



Eric Milstead
Director

Legislative Services Office Idaho State Legislature

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MEMORANDUM

TO: Senators HEIDER, Souza, Jordan and,
Representatives WOOD, Packer, Chew

FROM: Elizabeth Bowen - Senior Legislative Research Analyst

DATE: April 05, 2018

SUBJECT: Temporary Rule

IDAPA 16.03.15 - Secure Treatment Facility for People with Intellectual Disabilities (New Chapter) -
Adoption of Temporary Rule and Notice of Public Hearing - Docket No. 16-0315-1801

We are forwarding this temporary rule to you for your information only. No analysis was done by LSO. This rule is posted on our web site. If you have any questions, please call Elizabeth Bowen at the Legislative Services Office at (208) 334-4834. Thank you.

Attachment: Temporary Rule

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IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.15 – SECURE TREATMENT FACILITY FOR PEOPLE WITH INTELLECTUAL DISABILITIES

DOCKET NO. 16-0315-1801 (NEW CHAPTER)

**NOTICE OF RULEMAKING –
ADOPTION OF TEMPORARY RULE AND NOTICE OF PUBLIC HEARING**

EFFECTIVE DATE: The effective date of the temporary rule is February 22, 2018.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule and scheduled a public hearing on the proposed rulemaking that will publish in the May 2, 2018 Administrative Bulletin. The action is authorized pursuant to Sections 56-1003, 56-1004, 56-1004A, 56-1005, 56-1009, 66-1402, and 66-1407, Idaho Code; and H0222 (2017).

COORDINATOR’S NOTE: A public hearing has been scheduled and will be held on the same day that the proposed rule will publish in the May Administrative Bulletin. Because the text of this temporary rule is the same as the text that will be used for the promulgation of the proposed rule, this temporary rule may be used for the preparation of any written comments or oral presentations that may be submitted or made at the scheduled public hearing on May 2nd that will be part of the proposed rule promulgation.

Also as part of the proposed rule promulgation process, upon publication in the May Administrative Bulletin, the written comment submission deadline will be extended and written comments will be received by the Department until June 30, 2018.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking is scheduled for the following:

PUBLIC HEARING
Wednesday, May 2, 2018 - 1:30 to 3:30 pm (MDT)
Medicaid Central Office 3232 Elder Street Conference Rooms D East & D West Boise, ID 83705

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary:

This rule sets standards and provides the licensing requirements and the criteria for use of restrictive or secure features at this type of facility, including staffing, treatment requirements and enforcement remedies. This rule will also provide and address client rights.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This temporary rule confers a benefit to and protects the rights of those receiving Department services and provides protection for the health, safety and welfare of facility employees and the general public.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein:

There are no fees or charges being imposed in this temporary rule.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Tamara Prisock, (208) 364-1959.

DATED this 22nd day of February, 2018.

Tamara Prisock
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THE FOLLOWING IS THE TEMPORARY RULE FOR DOCKET NO. 16-0315-1801
(New Chapter)

IDAPA 16
TITLE 03
CHAPTER 15

16.03.15 – SECURE TREATMENT FACILITY FOR PEOPLE WITH INTELLECTUAL DISABILITIES

000. LEGAL AUTHORITY.

The Board of Health and Welfare is authorized according to Section 66-1407, Idaho Code, to develop appropriate standards and rules for treatment of persons in the facility for people with intellectual disabilities. According to Sections 56-1003, 56-1004, 56-1004A, 56-1005, 56-1009, and 66-1402, Idaho Code, the Department and the Board of Health and Welfare have prescribed powers and duties to provide for the administration and enforcement of Department programs and rules. (2-22-18)T

001. TITLE AND SCOPE.

01. Title. The title of this chapter of rules is IDAPA 16.03.15, “Secure Treatment Facility for People With Intellectual Disabilities.” (2-22-18)T

02. Scope. These rules include the licensing standards and requirements for the administration of the facility for treatment of persons with intellectual or developmental disability under Title 66 Chapter 14, Idaho Code. The secure treatment facility must be operated by the Department and identifiably separate from other facilities operated by the Department for persons with intellectual or developmental disabilities or for persons with severe and persistent mental illness. (2-22-18)T

002. WRITTEN INTERPRETATIONS.

According to with Section 67-5201(19)(b)(iv), Idaho Code, the Department’s Division of Licensing and Certification may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. (2-22-18)T

003. ADMINISTRATIVE APPEALS.

Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings.” (2-22-18)T

004. INCORPORATION BY REFERENCE.

The following are incorporated by reference in this chapter of rules: (2-22-18)T

01. National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, 2012 edition. The following document is incorporated by reference in these rules: National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, NFPA 101 for “New Healthcare Occupancies” published by the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471. A copy is available for review at the Department’s Division of Licensing and Certification located at 3232 Elder Street, Boise, Idaho 83705. The NFPA 101: Life Safety Code may be accessed online at: <https://www.nfpa.org>. (2-22-18)T

02. Idaho Diet Manual, 11th Edition. This manual is available from the Idaho Dietetic Association, online at <http://eatrightidaho.org>. (2-22-18)T

005. OFFICE – OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS – TELEPHONE NUMBER – INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (2-22-18)T

02. Mailing Address. (2-22-18)T

a. The mailing address of the Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (2-22-18)T

b. The mailing address of the Department’s Division of Licensing and Certification, P.O. Box 83720, Boise, Idaho 83720-0009. (2-22-18)T

03. Street Address. (2-22-18)T

a. The street address of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (2-22-18)T

b. The street address of the Department’s Division of Licensing and Certification is located at 3232 Elder Street, Boise, Idaho 83705. (2-22-18)T

04. Telephone. (2-22-18)T

a. The telephone number of the Idaho Department of Health and Welfare is (208) 334-5500. (2-22-18)T

b. The telephone number of the Department’s Division of Licensing and Certification is (208) 334-1959. (2-22-18)T

05. Internet Websites. (2-22-18)T

a. The Department internet website is found at <http://www.healthandwelfare.idaho.gov>. (2-22-18)T

b. The Department’s Division of Licensing and Certification internet website is found at <http://lc.dhw.idaho.gov>. (2-22-18)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department’s business is subject to the restrictions in state or federal law, and must comply with IDAPA 16.05.01, “Use and Disclosure of Department Records.” (2-22-18)T

02. Public Records Act. The Department will comply with Title 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (2-22-18)T

03. Disclosure of a Person's Identity. According to Section 39-1310, Idaho Code, information received by the Department's Division of Licensing and Certification through filed reports, inspections, or as required by law, will not be disclosed publicly in such a manner as to identify persons except as necessary in a proceeding involving a question of licensure. (2-22-18)T

