made this change.

§3800.201. Restrictive procedure
The IRRC and one commentator requested a change in terms from "behavior intervention" to "restrictive" to be consistent with current 55 Pa. Code Ch. 6400 regulations relating to community residential mental retardation facilities. Commentators contend that the term behavior intervention includes a much broader set of procedures and techniques than is meant by use of the term in this chapter.

Response
The Department concurs and has made this change.

§3800.202. Appropriate use of restrictive procedures
One commentator and the IRRC requested the addition of "or as a program substitution" in (a), consistent with current 55 Pa. Code Ch. 6400 regulations relating to community residential mental retardation facilities. Four commentators and the IRRC requested that restrictive procedures also be permitted to prevent serious property damage in (b). The IRRC requested examples of less intrusive techniques.

Response
The addition of "or as a program substitution" was added to (a). However, the Department did not add that restrictive procedures may be used to prevent property damage in (b).

Use of restrictive procedures should always be the method of last resort in any behavior management program, even for children with difficult and aggressive behaviors. Other less intrusive methods and techniques to encourage positive behaviors are available and encouraged such as close observation and supervision of a child to anticipate and de-escalate frustration and anger in advance of aggressive behavior, positive rewards for good behavior, giving the child clear expectations and rules, teaching all staff persons to apply the facility rules consistently, separating the child from an activity or person before aggressive behavior escalates, removing the child from the group accompanied by staff consultation, and developing an active and interesting program for the children so they are not idle.

If a child's behavior escalates and damage to property is threatened or occurs, often the property damage may be a direct threat to the health and safety of others, such as throwing a large heavy item or breaking glass. In such a case, the property damage poses a threat to the child or others, and a restrictive procedure may be used to prevent injury, as long as other less intrusive methods have been tried but have failed. If however, the child threatens or engages in property damage that does not pose a health and safety threat, such as writing on a wall or tearing pages from a book, other methods of behavior management must be used and restrictive procedures are not permitted. The Department believes that restrictive procedures are generally unnecessary and that they are ineffective in treating or changing maladaptive behavior. Positive behavior management methods have been used as a successful tool for the treatment of even the most difficult and challenging behaviors.

§3800.203. Restrictive procedure plan
Three commentators stated that this will significantly increase paperwork. One commentator requested an addition to the planning group to include any person invited by the child or parent.

Response
The Department believes that benefit of protecting children from abuse or misuse of restrictive procedures justifies any additional time spent in developing the restrictive procedure plan. Paperwork will not be required if restrictive procedures are not used, which is strongly encouraged whenever possible.

Other persons invited by the child and parent were added.

§3800.204. Unanticipated use
The IRRC and several commentators asked for clarification of the meaning of "unanticipated" and "used more than four times". One commentator wrote in full support of the proposed

regulation. One commentator suggested that by eliminating options for behavior management, it may limit the ability to manage aggressive youth. Another commentator asked for the ability to apply restrictive procedures for up to five weeks after admission with no plan in place. One commentator suggested that this may be appropriate for children with disabilities, but it is not appropriate for children in children and youth programs.

Response
The Department does not agree that this limits options for managing difficult behaviors. Rather it allows restrictive procedures to be used as part of an array of options, with appropriate assessment and planning for each individual child. Allowing the use to restrictive procedures for up to five weeks without assessment or planning does not assure the child's safety. After restrictive procedures have been necessary for four incidents within a three-month period, assessment and planning for the individual child is very reasonable and necessary.

The Department clarified that this requirement applies after any type of restrictive procedure is used four times for the same child in any three month period. "Unanticipated" as per Webster's dictionary, means "unexpected or unforseen". There is no special use of this word in these regulations, therefore a definition in this chapter is not appropriate. If the facility does not have any reason to expect that child may have behaviors that may require the use of restrictive procedures, but a situation arises where as a last resort restrictive procedures are necessary, that is an unanticipated situation. If on the other hand, a child is admitted that has a history of aggressive and assaultive behaviors, and the facility expects that restrictive procedures may be used for this child, a restrictive procedure plan must be developed prior to use of a restrictive procedure.

§3800.205. Staff training
Three commentators suggested that the Department should not approve restrictive procedure training programs. Four commentators asked for clarification about the Department's approval process and criteria. One commentator thought this was a reduction in training requirements. One commentator suggested adding training in cultural competence. One commentator wrote in support of the proposed regulation. The IRRC asked to add "for as long as the person is employed" after the work "kept" in (c).

Response
In response to public comment, the Department has eliminated the requirement to formally approve each training program. However, compliance with the training components specified in (b) must be met. The Department will monitor each facility and assess the training programs as part of the inspection process to determine if the components specified in (b) are included.

In response to the commentator that perceived the training requirements to be a reduction from current regulation, the Department disagrees. This particular area of regulation has been improved and strengthened for all existing sets of regulations, particularly in the children and youth and mental health areas where no specific restrictive procedure training content was previously specified.

Training in cultural competence was not added since this is not a direct health and safety issue for the appropriate use of restrictive procedures.

A change was not made to require facilities to keep staff training records for as long as a person is employed. This is not necessary. The length of time staff records are kept should be determined by facility policy and not subject to state regulations, with the exception of keeping documentation long enough to verify compliance with the regulations.

§3800.208. Pressure points
Five commentators and the IRRC suggested allowing the use of pressure point techniques at the jaw point for bite release.

Response
This change was made.

§3800.209. Chemical restraints
The IRRC questioned why a physician must examine a child before administration of a chemical restraint, for how long vital signs must be monitored, and for how long and where documentation in (g) must be kept. Two commentators suggested that it is not reasonable to require a physician to examine a child before a chemical restraint is administered. One commentator requested parent consent be required prior to administration of a chemical restraint. One commentator objected to the prohibition of Pro Re Nata (PRN) orders for control of acute, episodic behavior.

Response
Subsection (d) was changed to reflect that documentation must be kept in the child's record. The period of time records must be kept is specified in §3800.244.

No other changes were made. Injecting or administering drugs into a child to control behavior on an emergency basis is perhaps the most serious and intrusive procedure that can be used. Only by conducting an on-site, direct physical examination of the child's medical condition, by a licensed physician, prior to each administration of a chemical restraint, can the child's health and safety be reasonably assured. This requirement is not intended to support the use of chemical restraints or in any way aid in the ease of administering chemical restraints to children. The Department does not encourage the use of chemical restraints.

Parental consent prior to administration of a chemical restraint is required and regulated in accordance with §3800.19 relating to consent to treatment.

Facility administration of PRNs to control a child's behavior is a very dangerous use of medication and subjects the child to unnecessary and unreasonable health risks.

§3800.210. Mechanical restraints
One commentator asked to add papoose boards to the list of prohibited mechanical restraints. One commentator suggested that the prohibition of mechanical restraints does not permit facilities to appropriately serve aggressive youth.

Response
Papoose boards was added to the list of examples.

If positive behavior management methods are used, such as those listed in the response to

§3800.202, coupled with limited and reasonable use of exclusion and manual restraints in extreme situations as permitted in §3800.211 and 212, use of mechanical restraints are not necessary to control behavior in non-secure facilities. Use of mechanical restraints in secure care facilities is permitted.

§3800.211. Manual restraints
Seven commentators and the IRRC recommended that the requirement in (d) to change positions every 10 consecutive minutes of using a manual restraint be eliminated due to safety issues for staff and children when releasing a child from a manual restraint before a child has gained control. Ten commentators and the IRRC recommended that the requirement in (e) to observe and document the condition of the child every ten minutes a manual restraint is used be eliminated due to staffing costs. One commentator suggested increasing the time for staff observation from ten to fifteen minutes.

Response
The Department did not lessen the requirements for use of manual restraint. Extended use of hands-on control of children beyond ten minutes is potentially very dangerous and if not properly administered, controlled, and monitored can result in serious injury or death of a child. There have been several incidences when a person had died due to the misuse of a manual restraint.

The Department does not encourage the use of manual restraints. Use of manual restraints may be used as a last resort only when all other methods of behavior intervention have been tried but have failed. Manual restraints must be immediately released when the child had regained self-control. The Department believes that by changing positions and requiring another staff person observe and document the physical and emotional conditions of the child every ten minutes, the child will be best protected during use of manual restraints.

Throughout the regulatory development process, advocacy organizations have supported these safeguards for use of manual restraints.

§3800.212. Exclusion
One commentator requested further prohibitions on the use of exclusion. One commentator suggested that the time frame in (b) be eliminated. One commentator suggested that use of exclusion be part of the child's individual service plan. Two commentators and the IRRC requested that (c), that restricts the frequent use of exclusion within the same day, be eliminated.

Response
No changes were made to this section. Comments indicate a difference of opinion on the regulation of exclusion including those who believe there should be more stringent requirements to those who believe the requirements are overly restrictive. The Department believes the regulations strike the proper balance of interests and that, as proposed, will protect children from the potentially harmful effects of overuse of exclusion. The use of exclusion for a child for more than 4 times in a day is confusing for the child, and, frequent use of exclusion decreases the effectiveness of this method of behavior intervention.

As suggested, the regulations do require the development of an extensive plan for use of

exclusion (§3800.203) and that plan must be part of the individual service plan (§3800.226(5)).

§3800.221-223. Description of services, Admission, and Placement process
The IRRC and several commentators raised concern about reduction in program standards, particularly relating to placement and admission procedures and safeguards.

Response
In response to these concerns, the Department reevaluated the existing regulations to determine where, if any, reductions in program standards occurred. As suggested by commentators, the Department found the reductions largely in the areas of service description, admissions, and placement. Based on public comment, the Department has made additions to the final regulations to address these areas (§3800.221-223). In response to the concerns about the prevention of inappropriate placement of children in facilities that cannot meet the child's needs, application of these three new sections will assure that a child is placed in an appropriate facility that can meet the child's needs.

§3800.224. Development of ISP
Two commentators and the IRRC requested increased facilitated involvement of the child's parent. One commentator suggested that a short term ISP be developed within 72 hours of arrival at the facility. One commentator and the IRRC requested addition of an emergency care plan for children who are in short-term emergency placements of 30 days or fewer.

Response
The Department strengthened the requirements for facilities to involve the child's parent by adding requirements to include any person invited by the child or the child's parent in (b), mutually convenient meeting times and places in (c), documentation of efforts to involve the parent in (d), and explanation that the child's and parent's signature on the plan signifies participation and not approval of the plan in (e).