04. Public Availability of Survey Reports. The Department's Division of Licensing and Certification will post on its website, survey reports and findings of complaint investigations relating to the facility at <http://lc.dhw.idaho.gov>. (2-22-18)T

007. – 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

Administrators, employees, consultants, and contractors for the facility must have a criminal history and background check clearance as provided in IDAPA 16.05.06, "Criminal History and Background Checks." (2-22-18)T

010. DEFINITIONS AND ABBREVIATIONS – A THROUGH K.

For the purposes of this chapter of rules, the following terms apply. (2-22-18)T

01. Abuse. The infliction of injury, unreasonable confinement, intimidation, or punishment with the resulting physical harm, pain, or personal anguish. Specifics are as follows: (2-22-18)T

a. Physical abuse is any action that causes physical harm or pain, trauma, or bodily harm such as hitting, slapping, punching, kicking, and pinching. It includes the use of excessive force or improper technique when placing a person in restraints, the use of restraints that are not specified in the facility's policies and procedures or ordered by the physician and consented to by the legal guardian in the person's Individual Treatment Plan (ITP) and restraint of any form imposed as a means of coercion, punishment, convenience, or retaliation by staff. All injuries sustained by the person during restraint or injuries suspected to be sustained during restraint must be investigated for potential abuse. (2-22-18)T

b. Psychological abuse is any action, situation, or circumstance that is detrimental to the person's psychological well-being including humiliation, harassment, and threats of punishment or deprivation, sexual coercion, and intimidation. People residing in the facility may be unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically abusive by the general public, would also be viewed as abusive by the person residing in the facility, regardless of that person's perceived ability to comprehend the nature of the incident. (2-22-18)T

c. Sexual abuse is rape, sexual assault, or any incident where a person is coerced, manipulated, or otherwise enticed by another individual to engage in any form of sexual activity. (2-22-18)T

d. Verbal abuse is any use of insulting, demeaning, disrespectful, oral, written, or gestured language directed towards and in the presence of a person. People residing in the facility may be unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as verbally abusive by the general public, would also be viewed as abusive by the person residing in the facility, regardless of that person's perceived ability to comprehend the nature of the incident. (2-22-18)T

e. Punishment is modifying a person's diet, or withholding food, or hydration, medical care or treatment, or the use of restrictive interventions, including physical restraint and chemical restraints as a means to discipline or penalize a person. (2-22-18)T

02. Administrator. The individual delegated the responsibility for management of the facility. (2-22-18)T

- 03. Advocate.** A individual who assists the person in exercising his rights within the facility and as a citizen of the United States. An advocate cannot make legal or other decisions on behalf of the person. The role of the advocate is limited to assisting the person only. (2-22-18)T
- 04. Behavioral Management Needs.** Behaviors that interfere with progress, prevent assimilation into the community, decrease freedom, or increase the need for restriction of activities. (2-22-18)T
- 05. Board.** The Idaho State Board of Health and Welfare. (2-22-18)T
- 06. Chemical Restraint.** A drug or medication when it is used as a restriction to manage the person's behavior or restrict the person's freedom of movement and it not a standard treatment or dosage for the person's condition. (2-22-18)T
- 07. Clinical Case Manager.** The professional staff person responsible for the assessment, implementation, coordination, integration, and monitoring of each person's treatment program. The clinical case manager must hold a master's degree in a human service related field and have a minimum of one (1) year of experience working with people who have an intellectual disability, a serious chronic mental illness, or both. (2-22-18)T
- 08. Deficient Practice.** The facility's failure to meet an individual requirement stated in these rules. (2-22-18)T
- 09. Department.** The Idaho Department of Health and Welfare. (2-22-18)T
- 10. Developmental Disability.** A developmental disability as defined in Section 66-402, Idaho Code, or an intellectual disability as defined in Section 73-114, Idaho Code. (2-22-18)T
- 11. Director.** The Director of the Idaho Department of Health and Welfare, or his designee. (2-22-18)T
- 12. Discharge.** The permanent movement of a person to another facility or setting that is physically separate and distinct from the secure treatment facility. (2-22-18)T
- 13. Facility.** See "Secure Treatment Facility" in these rule definitions. (2-22-18)T
- 14. Facility Administration.** The individual or individuals identified by the Director to manage the secure treatment facility. (2-22-18)T
- 15. Forced Compliance.** The act of physically forcing a person to complete a task or activity. (2-22-18)T
- 16. Grievance.** A formal or informal written or verbal complaint that is made to the facility by a person, or the person's representative, regarding the person's care. This does not include complaints that are resolved at the time of the complaint by staff present, allegations of abuse, neglect or mistreatment, or appeals. (2-22-18)T
- 17. Immediate Jeopardy.** A situation in which the facility's noncompliance with one (1) or more of the requirements of licensure has caused, or is likely to cause serious injury, harm, impairment, or death to a person. (2-22-18)T
- 18. Independent Living Skills.** Skills essential to independent living that include bathing, dressing, food shopping, meal preparation, housekeeping and kitchen chores, laundry, bed making, and budgeting. (2-22-18)T
- 19. Individual Treatment Plan (ITP).** A written plan developed by the interdisciplinary team for each person in the facility that is consistent with trauma-informed care and person-centered care principles. The ITP is based on a complete, thorough assessment of the person. The ITP must include program strategies that are effective in ameliorating the behaviors that resulted in the person's admission to the secure treatment facility, the teaching of self-management strategies to promote discharge to a less restrictive living environment, and prevent or decelerate the regression or loss of optimal functional status. Each person's ITP addresses what a person needs in order to function

with as much independence as possible by stating the following: (2-22-18)T

- a. The desired outcomes the person is trying to achieve; (2-22-18)T
- b. The specific steps and actions that will be taken to reach the desired outcomes; and (2-22-18)T
- c. Any additional adaptive equipment, assistive technology, services, and supports required to meet the person's needs. (2-22-18)T

20. Interdisciplinary Team (IDT). Professionals, paraprofessionals, and nonprofessionals who possess the knowledge, skills, and expertise necessary to accurately assess and identify the function of the behavior(s) that resulted in a person's admission to the facility and design a program that includes strategies that are effective in ameliorating those behaviors and teaching self-management strategies to promote discharge to a less restrictive living environment. The IDT must include the person, unless inability or unwillingness is documented, the person's legal guardian, and any other individual the person wishes to be present, including advocates and family members unless documented to be inappropriate or unobtainable, a physician, a social worker, and other appropriate professional and nonprofessional staff, at least one (1) of whom is a clinical case manager. (2-22-18)T