The Department did not add a requirement for a short-term plan within 72 hours of the child's arrival or for children in placement for 30 days or fewer. It would be very difficult for facilities to prepare an effective service plan within a few days of a child's arrival due to staffing issues, time to notify and involve appropriate persons, and the lack of time to observe the child's needs and behaviors at the new setting. Preparing a plan within a few days or a week of a child's arrival could result in staff time misdirected to unnecessary paperwork without increased protections for the child.

Emergency care and placement can be received at any setting covered by these or other regulations such as child foster care. Emergency placement as used by the children and youth system refers to a payment status rather than a particular physical site setting. A funding agency that purchases emergency placement services, may require short-term planning services as part of its funding requirements.

§3800.222. Review and revision of the ISP
Three commentators suggested that quarterly reporting should be required. The IRRC and one commentator suggested that these regulations should be consistent with the Mental Procedures Act relating to progress reviews every 30 days. The IRRC also questioned if parents would be involved in the review and revision of the plan.

Response
As suggested by the IRRC, the Department added a cross-reference to §3800.224 to specify that parents must be involved in review and revision of the plan.

The time frame for formal review and revision of the plan remains at six months. This time frame is based upon federal statute (P.L. 105-89 §475 V B) and the Pennsylvania Juvenile Act, 42 Pa. C.S. §6351 (e), both of which require six month program reviews. The Department did consider, and an original draft of the regulations shared with external stakeholders included, quarterly reviews of the ISP; however, many objections were received from external groups citing statutory requirements and current 55 Pa Code §3810.35 requiring six month reviews.

The Mental Health Procedures Act and 55 Pa. Code Ch. 5100 regulations (titled Mental Health Procedures) are not referenced in this section because only some of the children served in these facilities fall under the jurisdiction of the act. The Mental Health Procedures Act applies independently and separately from these regulations. These regulations are the minimum requirements for any facility serving children from a wide variety of funding sources. These regulations apply in tandem with the Mental Health Procedures Act, if applicable for an individual child. If there are different or conflicting requirements, the more stringent requirement must be met.

While the formal review and revision period for the ISP remains at a minimum of six months, the Department did consider the IRRC's suggestion to require monthly progress reports and has added this requirement in §3800.226.(3) relating to the content of the ISP. Monthly progress reports will serve to assess a child's progress, provide regular updates for parents, and support the requirements of the 55 Pa. Code §5100.16 relating to Mental Health Procedures requiring monthly reviews of the plan.

§3800.226. Content of ISP
One commentator suggested reduction in the ISP content in that it exceeds minimum health and safety requirements. The IRRC and several commentators suggested adding measurable and individualized goals, how progress will be measured, who will measure progress, and what criterion will be used to measure progress. Other suggested additions include a component on educational needs, a schedule of family visits, strengthened family involvement, special education services, medication plan, community linkages, and more detail related discharge planning and parental involvement.

Response
The Department added measurable and individualized goals, monthly documentation of the child's progress (see comments received on §3800.225), the child's need for safety and permanency, an educational component, methods to measure progress, who is to measure progress, and objective criterion to measure progress. The Department also added a new section at §3800.230 to address parental involvement in discharge planning and notification.

§3800.229. Education
Two commentators and the IRRC suggested adding several specific requirements of other laws and regulations regarding educational requirements. Three commentators suggested that facilities be prohibited from requiring a child to attend on-grounds schools as a condition of participation at the residential facility.

Response
The Department revised this section to broaden the citations of appropriate education regulations at 22 Pa. Code Chs. 11, 14, and 15. However, it is the Department of Education thorough statutory authority and regulations that will apply and enforce these right to education protections, and not the Department of Public Welfare through these residential licensure regulations. If in the course of Department of Public Welfare licensure inspections, suspected violation of education laws and regulations is observed, the Department will notify the appropriate educational authority.

§3800.271. Criteria for secure care
Two commentators suggested additional clarification that secure care is only permitted for children who are alleged delinquent or adjudicated delinquent.

Response
This change was made.

§3800.272. Admission to secure care
One commentator suggested the addition of admission requirements for secure care facilities.

Response
This change was made.

§3800.274 (14) - (15). Additional requirements for secure care-dangerous items
In response to concerns raised at the August 1998 Regulations Work Group meeting, the Department added two new paragraphs relating to furnishings and other items that could pose a danger to children whose health and safety assessment indicates known or suspected suicide or self-injury attempts or known incidents of aggressive or violent behavior. These additional requirements were supported by consensus of the work group members.

§3800.274 (16) - (17). Additional requirements for secure care-use of handcuffs, leg restraints and seclusion
Several commentators and the IRRC suggested that the use of handcuffs, leg restraints and seclusion be prohibited completely or further restricted by decreasing times permitted for their use. IRRC suggested that the current requirements at 55 Pa. Code Ch. 3760 provide more guidance to facilities and more protection to children and that they be retained.