21. Isolation. See "Seclusion" in these rule definitions. (2-22-18)T

011. DEFINITIONS AND ABBREVIATIONS – L THROUGH Z.
For the purposes of this chapter of rules, the following terms apply. (2-22-18)T

01. Legal Guardian. An individual appointed by the court in accordance with Section 15-5-301, Idaho Code, or Section 66-404, Idaho Code. The guardian's role is to act in the person's best interest, encourage self-reliance and independence, as well as make decisions on behalf of the person. (2-22-18)T

02. Licensing and Certification. The Department's Division that is responsible for the licensing and surveying activities of the facility. (2-22-18)T

03. Mistreatment. Behavior or facility practices that result in any type of person's exploitation such as financial, physical, sexual, or criminal exploitation. Mistreatment also refers to the use of behavioral management techniques outside of their use as specified in the facility policies and procedures or ordered by the physician and consented to by the legal guardian in the person's Individual Treatment Plan (ITP). (2-22-18)T

04. National Association for Persons with Developmental Disabilities and Mental Health Needs (NADD). NADD is a not-for-profit membership association established for professionals, care providers, and families to promote understanding of and services for individuals who have developmental disabilities and mental health needs. NADD offers information and multiple resources regarding trauma-informed care principles, reduction and elimination of restraint and seclusion, person-centered care, and other related topics that are available online at <http://thenadd.org>. (2-22-18)T

05. Neglect. The failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness. Staff failure to intervene appropriately to prevent self-injurious behavior will constitute neglect. Staff failure to implement safeguards, once person to person aggression is identified, will also constitute neglect. (2-22-18)T

06. Noxious Stimuli. A startling, unpleasant, or painful action used in response to a person's behavior that has a potentially aversive or harmful effect. (2-22-18)T

07. Person. An individual subject to judicial proceedings, authorized by the provisions of Title 66, Chapter 14, Idaho Code, who is being considered for disposition or is admitted and dispositioned into the secure treatment facility. (2-22-18)T

08. Person-Centered Care. To focus on the person as the locus of control and to support the person in making his own choices and having control over his daily life. (2-22-18)T

- 09. Physical Restraint.** Any manual hold or mechanical device, material or equipment that the person cannot remove easily, and that restricts the free movement of, normal functioning of, or normal access to a portion or portions of a person's body. (2-22-18)T
- 10. Physician.** An individual licensed to practice medicine and surgery by the Idaho State Board of Medicine or the Idaho State Board of Podiatry according to Section 39-1301(h), Idaho Code. (2-22-18)T
- 11. PRN.** "Pro Re Nata" meaning "as needed." (2-22-18)T
- 12. Provisional License.** A license issued to a facility that conforms substantially to these rules, during which time the facility implements administrative or major structural changes. (2-22-18)T
- 13. Reportable Incident.** A situation when a facility is required to report information to the Department's Division of Licensing and Certification that includes the following: (2-22-18)T
- a.** An injury must be reported as an "injury of unknown source" when the following occurs: (2-22-18)T
 - i.** The source of the injury was not witnessed by anyone and the source of the injury could not be explained by the person; and (2-22-18)T
 - ii.** The injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the number of injuries observed over time. (2-22-18)T
 - b.** Elopement is when a person physically leaves the facility premises without the facility's knowledge. (2-22-18)T
 - c.** Person to person physical altercations with or without injury. (2-22-18)T
 - d.** An incident that results in the person's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. Reporting of these incidents must include documentation of when the person was last subjected to physical and chemical restraint. (2-22-18)T
 - e.** All allegations of staff abuse, neglect, and mistreatment. (2-22-18)T
- 14. Restrictive Intervention.** An intervention that is used to restrict the rights or freedom of movement of a person. (2-22-18)T
- 15. Seclusion.** The involuntary isolation and confinement of a person in a locked room or area. (2-22-18)T
- 16. Secure Treatment Facility.** The facility to be operated by the Department to fulfill the purposes of this chapter. A secure treatment facility will be referred to as "facility" in these rules. The facility will include: (2-22-18)T
- a.** Locked, fenced, and enclosed grounds accessible only to persons, staff, and authorized individuals; (2-22-18)T
 - b.** Locked residential units; (2-22-18)T
 - c.** Bedroom and building exit alarms; (2-22-18)T
 - d.** Monitoring cameras in all common areas; (2-22-18)T
 - e.** Modified interiors to reduce risk of suicide; and (2-22-18)T

- f. Restricted access to items that could be used as weapons. (2-22-18)T
- 17. Serious Injury.** Any significant impairment of the physical condition of the person as determined by qualified medical personnel. This includes burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else. (2-22-18)T
- 18. Serious Mental Illness.** Any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders: (2-22-18)T
- a. Schizophrenia spectrum and other related disorders; (2-22-18)T
- b. Paranoia and other psychotic disorders; (2-22-18)T
- c. Bipolar and other related disorders; (2-22-18)T
- d. Depressive disorders; (2-22-18)T
- e. Trauma and stressor-related disorders; (2-22-18)T
- f. Anxiety disorders; (2-22-18)T
- g. Obsessive-compulsive and other related disorders; (2-22-18)T
- h. Dissociative disorders; and (2-22-18)T
- i. Personality disorders. (2-22-18)T
- 19. Substance Abuse and Mental Health Administration (SAMHSA).** SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA offers information and multiple resources regarding trauma-informed care principles, the reduction and elimination of restraint and seclusion, person-centered care, and other related topics that are available online at <https://www.samhsa.gov>. (2-22-18)T
- 20. Substantial Compliance.** The facility is in substantial compliance with these rules when all Standards of Licensure are met. (2-22-18)T
- 21. Substantial Threat to the Safety of Others.** The presentation, by a person, of a substantial risk to physically harm other persons, as manifested by evidence of violent behavior. (2-22-18)T
- 22. Sufficient Staff.** Enough on duty, trained personnel to effectively implement the treatment programs as defined in the Individual Treatment Plan (ITP), to meet each person's needs, and to respond to emergencies, illness, or injuries on a twenty-four (24) hour basis. (2-22-18)T
- 23. Time-Out.** Reducing or limiting the amount of reinforcement that is available to a person for a period of time, either by removing a person from his environment (exclusionary) or changing the existing environment (inclusionary). (2-22-18)T
- 24. Time-Out Room.** A specific room used in exclusionary time-out procedures from which egress is prevented. (2-22-18)T
- 25. Transfer.** A transfer means the following: (2-22-18)T
- a. The temporary movement of a person from the facility to a psychiatric or medical hospital for medical reasons; (2-22-18)T
- b. The permanent movement of an entire facility to a new location, including people served, staff, and records. (2-22-18)T

26. Trauma-Informed Care. Under the Substance Abuse and Mental Health Administration (SAMHSA), trauma-informed care is a system of care that incorporates key trauma principles into the facility's culture and each person's treatment interventions and supports. Key trauma principles include: (2-22-18)T

a. Safety. The facility staff and persons feel physically and psychologically safe based on the physical environment and interpersonal interactions that promote a sense of safety. (2-22-18)T

b. Trustworthiness and Transparency. The facility's operations and decisions are conducted with transparency with the goal of building and maintaining trust among persons, guardians, advocates, staff, and all other individuals involved with the facility. (2-22-18)T

c. Peer Support. Peer support and mutual self-help are utilized to build safety, hope, and trust and to enhance collaboration. Shared stories and life experiences are utilized to promote recovery and healing. (2-22-18)T

d. Collaboration and Mutuality. All facility staff actively work to reduce the power differences between staff and persons to the maximum extent possible through the meaningful sharing of power and decision-making. (2-22-18)T

e. Empowerment, Voice, and Choice. The facility's operations and staff training programs are organized to ensure the safety and empowerment of both persons and staff. Individual strengths and experiences are recognized and built upon, and shared decision-making, choices, and goal-setting is supported. Each staff's role as a facilitator rather than a controller is recognized and promoted. (2-22-18)T

f. Cultural, Historical, and Gender Issues. The facility's operations are responsive to gender and the racial, ethnic, and cultural needs of each person, and recognize and address each person's historical trauma. (2-22-18)T

27. Treatment. The implementation of a professionally developed and supervised Individual Treatment Plan (ITP) designed to achieve the person's discharge from the facility at the earliest possible time. Treatment requires the person to be actively involved in the development and implementation of his own treatment plan with the support of his legal guardian, advocate, family members, friends, professional, paraprofessional, and non-professional facility staff. (2-22-18)T

28. Unremoved Immediate Jeopardy. An immediate jeopardy situation that the facility could not resolve by the time of the survey exit conference. (2-22-18)T

012. – 019. (RESERVED)

020. LICENSURE – GENERAL REQUIREMENTS.

01. License Requirement. The facility for persons with intellectual disabilities cannot be established, maintained, or operated within Idaho without obtaining a license from the Department's Division of Licensing and Certification as required in Section 66-1402, Idaho Code. Only one (1) facility in Idaho can be licensed as a secure treatment facility for people with intellectual disabilities. The facility must be in compliance with applicable federal, state, and local laws, regulations, codes, and this chapter of rules in order to hold a license. (2-22-18)T

02. Facility Name. The facility must use a distinctive name. The facility cannot change its name without written notification to the Department's Division of Licensing and Certification at least thirty (30) calendar days prior to the date the proposed name change is to be effective. (2-22-18)T

03. Physical Location. The facility must meet the requirements according to Sections 67-6530 through 67-6532, Idaho Code, for local planning and zoning laws or ordinances. (2-22-18)T

04. Size Limitation. The maximum size of this facility must be no more than four (4) beds. (2-22-18)T

05. Compliance with Water and Sanitation Rules. This facility must have a statement from the

Public Health District indicating that the municipal water supply and sewage disposal systems meet the requirements in Section 004 of these rules. (2-22-18)T

06. Approval of Facility Construction Plans. This facility must obtain written approval from the Department's Division of Licensing and Certification prior to any proposed construction of a facility or alterations to the facility. Construction or alteration plans must be provided prior to licensing of the facility and must meet Sections 830 through 844 of these rules. (2-22-18)T

021. – 024. (RESERVED)

025. INITIAL APPLICATION FOR LICENSURE.

The facility must apply to the Department's Division of Licensing and Certification for an initial license to operate the facility. (2-22-18)T

01. Form of Application. The applicant must complete an initial application form provided by the Department's Division of Licensing and Certification. The application and documents required in Subsection 025.02 of this rule must be submitted to the Division of Licensing and Certification at least ninety (90) calendar days prior to the planned opening date. (2-22-18)T

02. Documents Required. In addition to the application form, the following documents must be submitted with the application prior to approval of a license: (2-22-18)T

- a. A certificate of occupancy from the local building and fire authority; (2-22-18)T
- b. Fire alarm record of completion; (2-22-18)T
- c. Sprinkler contractors material and test certificate for aboveground piping; (2-22-18)T
- d. Installers letter of code compliance for fuel fired appliances; (2-22-18)T
- e. Acceptable policies and procedures governing the facility; and (2-22-18)T
- f. A sample of a person's record. (2-22-18)T

026. – 029. (RESERVED)

030. ISSUANCE OF LICENSE.

The facility license is issued when the Department's Division of Licensing and Certification finds that the applicant has demonstrated compliance with the requirements in Idaho statutes and these rules. (2-22-18)T

01. Initial License. When the Department's Division of Licensing and Certification determines that all required application information has been received and demonstrates compliance, a license is issued. The initial license expires at the end of the calendar year in which the license was issued. (2-22-18)T

02. License Issued Only to Named Applicant and Location. The license is issued only for the facility named and location stated in the application. (2-22-18)T

03. License Specifies Maximum Allowable Beds. The license specifies the maximum allowable number of beds in the facility. (2-22-18)T

04. Provisional License. A provisional license is valid for a period not to exceed six (6) months from the date of issuance by the Department's Division of Licensing and Certification. A provisional license may be issued to the facility for the following reasons: (2-22-18)T

- a. Implement administrative changes; or (2-22-18)T
- b. Implement structural changes to a facility's premises. (2-22-18)T

031. EXPIRATION AND RENEWAL OF LICENSE.

The facility license issued by the Department's Division of Licensing and Certification is valid until the end of the calendar year in which it is issued. The license is renewed annually unless the license is revoked or suspended. (2-22-18)T

032. LICENSE AVAILABLE.

The facility must have its license on the premises and available upon request. (2-22-18)T

033. – 039. (RESERVED)

040. INSPECTION OF FACILITY.

01. Representatives of the Department's Division Licensing and Certification. The Department's Division of Licensing and Certification is authorized to enter the facility, or its buildings associated with its operation, at all times for the purpose of inspection surveys. The Department's Division of Licensing and Certification may, at its discretion, utilize the services of any legally qualified person or organization, either public or private, to examine and inspect the facility for licensure requirements. (2-22-18)T

02. Accessible With or Without Prior Notification. Inspection surveys are made unannounced and without prior notice at the discretion of the Department's Division of Licensing and Certification. (2-22-18)T