Response
The Department does not agree that the current regulations at Ch. 3760 provide more guidance and more protection than the proposed regulations. Many of the sections in Ch. 3760 are vague and subject to broad interpretation and the proposed regulations include better protections for children. Several examples follow: a) while §3760.42(1)(i) allows use of seclusion for up to 16 hours in a 48-hour period, the proposed regulations limit use of seclusion to no more than 12 hours in a 48 hour period, b) while §3760.42(2) states that an administrator may order handcuffs for a period not to exceed one hour there is no requirement about extended use of handcuffs or any limitation of how long they can be used in a 48 hour period as addressed fully in the proposed regulations, 3) there is no requirement in Ch. 3760 for a restrictive procedure plan for each child as in the proposed regulations, 4) there is no regulation of exclusion or manual restraints in Ch. 3760 as in the proposed regulations, 5) there are no staff training

requirements for the use of restrictive procedures in Ch. 3760 as in the proposed regulations, and 6) there is no requirement for any medical examination regarding the physical health of the child prior to extended use of the seclusion or restraint as in the proposed regulations.

The Department concurs with the commentators that use of seclusion, leg restraints and handcuffs should be used as a last resort and that the restraint or seclusion must be removed as soon as the child regained control of his/her behavior. It should be emphasized that the requirements at §3800.202 apply to the use of seclusion, handcuffs, and leg restraints including: use only to prevent a child from injuring himself or others, may not be used in punitive manner, other less restrictive methods must have been tried and failed, and discontinued use as soon as the child regains control of his/her behavior.

The Department did reduce the time frames for use of handcuffs and leg restraints from six hours to two hours. The time for a supervisory check of handcuffs and leg restraints was reduced from two hours to one hour. A new requirement was added to limit use of handcuffs and leg restraints to no more than 4 hours in any 48 hour period.

The use of seclusion was reduced from six hours to four hours and from 12 hours to eight hours in any 48 hour period. Requirements for the seclusion room were added.

Lastly, new requirements were added to restrict use of mechanical restraints and seclusion simultaneously, and to limit use of seclusion and mechanical restraints to no more than six hours in a 48 hour period.

The final regulations regarding use of seclusion, leg restraints and handcuffs in secure facilities represent significantly increased protections to children from the current regulations and are supported by those commentators who were concerned about protecting children from overuse of seclusion, handcuffs and leg restraints.

§3800.283. Additional requirements for secure detention-bedrooms
Three commentators requested that the special requirement for detention for no more than one child per bedroom be eliminated, since many detention centers currently permit two children per room as required at §3800.274(11).

Response
This change was made.

§3800.283. Additional requirements for secure detention-other
One commentator suggested that several additional requirements that exist in 55 Pa. Code Ch. 3760 be added including compliance with specific portions of the Juvenile Act, minimum age of children in detention, continual contact with children, prohibition of children and adult offenders in same areas, reporting to Department for children detained for more than 35 days, placement reviews, limits on new buildings, living and study areas, and recreation program.

Response
The Department very seriously considered these additions. The Department carefully reviewed the current Ch. 3760 requirements and the proposed regulations for gaps and important requirements that were excluded. In response to public comment, the Department added the

following requirements: compliance with all the sections of Juvenile Act relating to detention, the minimum age of children in detention, continual visual or audio contact with children, prohibition of children and adult offenders in same space, quarterly reporting to the Department for children detained for more than 35 days, and placement reviews. The Department did not add the requirement for limitations on new buildings because this is not appropriate for licensure regulations. The Department did not add a requirement for living and study areas or recreation programs since these are issues for all facilities and not just secure detention, no other comments were received on these issues, and these are not health and safety protections appropriate for minimum licensure regulations.

§3800.291.Criteria for transitional living
Three commentators suggested eliminating of clarifying the Departmental approval of training courses.

Response
Upon reconsideration, the Department eliminated the requirement for Department approval.

§3800.293. Additional requirements for transitional living
The IRRC requested clarification of this section as it relates to on-site staff supervision and the number of children on the premises.

Response
The Department agrees this was confusing as proposed and has made this clarification.

§3800.303 (a) (3). Additional requirements for outdoor and mobile programs-Handwashing
The Department of Agriculture and the IRRC suggested that children have the opportunity to wash their hands before each meal and brush their teeth at least daily.

Response
This change was made.

§3800.303 (a) (6). Additional requirements for outdoor and mobile programs-Litter
One commentator requested deletion of a litter from the list of emergency items.

Response
This change was not made. A portable litter is necessary for transportation of a child in an emergency situation if the children are not in an area that can be reached by a rescue vehicle.

§3800.303 (a) (8) - (9). Additional requirements for outdoor and mobile programs-Map and schedule
One commentator suggested that the requirement for staff to have a map and the seven day schedule apply only when the children are away from the stationary site.

Response
This change was made.

§3800.303 (b) (4). Additional requirements for outdoor and mobile programs-training
The IRRC suggested that the Department clarify appropriate recognized training sources. One

commentator suggested that there is no such thing as an appropriate recognized training source and that some outdoor programs have their own in-house training programs for staff and children.

Response
The Department eliminated "by an appropriate, recognized source" and will instead assess each training program as to the appropriateness and effectiveness of the training program, as part of the annual licensing inspection.

§3800.311. Exceptions for day treatment
Several commentators suggested additions to the list of exceptions for day treatment facilities including: child funds, certain reportable incidents, fire drills, vision care, hearing care, and meals.

Response
These exemptions were added.

§3800.312 (4). Additional requirements for day treatment-Staffing
A commentator suggested that in day treatment, children are often not directly supervised at all times.