03. Inspection of Records. For the purposes of these rules, the Department's Division of Licensing and Certification is authorized to inspect all paper, electronic, video, and audio records pertinent to a person's care as required to be maintained by the facility. (2-22-18)T

04. Interview Authority. A surveyor has the authority to interview any individual associated with the facility or the provision of care including the license holder, administrator, staff, people residing at the facility, their family members and advocates, service providers, physicians, or other legally responsible individuals. Interviews are confidential and conducted privately unless otherwise specified by the interviewee. (2-22-18)T

05. Inspection of Outside Services. The Department's Division of Licensing and Certification is authorized to inspect any outside services that a licensed facility uses for the people residing at the facility. (2-22-18)T

041. LICENSURE SURVEYS.

01. Surveys of Facilities. The Department's Division of Licensing and Certification will ensure that surveys are conducted at specified intervals in order to determine compliance with this chapter and applicable rules and statutes. The intervals of surveys will be as follows: (2-22-18)T

a. An initial survey is conducted within sixty (60) calendar days from initial licensure. The initial survey may be delayed until a person has been admitted and is present at the facility. (2-22-18)T

b. A relicensure survey is conducted on average once per year, or more frequently at the discretion of the Department's Division of Licensing and Certification. A relicensure survey may be delayed until a person has been admitted and is present at the facility. (2-22-18)T

c. A complaint investigation survey is conducted based on the severity of an alleged violation of these rules or statutes, or any reportable incident that indicates there was a violation of the rules or statute. (2-22-18)T

i. A complaint alleging immediate jeopardy to a person is conducted within one (1) business day. (2-22-18)T

ii. A complaint not alleging immediate jeopardy to a person is conducted within five (5) calendar days. (2-22-18)T

02. Follow-up Surveys. Follow-up surveys may be conducted at the discretion of the Department's

Division of Licensing and Certification to ascertain corrections to noncompliance with these rules. Follow-up surveys are conducted per time frames established in the facility's acceptable plan of correction, but must not exceed the following: (2-22-18)T

a. Offsite follow-up surveys may be conducted at the discretion of the Department's Division of Licensing and Certification to ascertain corrections to deficiencies within ninety (90) calendar days of the facility's alleged compliance date. (2-22-18)T

b. Onsite follow-up surveys may be conducted by the Department's Division of Licensing and Certification to ascertain corrections to deficiencies that do not include an unremoved immediate jeopardy to health and safety within a period of ninety (90) calendar days from the originating survey exit date. If an onsite follow-up is conducted, and it is not verified by the Department's Division of Licensing and Certification that the facility is in substantial compliance by the end of the 90-day period, then the facility's license will be revoked. (2-22-18)T

i. The Department's Division of Licensing and Certification will conduct onsite follow-up surveys to ascertain corrections to deficiencies that include an unremoved immediate jeopardy to health and safety within thirty (30) calendar days after the receipt of the Statement of Deficiencies and Plan of Correction form if cited deficiencies include an immediate jeopardy to health and safety that was not removed prior to the survey exit date. (2-22-18)T

ii. Expedited revocation will occur in no less than five (5) calendar days and no more than thirty (30) calendar days after the receipt of the Statement of Deficiencies and Plan of Correction form. Specific time frames will be determined by the Department's Division of Licensing and Certification on a case-by-case basis and provided to the facility in writing. (2-22-18)T

iii. The facility may request that an onsite follow-up be conducted immediately upon receipt of the written notice by submitting an acceptable plan of correction alleging that the immediate jeopardy has been removed. If an onsite follow-up is conducted, and it is verified that the immediate jeopardy has been removed, then expedited revocation action will convert to a 90-day revocation action. (2-22-18)T

042. – 049. (RESERVED)

050. COMPLAINTS.

01. Filing a Complaint. Any individual who believes that the facility has failed to meet any provision of the rules or statute may file a complaint with the Department's Division of Licensing and Certification. All complaints must have a basis in rule or statutory requirements. If it does not, the complainant will be referred to the appropriate entity or agency. (2-22-18)T

02. Disclosure of Complaint Information. The Department's Division of Licensing and Certification will not disclose the name or identifying characteristics of a complainant unless one (1) of the following events occurs: (2-22-18)T

a. The complainant consents in writing to the disclosure; (2-22-18)T

b. The investigation results in a judicial proceeding, and disclosure is ordered by the court; or (2-22-18)T

c. The disclosure is essential to prosecution of a violation. The complainant is given the opportunity to withdraw the complaint before disclosure. (2-22-18)T

03. Notification to Complainant. The Department's Division of Licensing and Certification will inform the complainant of the results of the investigation survey when the complainant has provided a name and address. (2-22-18)T

051. – 059. (RESERVED)

060. WRITTEN REPORT OF DEFICIENCIES.

The Department's Division of Licensing and Certification will provide a written Statement of Deficiencies and Plan of Correction form to the facility to support any deficiencies found. (2-22-18)T

01. Written Reports with Removed Immediate Jeopardy. Written reports of deficiencies, including immediate jeopardy to health and safety that was removed prior to the survey exit date, will be provided within ten (10) business days from the survey exit date. (2-22-18)T

02. Written Reports with Unremoved Immediate Jeopardy. Written Reports of deficiencies that include immediate jeopardy to health and safety that was not removed prior to the survey exit date will be provided within two (2) business days from the survey exit date. (2-22-18)T

061. – 069. (RESERVED)

070. ENFORCEMENT PROCESS.

The Department's Division of Licensing and Certification may impose a remedy or remedies when it determines the facility is not in compliance with these rules. (2-22-18)T

01. Determination of Remedy. In determining which remedy or remedies to impose, the Department's Division of Licensing and Certification will consider the facility's compliance history, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to persons. Subject to these considerations, any of the remedies in Sections 071 through 073 of these rules may be imposed, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal. Written notification of all remedies imposed will be provided to the facility with the Statement of Deficiencies and Plan of Correction form. (2-22-18)T

02. Enforcement Remedies. When the Department's Division of Licensing and Certification determines that the facility is out of compliance with these rules, it may impose any of the following remedies: (2-22-18)T

- a.** Require the facility to submit an acceptable plan of correction that must be approved by the Department's Division of Licensing and Certification; (2-22-18)T
- b.** Revoke the facility's license; (2-22-18)T
- c.** Issue a summary suspension of the facility's license. (2-22-18)T

071. PLAN OF CORRECTION.

An acceptable plan of correction must be developed and returned to the Department's Division of Licensing and Certification for all deficiencies within ten (10) calendar days of receipt of the Statement of Deficiencies and Plan of Correction form. An acceptable plan of correction must include the following: (2-22-18)T