Response
The Department eliminated the requirement for direct supervision at all times. The Department also clarified and reduced the number of children present in the facility requiring a supervisor, from 36 to 32, to increase protection for children and in keeping with multiples of the staff to child ratios at 1:8.

§3800.312 (5). Additional requirements for day treatment-Indoor square footage
A commentator suggested reducing the amount of indoor square footage from 50 to 15 square feet in accordance with school requirements.

Response
This change was made.

Six commentators requested the acceptance of a school health examination.

Response
In an effort to avoid duplication, this change was made. The school examination may be accepted by the day treatment facility, if the examination meets public school requirements and has been done within the periodicity schedule required by the public school.

§3800.312 (9). Additional requirements for day treatment-Meals
The IRRC and two commentators suggested adding "break" after meal to assure that day treatment programs do not need to provide meals to the children but can instead require children to bring meals form home.

Response
This change was made.

§5310.3. Applicability
The IRRC requested clarification about the applicability of host homes.

Response
This change was made.

Fiscal Impact:

Some commentators suggested that the proposed regulations would have a significant impact on the cost of providing care, particularly related to staff training, incident reporting and a few physical site requirements. In drafting the final regulations, careful consideration was given to the effect the regulations will have on the cost of providing care. Following is discussion regarding the regulatory areas that will have the greatest impact on the cost of care.

1. Staff Training. The new regulations place a strong emphasis on initial and ongoing staff training as an important component to protect the health and safety of children. The regulations require that new staff persons receive at least 30 hours of specific health and safety related training prior to working alone with children and within 120 days after the date of hire. The regulations also require that veteran staff persons receive at least 40 hours of training each year in general child care topics including first aid, Heimlich techniques, cardiopulmonary resuscitation, and fire safety.

The current regulations for child residential facilities (55 Pa. Code Ch. 3810), which apply to the majority of facilities governed by this new chapter, require an unspecified number of hours of training for new staff persons in most of the same areas required by the new regulations and 40 hours of training in the first year of employment. Also required currently is 40 hours of training each year for veteran staff. The current regulations for community mental retardation homes (55 Pa. Code Ch. 6400) require orientation for new staff persons and at least 24 hours of training each year for veteran staff persons. The current regulations for secure detention and community residential mental health facilities do not address staff training hours or content areas.

While community mental retardation homes may need to increase the number of training hours from 24 to 40 hours per year, and community mental health and secure detention facilities may need to enhance their training programs, the Department does not anticipate the staff training requirements to be cost prohibitive for providers. The Department will permit a variety of staff training models and options including effective on-the-job training programs and staff meetings that include training components. In addition, the Department offers many free and low-cost training programs for staff persons in children's residential and day treatment facilities. For children and youth programs, the cost of providing training is an allowable cost for federal, state and county reimbursement.

The staff training requirements have been widely supported by the Regulations Work Group, providers of service, parents and consumers, and child advocates as being essential to protecting the health and safety of children. Any minimal increase in costs associated with the new staff training requirements is outweighed by the benefit of protecting children.

2. *Reportable incidents.* The new requirements for reporting reportable incidents will increase paperwork for certain facility types. The regulations require reporting of specific types of incidents to the Department and the funding agency. This reporting system is imperative to protect children from harm by studying patterns of incidents and taking action where appropriate to improve health and safety protections to children.

In response to public comment regarding the anticipated cost of reporting incidents in the proposed regulations, the Department amended §3800.16(a) to eliminate some of the proposed reporting requirements.

Current regulations for child residential and day treatment facilities (55 Pa. Code Ch. 3680) and community mental retardation homes (55 Pa. Code Ch. 6400) currently require reporting systems for many incidents. While the requirements for the types of incidents in children and youth facilities has been expanded, facilities do already have reporting systems and procedures established.

The amount of increased paperwork to comply with the regulations will be negligible.

3. *Physical Site.* Public comment regarding the cost of the new physical site requirements were mainly concerned with the proposal to fence ponds and lakes and to limit bedrooms to one child per room in secure detention. The Department amended §3800.106 and §3800.283 to eliminate these requirements.

4. *Administration.* Many administrative and fiscal requirements governing the operation and administration of child residential and day treatment facilities (55 Pa. Code Ch. 3680) and community mental health residential facilities (55 Pa. Code Ch. 5310) have been eliminated. Requirements governing areas such as independent audits, governing body, administrative records, hiring practices, personnel management, job descriptions, and staff discipline procedures are no longer required.

The reduction in paperwork requirements in the area of administration will result in a cost savings, with no diminished protection to children.

Effective Date:

With the exception of §3800.187-188, this chapter is effective (4 months after publication in the *Pennsylvania Bulletin*). Sections 3800.187 - 188 (relating to medication administration) is effective (12 months after publication in the *Pennsylvania Bulletin*).

Implementation:

As requested by providers of service, the Department will develop a licensing measurement instrument that regional licensing inspectors will use to apply and measure compliance with the new regulations. The draft measurement instrument will be shared with statewide external stakeholder organizations for review and comment prior to implementation of the regulations and the instrument.

The Department will provide a training and orientation course on the new regulations, in

each of the Department's regions, for providers and other interested persons, prior to implementation of the regulations.