01. Correcting Deficient Practice. How the corrective action will be accomplished for each person found to have been affected by the deficient practice; (2-22-18)T

02. Identify Potentially Affected Persons. How the facility will identify other people who have the potential to be affected by the same deficient practice, and how the facility will act to protect those people in similar situations; (2-22-18)T

03. Changes to Prevent Recurrence. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; (2-22-18)T

04. Monitoring Corrective Actions and Performance. How the facility will monitor its corrective actions and performance to ensure that the deficient practice is being corrected and will not recur, including what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; (2-22-18)T

05. Target Date of Corrective Action Completion. The date when corrective action must be accomplished. Except in unusual circumstances, and only with the approval of the Department's Division of

Licensing and Certification, no correction date will be more than ninety (90) calendar days from the inspection exit date as printed on the Statement of Deficiencies and Plan of Correction form; and (2-22-18)T

06. Administrator's Signature and Date Submission. The administrator's signature and the date submitted. (2-22-18)T

072. DENIAL OR REVOCATION OF LICENSE.

The Department's Division of Licensing and Certification may deny an application for a license or revoke an existing license when the facility's noncompliance with the requirements in this chapter of rules lead to a substantial risk to the health and safety of a person. (2-22-18)T

01. Notice to Deny or Revoke. The Department's Division of Licensing and Certification will send a written notice to the facility by certified mail, registered mail, or personal delivery service, to deny an application for a license or revoke an existing license. The notice will inform the facility of the opportunity to request a hearing as provided in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (2-22-18)T

02. Repeated Noncompliance. The Department's Division of Licensing and Certification may revoke an existing license for the repeated violations of any requirements in Idaho Code or these rules. (2-22-18)T

03. Accumulation of Citations for Noncompliance. The Department's Division of Licensing and Certification may revoke an existing license for the accumulation of citations for noncompliance at the facility that, taken as whole, would endanger the health, safety, or welfare of a person. (2-22-18)T

04. Personnel Inadequacies. The Department's Division of Licensing and Certification may deny an application for a license or revoke an existing license when the facility lacks sufficient staff in number or qualification to properly care for the proposed or actual number of people residing at the facility. (2-22-18)T

05. Inadequate or False Disclosure. The Department's Division of Licensing and Certification may deny an application for a license or revoke an existing license when the administrator has misrepresented, or failed to fully disclose, any facts or information or any items in any application or any other document requested by the Department's Division of Licensing and Certification, when such facts and information were required to have been disclosed. (2-22-18)T

073. SUMMARY SUSPENSION OF A LICENSE.

The Director may summarily suspend the facility license in the event of any emergency endangering the health, safety, or welfare of a person in the facility. At the time of suspension, the Director will redispotion each person residing at the facility. The Director will provide an opportunity for a contested case hearing according to IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (2-22-18)T

074. – 079. (RESERVED)

080. RETURN OF SUSPENDED, REVOKED, OR RELINQUISHED LICENSE.

The facility license is the property of the State of Idaho and must be returned to the Department's Division of Licensing and Certification immediately upon its suspension, revocation, or the voluntary closure of the facility. (2-22-18)T

081. – 089. (RESERVED)

090. WAIVER.

According to Section 39-1306, Idaho Code, a temporary waiver to these rules and minimum standards, either in whole or in part, may be granted by the Department's Division of Licensing and Certification to the facility for a period not to exceed one (1) year. Waivers are granted on a case-by-case basis according to the following conditions: (2-22-18)T

01. Waiver for Good Cause. The Department's Division of Licensing and Certification finds good cause to grant a waiver and no person's health, safety, or welfare is endangered by the waiver being granted. (2-22-18)T

02. No Precedent. Precedent will not be set by granting the requested waiver, and such waiver will have no force or effect in any other proceeding. (2-22-18)T

091. – 099. (RESERVED)

100. STANDARD OF LICENSURE: FACILITY ADMINISTRATION.

The Director must identify an individual or individuals to manage the facility. To the degree possible, considering the limitations in the facility, the facility's administration is responsible to ensure the facility's culture is consistent with trauma-informed care principles and person-centered care principles through policy development, implementation, quality assurance monitoring, and physical environment organization. The facility's training and development must be ongoing and must include person-centered, evidence-based trauma-specific screening, assessment, and interventions necessary to develop and sustain a culture that promotes the engagement, involvement, and collaboration of the person, the person's legal guardian, the person's family members, the person's advocate, all professional, paraprofessional, and direct care staff, and all other interested parties, including the facility's Human Rights Committee. (2-22-18)T

01. Necessary Staffing, Training Resources, Equipment, and Environment. The individuals charged with managing the facility must develop, monitor, and revise, as necessary, policies and operating directions that ensure the necessary staffing, training resources, equipment, and environment to provide each person with comprehensive treatment, and to provide for his health and safety consistent with trauma-informed care principles and person-centered care principles; (2-22-18)T

02. Health, Safety, Sanitation, Maintenance, and Repair. Facility administration must exercise general policy, budget, and operating direction over the facility, and include areas such as health, safety, sanitation, maintenance and repair, utilization and management of staff, and maintenance and oversight of the facility's quality assessment performance improvement program; and (2-22-18)T

03. Federal, State and Local Laws, Regulations, and Codes. Facility administration must maintain compliance with all applicable federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation. (2-22-18)T

101. SERVICES PROVIDED UNDER AGREEMENTS WITH OUTSIDE SOURCES.

If the facility does not directly provide a service, facility administration must have a written agreement with an outside program, resource, or service provider to furnish the necessary service. The agreement must contain the responsibilities, functions, objectives, and other terms agreed to by both parties and meet the needs of each person. (2-22-18)T

102. GRIEVANCE PROCESS.

Facility administration must develop, implement, and monitor policies and procedures for the prompt resolution of each person's grievances according to Subsection 304.08 of these rules. The facility must inform each person, each person's legal guardian, and the person's advocate whom to contact to file a grievance under Subsection 302.01 of these rules. (2-22-18)T

103. ABUSE, NEGLECT, AND MISTREATMENT PREVENTION, DETECTION, INVESTIGATION, AND RESOLUTION PROCESS.

Facility administration must develop, implement, and monitor policies and procedures for the prevention, detection, investigation, and resolution of abuse, neglect, mistreatment, and suspicious injuries of unknown source according to Subsection 304.02 of these rules. The facility must inform each person, the person's legal guardian, the person's advocate, and whom to contact to file an allegation of abuse, neglect, mistreatment, and report a suspicious injury of unknown source according to Subsection 302.01 of these rules. (2-22-18)T