Sunset Date:

The effectiveness of these regulations will be evaluated as part of the Department's annual licensing inspection process for child residential and day treatment facilities. While, no sunset date has been established for these regulations, it is anticipated that the Department will pursue necessary revisions to the regulations, based on public comment and research, within 5 years from the date of this publication.

Contact Person:

Questions on these regulations should be directed to:

Department of Public Welfare
Office of Policy Development
Ms. Karen E. Kroh, Licensing Manager
P.O. Box 2675
Harrisburg Pennsylvania 17105-2675
Telephone (717) 783-2207; FAX (717) 772-4957

Regulatory Review:

Under § 5(a) of the Regulatory Review Act, the Act of June 30, 1989 (P.L.73, No. 19) (71 P.S.§§745.1-745.15), the agency submitted a copy of this final regulation on _____ to the Independent Regulatory Review Commission and to the Chairmen of the House Committee on Aging and Youth and the Senate Committee on Public Health and Welfare. The Department provided the Commission and the Committees with copies of all comments received during the public comment period. The agency has also provided the Commission and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the agency in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation". A copy of this material is available to the public upon request.

In preparing the final-form regulations, the agency has considered all comments received from the public, the Commission, and the Committees.

These final-form regulations were deemed approved by the House Aging and Youth Committee and the Senate Public Health and Welfare Committee on _____.The Independent Regulatory Review Commission approved the regulations on _____, in accordance with section 5 (c) of the Regulatory Review Act.

Finding:

The Department of Public Welfare finds that:

(1) Public notice of proposed rulemaking was given under sections 201 and 202 of the Commonwealth Documents Law (45 P.S. §§1201 - 1202) and the regulations thereunder at 1 Pa. Code §§7.1 and 7.1.

(2) A public comment period was provided as required by law and all comments were

considered.

(3) These final-form regulations are necessary and appropriate for the administration and enforcement of Articles IX and X of the Public Welfare Code.

The Department of Public Welfare, acting under the Public Welfare Code, orders that:

(1) The following regulations are hereby repealed in whole: 55 Pa. Code Ch. 3810 titled Residential Child Care Facility; 55 Pa. Code Ch. 3710 titled Maternity Homes; and 55 Pa. Code Ch. 3760 titled Secure Detention Facility.

(2) The following regulations are hereby repealed in part, insofar as they apply to facilities governed by 55 Pa. Code Ch. 3800: 55 Pa. Code Ch. 3680 titled Administration and Operation of a Children and Youth Social Service Agency (as it applies to child residential and day treatment facilities); 55 Pa. Code Ch. 5310 titled Community Residential Rehabilitation Services for the Mentally Ill (as it applies to facilities serving exclusively children, with the exception of host homes), and 55 Pa. Code Ch. 6400 titled Community Homes for Individuals with Mental Retardation (as it applies to facilities serving exclusively children).

(3) The following unofficial regulations (never codified in the Pa Code) are hereby repealed in whole: Training School Requirements, formerly referred to as title 6500; and Secure Residential Facilities, formerly referred to as draft Ch. 3820 regulations and applicable to the Department-operated youth development centers.

(4) The Secretary of Public Welfare shall submit this order and Annex A to the Office of General Counsel and the Office of the Attorney General for approval as to legality and form as required by law.

(5) The Secretary of Public Welfare shall certify and deposit this order and Annex A with the Legislative Reference Bureau as required by law.

(6) This order shall take effect on (4 months from the date of publication in the *Pennsylvania Bulletin*), with the exception of §3800.187-188 which shall take effect on (12 months from the date of publication in the *Pennsylvania Bulletin*).

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Sandusky
Legal (2)
FORM LETTER #4 3

March 21, 1998

Department of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

I am the parent of a child who has mental retardation as well as some serious emotional problems who is under twenty-one and resides in a community group home. I am very upset to learn that your department intends to further reduce the proposed 3800 Regulations that protect our children who live in these facilities. The regulations that exist are minimal at best.

It is my fear that without regulations that insure that my child has all of the appropriate services he needs it will further minimize his chances of being able to enjoy independence.

My child and my family have been fortunate to have needed services during a time where following CASSP principles is important in our community. I believe that these proposed 3800 Regulations undermine those very ideals and will erode them so that future children and families will be in the same place that families were ten years ago.

Please, I ask you to reconsider these regulations. They are not enough. Our children will pay a very dear price for many years to come if you enact these proposed 3800 Regulations.

Thank you for your considerations.

Wayne B Bloom
Parent

Telephone No: (610) 845 8431
County: Berks

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Sandusky
Legal (2)
FORM LETTER #3 15

March 21, 1998

Department of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

I am writing to you to express my concern over the proposed 3800 Regulations. I am extremely upset that the need for culturally competent services is completely ignored as well as the right of parents to be partners in the service and treatment process. I believe this is a huge waste of my tax dollars if it is enacted as written.

People who are going to provide good services for children are going to do so regardless of any set of regulations. Those aren't the people I am concerned about. I am concerned about the people who want to make a huge profit because of the disabilities of some of our children. Those are the people who will benefit most from these regulations. With these regulations, almost anyone can set up shop and get a license.

Please give us more time to respond and give you input. Then, rewrite these regulations so that they insure that our children are getting good services.

Thank you for your consideration.

Clifford B. Price
Parent

Telephone No: (717) 397 6728
County: Lancaster

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Sandusky
Legal (2)
#1 FORM LETTER 9

March 21, 1998

Department of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

I am writing to you as a parent of a child who has serious behavioral problems. My child has been in and out of treatment and programs for several years. It is very likely that she will continue to need services from a variety of programs for a very long time.

I am concerned that the proposed 3800 Regulatory changes your office is proposing will not adequately insure that my child receives the quality of services that she needs. As I look at the proposed regulations, it is clear to me that this document does not intend to insure that I am treated as a partner in developing services for my daughter. As parents, we fought very hard for this. Your regulations take that away from us and put us back in a position of blame.

I strongly urge you to revisit these regulations and write them in a way that is going to help children and families.

Sincerely,

Wayne D. Klein
Parent

Telephone No: (610) 845 8431
County: Berks

March 21, 1998

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Sandusky
Legal (2)
FORM LETTER #2 6

Department of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Gioffre:

I am the parent of a child who has both mental health problems and drug dependence problems. She has needed to be in programs to help her with all of her issues several times. I don't know if she will need to again or not.

If my daughter needs to go into a program again, I want to know that it is run both efficiently and with the needs of the children and families in mind. I cannot trust that everyone who runs a program has my daughter's best interest at heart. I need to rely on people like you who write the regulations that govern institutions to insure that quality is there.

The proposed 3800 Regulations do not do that. They have a lot of things about floor space and fire alarms, but nothing about the people who will be working with my daughter and the rest of my family. The proposed 3800 regulations don't even insure that the people who will be treating my daughter communicate with me at all. These are the kind of regulations that let people who want to do a poor job do it legally.

I am very upset about this. I sincerely hope that you rewrite these proposed 3800 Regulations in a way that protects and helps our children. The way these regulations are currently written all they do is protect the people who make money off my daughter's disability.

Thank you.

Parent

Telephone No: (610) 449-6536
County: Delaware

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Dept. of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, Pa. 17105-2675

Dear Mr. Gioffre,

I am writing to you about the proposed regulatory changes for licensing of residential facilities and day treatment programs for children.
I agree that their needs to be streamlining and a reduction of the huge bureaucratic boondoggle we now have. However, I feel that the document that you have written falls way short of covering the needs of our children.
It is extremely family unfriendly. It is not sensitive to the needs of minority children. It has no level of quality assurance. There is no proscribed set of sanctions for those who are in violation. It is a bad document.
I am asking that you give more time for us to share with you our needs and ideas. I am also asking that you rewrite this to reflect those needs.

Thank-you for your consideration.

Sincerely,

Lena Sulke

Received Apr 15

(133)

98 APR 15 PM 12:52

INDEPENDENT REGULATORY REVIEW COMMISSION

Division of Program Development

APR 14 1998

Received:

Refer to: [redacted]

March 21, 1998

Department of Public Welfare
Robert L. Gioffre
P.O. Box 2675
Harrisburg, PA 17105-2675

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FORM LETTER 4

Dear Mr. Gioffre:

As the parent of a child who has special needs, I feel it is important to give you my input on the proposed 3800 Regulations.

Beyond what the regulations cover, you need to address areas such as the requirements for the therapists who will treat the children and how you will include the families of the children in therapy and treatment, the times when the parents must be notified of things, not just the agency who arranged for the child to be in a program and what kinds of checks your department will do to make sure that programs are running the way they say they will.

There are a great number of things that I think your regulations should cover that they do not. I believe that most service agencies will do nothing more than the basics if you don't put those things into your regulations and have a way of monitoring them.

Please, to protect all of our children who need these services, make these regulations force good services or not allow people who will do a poor job get a license.

Thank you,

Karen Sue Neblock
Parent

Telephone No: (717) 270-1954
County: Lebanon

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Sandusky
Legal (2)

Commonwealth of Pennsylvania
Department of Public Welfare
Office of Policy Development
Room 323 Health & Welfare Building
Harrisburg, Pennsylvania 17105-2675
Telephone: (717) 783-2207
Fax: (717) 772-4957
Internet: karenkr@dpw.state.pa.us

98 MAY -7 P 12:27

RECEIVED

FACSIMILE COVER SHEET

DATE: 5/7/98

SUBJECT: Child Resid. & Day Treatment Regs.

FAX #: 3-2664

TO: Fiona Wilmarth

FROM: Karen Kroh, Licensing Manager

NUMBER OF PAGES TO FOLLOW: 3

NOTE: Attached as you requested on 5/4 is a table listing AAP requirements for health care. You will see vision & hearing specifically included, as well as many other comprehensive exam/testing requirements. The second table is one I prepared, comparing AAP to one federal funding source requirement (EPSDT).

If you do not receive this fax in its entirety, please contact Rochelle Scott at (717) 772-2287.

American Academy of Pediatrics

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE

Committee on Practice and Ambulatory Medicine

...child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are living competent parenting, have no manifestations of any important health ...lems, and are growing and developing in satisfactory fashion. Additional ...s may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with external committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance and pertinent medical history. Every infant should have a newborn evaluation after birth.