104. – 109. (RESERVED)

110. ADMINISTRATOR.

The administration of the facility must appoint an administrator that meets the requirements and is responsible for the duties in this Section of rule. (2-22-18)T

- 01. Administrator Requirements.** The facility must have an administrator who meets the following requirements: (2-22-18)T
- a.** Is at least twenty-one (21) years of age; (2-22-18)T
 - b.** Has a minimum three (3) years direct experience working with people with intellectual or developmental disabilities, or mental illness, or both; and (2-22-18)T
 - c.** Meets all other qualifications required by the facility administration. (2-22-18)T
- 02. Administrator Duties.** The administrator's responsibilities and duties are to perform the following: (2-22-18)T
- a.** Implement and monitor written policies and procedures for the facility, and the operation of its physical plant. The administrator is the responsible and accountable for implementation of the policies established by facility administration. The administrator must see that these policies and procedures are adhered to, and must make them available to authorized representatives of the Department's Division of Licensing and Certification. (2-22-18)T
 - b.** Notify the Department's Division of Licensing and Certification of an anticipated or actual termination of any service vital to the continued safe operation of the facility or the health, safety, and welfare of its persons and personnel within one (1) business day. (2-22-18)T
 - c.** Notify the Department's Division of Licensing and Certification, in writing, of all reportable incidents within one (1) business day of the incident's occurrence. (2-22-18)T
 - d.** Notify the Department's Division of Licensing and Certification when the facility census changes from zero (0) to one (1) or from one (1) to zero (0). (2-22-18)T
 - e.** When not on duty, delegate the necessary authority to an administrator designee who is competent to handle the administrator's duties. Delegation of authority must occur according to the facility policies and procedures set by the facility administration. In the event of an emergency, the administrator designee must know how to contact the administrator. (2-22-18)T

111. – 119. (RESERVED)

120. FACILITY RECORDS.

- 01. Records Available Upon Request.** The facility must be able to print and provide paper copies of electronic records upon the request of the person who is the subject of the requested records, the person's legal guardian, payer, or the Department's Division of Licensing and Certification. (2-22-18)T
- 02. Census Register.** The facility must maintain a census register that lists the following: (2-22-18)T
- a.** Full name, age, sex, and diagnoses of each person admitted to the facility; (2-22-18)T
 - b.** The person's date of admission and discharge; and (2-22-18)T
 - c.** A daily census of each person who is in the facility on any given day. (2-22-18)T

121. RECORDS REQUIREMENTS.

- 01. Separate Record.** The facility must develop and maintain a record keeping system that includes a separate record for each person and that accurately documents comprehensive information related to the person's health care, treatment, social information, and protection of the person's rights. (2-22-18)T
- 02. Confidentiality.** The facility must keep confidential all information contained in each person's

records, regardless of the form or storage method of the records. (2-22-18)T

03. Release of Information. The facility must develop and implement policies and procedures governing the release of any person's information. The policy must include obtaining written informed consent from the person or the person's legal guardian prior to information being released. (2-22-18)T

04. Record Entries. Any individual who makes an entry in a person's record must make it legibly, date it, sign it, and include his position. (2-22-18)T

05. Legend. The facility must provide a legend, developed and maintained by facility administration, to explain any symbol or abbreviation used in a person's record. (2-22-18)T

06. Access by Staff. The facility must provide facility staff with appropriate aspects of each person's record. (2-22-18)T

122. – 129. (RESERVED)

130. FINANCES.

01. Established Financial System. The facility must establish and maintain a system to manage all personal funds entrusted to the facility on behalf of each person. The system must do the following: (2-22-18)T

a. Ensure a full and complete accounting of funds; (2-22-18)T

b. Preclude any commingling of a person's funds with facility funds or with the funds of any other individual; and (2-22-18)T

c. Ensure each person is not placed at risk of benefit loss. (2-22-18)T

02. Available upon request. The person's financial record must be available on request of the person, and the person's legal guardian or advocate. (2-22-18)T

131. – 199. (RESERVED)

200. STANDARD OF LICENSURE: FACILITY STAFFING.

The facility must provide sufficient numbers of qualified, trained, competent professional, paraprofessional, non-professional, technical, and consultative personnel to meet each person's needs. (2-22-18)T

201. SUFFICIENT PERSONNEL.

The facility must employ personnel sufficient in number and qualifications to meet the needs of each person residing at the facility. While minimum direct care staff ratios are defined in Subsection 201.01 of this rule, a person's treatment and services may require more staff than the minimum. The facility must provide sufficient numbers of staff to manage and supervise persons in accordance with their Individual Treatment Plans (ITP). (2-22-18)T

01. Minimum Direct Care Staff. The use of volunteers and students in the facility is not allowed. Minimum ratios of staff to persons must be maintained as follows: (2-22-18)T

a. When the total count of persons in the facility is one (1), a minimum of two (2) staff must be awake, on-duty, and available twenty-four (24) hours a day. (2-22-18)T

b. When the total count of persons in the facility is two (2), a minimum of three (3) staff must be awake, on-duty, and available during all person's waking hours. A minimum of two (2) staff must be awake, on-duty, and available during all person's sleeping hours. (2-22-18)T

c. When the total count of the persons in the facility is three (3), a minimum of four (4) staff must be awake, on-duty, and available during all person's waking hours. A minimum of two (2) staff must be awake, on-duty, and available during all person's sleeping hours. (2-22-18)T

d. When the total count of the persons in the facility is four (4), a minimum of five (5) staff must be awake, on-duty, and available during all person's waking hours. A minimum of three (3) staff must be awake, on-duty, and available during all person's sleeping hours. (2-22-18)T

02. Professional, Paraprofessional, Nonprofessional, Technical, and Consultative Personnel. The facility must employ adequate numbers of qualified professional, technical, and consultative personnel to be able to perform the following: (2-22-18)T

- a.** Evaluate each person; (2-22-18)T
- b.** Formulate written, individualized, comprehensive treatment plans; (2-22-18)T
- c.** Provide treatment measures; and (2-22-18)T
- d.** Engage in discharge planning. (2-22-18)T

202. FACILITY PERSONNEL DOCUMENTATION.

The facility must ensure that explicit and uniform policies and procedures are established for each employment position concerning hours of work, overtime, and related personnel matters. A statement of these policies must be provided to each employee. (2-22-18)T

01. Organizational Chart. A current organizational chart that clearly indicates lines of authority within the facility's organizational structure must be available at the facility to be viewed by all employees. (2-22-18)T