AGE[1]	INFANCY[3]								EARLY CHILDHOOD[3]					MIDDLE CHILDHOOD[3]				ADOLESCENCE[3]									
	NEWBORN[3]	2-4d[3]	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
HISTORY	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial/Interval																												
MEASUREMENTS																												
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•	•	•															
Blood Pressure														•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																												
Vision	S	S	S	S	S	S	S	S	S	S	S	O[4]	O	D	S	S	O	S	O	S	S	O	S	S	O	S	S	S
Hearing[5]	S/O	S	S	S	S	S	S	S	S	S	S	O	O	D	S	S	O	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT[7]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[8]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES – GENERAL																												
Hearing/Metabolic Screening[10]	←		→																									
Immunization[11]	←		→						←	→				←	→													
Lead Screening[12]							←	→																				
Hematocrit or Hemoglobin					←			→														←						→
Urinalysis																						←						→
PROCEDURES – PATIENTS AT RISK																												
Tuberculin Test[14]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Cholesterol Screening[15]														•	•			•	•	•	•	•	•	•	•	•	•	•
STD Screening[17]																		•	•	•	•	•	•	•	•	•	•	•
Pelvic Exam[16]																		•	•	•	•	•	•	•	•	•	•	•
ANTICIPATORY GUIDANCE[18]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention[19]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
INITIAL DENTAL REFERRAL[21]																												

Breastfeeding encouraged and instruction and support offered.
[1] For newborns discharged in less than 48 hours after delivery.
Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
If a child receives under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
[3] For patient in uncooperative, examine within six months.
Some experts recommend objective appraisal of hearing in the newborn period. The Joint Committee on Infant Hearing has identified patients at significant risk for hearing loss. All children needing these criteria should be objectively assessed. See the Joint Committee on Infant Hearing 1994 Position Statement.
[5] By history and appropriate physical examination; if suspicious, by specific objective developmental testing.
[6] At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
[7] These may be modified, depending upon every point visit schedule and individual need.
[8] Metabolic screening (eg, thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
[11] Scheduled per the Committee on Infectious Diseases, published periodically in Pediatrics.
Every well child should be an opportunity to update and complete a child's immunizations.
[12] Blood lead screen per AAP statement "Lead Poisoning: From Screening to Primary Prevention" (1992).
[13] All nonmenarcheal adolescents should be screened.
[14] Consult objective urinalysis for leukocytes for male and female adolescents.
[15] TB testing per AAP statement "Screening for Tuberculosis in Infants and Children" (1994). Testing should be done upon recognition of high-risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.
[16] Cholesterol screening for high risk patients per AAP "Statement on Cholesterol" (1992). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
[17] All sexually active patients should be screened for sexually transmitted diseases (STDs).
[18] All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
[19] Appropriate discussion and counseling should be an integral part of each visit for care.
[20] From birth to age 12, refer to AAP's injury prevention program (1991*) as described in "A Guide to Safety Counseling in Office Practice" (1991).
[21] Earlier initial dental evaluations may be appropriate for some children. Subsequent examinations as preventive dentistry dictated.

y: • = to be performed ◦ = to be performed for patients at risk S = subjective, by history O = objective, by a standard testing method ←→ = the range during which a service may be provided, with the dot indicating the preferred age.

s: Special ophthalmic, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, inborn errors of metabolism, sickle disease, etc.) is discretionary with the physician.

e recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

COMPARISON OF AAP AND EPSDT HEALTH SCREENING AND PERIODICITY STANDARDS

AREA OF STANDARD	AAP STANDARD	EPSDT STANDARD
Periodicity of physical exams	age 2-4 days age 1 month age 2-6 months-every 2 months age 6-18 months-every 3 months age 18-24 months-every 6 months age 3-6 years-every year 7-9 years-every 2 years 10-21 years-every year	at intervals which meet reasonable standards of medical practice
Type of exam	unclothed-infant undressed and draped-older than infant	comprehensive, unclothed
History	all ages	yes
Measurements-height,weight, head circum, blood pressure	height/weight-all ages head cir-birth through 24 mos blood pressure-age 3 and older	not specified
Vision	all ages by objective testing method-ages 3,4,5,10,12,15,18 years of age	at intervals which meet reasonable standards of medical practice
Hearing	all ages by objective testing method-ages birth, 3,4,5,10,12,15,18	at intervals which meet reasonable standards of medical practice
Developmental/ behavioral	all ages	not specified
Blood lead level	9-12 months and 2 years	appropriate to age and risk factor
Sickle cell disease	(done in neonatal period for all babies born in PA) discretionary by physician	not specified*

[illegible]	[illegible]	[illegible]
Metabolic (e.g. thyroid, PKU, hemoglobinopathies, galactosemia)	by 1 month and in accordance with state law	not specified*
Tuberculin	for high risk groups, annual testing from age 9 months to 21 years	not specified*
Cholesterol	for high risk groups, annual testing from age 2-21 years	not specified*
STD	for sexually active patients, annual testing from age 11-21 years	not specified*
Pelvic exam	for sexually active female patients, annual exam from age 11-21 years	not specified
Hematocrit or hemoglobin	1-9 months,11-21 years	not specified*
Urinalysis	5 years,11-21 years	not specified*
Guidance/ education	all ages	yes
Injury and prevention	all ages	not specified
Dental	initial referral to dentist at 1-3 years	at intervals which meet reasonable standards of dental practice

* = there is a general reference to laboratory tests which may or may not be intended to include this screening test