02. Job Descriptions. Current job descriptions outlining the authority, responsibilities, and duties of all personnel in the facility, including the administrator, must be established and maintained as required by facility administration. A copy of an employee's particular job description must be provided to each employee. (2-22-18)T

03. Daily Work Schedules. Daily work schedules must be maintained that show the personnel on duty at any given time for the previous three (3) month period. These schedules must be kept up to date and identify the employee as follows: (2-22-18)T

- a.** First and last names; (2-22-18)T
- b.** Professional designations such as licensed registered nurse (RN), licensed practical nurse (LPN), clinical case manager; and (2-22-18)T
- c.** Employment position in the facility. (2-22-18)T

203. PERSONNEL RECORDS.

A separate personnel record must be maintained for each employee of the facility that contains the following information: (2-22-18)T

- 01. The Employee's Name, Current Address, and Telephone Number.** (2-22-18)T
- 02. The Employee's Social Security Number.** (2-22-18)T
- 03. The Employee's Educational Background.** (2-22-18)T
- 04. The Employee's Work Experience.** (2-22-18)T

05. Other Employee Qualifications. The employee's other qualifications to provide care. If licensure is required to provide a service the employee was hired to provide, the facility must document verification of the license number and date the current license expires; (2-22-18)T

- 06. Criminal History Check.** The employee's criminal history and background check (CHC) clearance must be printed and on file, when a CHC is required; (2-22-18)T
- 07. The Employee's Date of Employment.** (2-22-18)T
- 08. Employee Date of Termination.** The employee's date of termination including the reason for termination; (2-22-18)T
- 09. The Employee's Position in the Facility and a Description of that Position.** (2-22-18)T
- 10. Employee Work Schedule.** The employee's hours and work schedule, paydays, overtime, and related personnel matters; and (2-22-18)T
- 11. Training Plan.** Training and competency plan based on evaluation of the employee's performance. (2-22-18)T
- 12. Documentation of All Allegations of Abuse, Neglect, and Mistreatment.** Staff personnel files must include documentation of all allegations of abuse, neglect, and mistreatment that have been made against the staff member, whether the allegation was substantiated or unsubstantiated, any corrective actions taken in response and the reasons why such actions were taken in accordance with IDAPA 15.04.01, "Rules of the Division of Human Resources and Idaho Personnel Commission," Section 190. (2-22-18)T

204. REQUIREMENTS OF PERSONNEL.

- 01. Health and Age Requirements.** All personnel employed by the facility must meet and observe the following requirements: (2-22-18)T
- a.** Each employee must be free of communicable disease and open skin lesions while on duty; (2-22-18)T
 - b.** At the time of employment, each employee must have a tuberculin skin test consistent with current tuberculosis control procedures; and (2-22-18)T
 - c.** Each employee providing direct care to a person must be eighteen (18) years of age, or older. (2-22-18)T
- 02. Training Requirements.** The facility must have and follow a structured, written training program designed to train each employee involved in each person's care in the responsibilities specified in the written job description, and to provide for quality of care, consistent with trauma-informed care, person-centered care principles, and compliance with these rules. Signed evidence of personnel training, indicating dates, hours, and topic, must be retained at the facility. The written training program must include information about how facility administration will ensure facility staff are able to demonstrate competence in applying the training to their job responsibilities. This training must include the following: (2-22-18)T
- a.** The facility must provide each employee with initial, continuing in-service training, and refresher training consistent with facility policy. Initial training must be provided prior to staff working directly with a person. At a minimum, refresher training must be provided annually. Training must enable the employee to perform his duties effectively, efficiently, and competently. Individuals providing staff training must be qualified as evidenced by documented education, training, and experience in the specific areas in which they are providing training. (2-22-18)T
 - b.** Professional program staff must participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members. Documentation must include training related to trauma-specific screening and person-centered care principles, assessment, and interventions. (2-22-18)T
 - c.** The facility must ensure all staff involved in a person's care must have ongoing education, training, and demonstrated knowledge to ensure each person's acute and chronic needs are met. Training must address the

- following: (2-22-18)T
- i. Rights, including specific training on the facility's policies and procedures for the prevention and detection of abuse, neglect, and mistreatment; (2-22-18)T
 - ii. Treatment of health care needs, including basic first aid, CPR certification, and training on the use of the facility's emergency medical equipment; (2-22-18)T
 - iii. Treatment of developmental needs; (2-22-18)T
 - iv. Treatment of mental health needs; (2-22-18)T
 - v. Intervention strategies to address behavioral needs; (2-22-18)T
 - vi. Techniques to identify the behaviors, events, and environmental factors of each person and staff that may trigger emergency safety situations; (2-22-18)T
 - vii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; (2-22-18)T
 - viii. Specific training on the use of and risks associated with physical restraint use, including psychological effects, bruising, lacerations, fractures, serious impairment, and death caused by restraint compression asphyxia, strangulation, aspiration, blunt trauma to the chest, catecholamine rush, rhabdomyolysis, and thrombosis; (2-22-18)T
 - ix. Specific training prohibiting the use of seclusion, prone restraints, supine restraints, or other restraints that force a person against a hard surface, such as a wall, chair, or the floor due to increased psychological and physical risks to the person; (2-22-18)T
 - x. Specific training regarding the assistance with medications and the detection of adverse reactions to medications; (2-22-18)T
 - xi. Specific training regarding increased risk to each person's health and safety when chemical restraint is used concurrently with physical restraint; (2-22-18)T
 - xii. Specific training on how to identify and respond to persons engaging in suicidal ideation or attempts; and (2-22-18)T
 - xiii. Specific training on trauma-informed care principles, person-centered care, and methods to reduce and eliminate restraints that are consistent with Substance Abuse and Mental Health Services Administration (SAMHSA) guidance, National Association for Persons with Developmental Disabilities and Mental Health Needs (NADD) guidance, or other nationally recognized organizations. (2-22-18)T

205. – 299. (RESERVED)

300. STANDARD OF LICENSURE – PROTECTION OF PERSONS RESIDING AT THE FACILITY.

The facility must develop, implement, and monitor policies and procedures to ensure each person is allowed and encouraged to exercise his rights as citizens of the United States, and all persons must be accorded those civil rights provided in Title 66, Chapter 4, Idaho Code, except as otherwise provided in Section 66-1406, Idaho Code. These procedures must include a written document that outlines the person's rights, restrictions, and rules of the facility. (2-22-18)T

301. ADVOCACY AND ADVOCATE SELECTION.

With input from the person and the person's interdisciplinary team, the administrator of the facility must appoint an advocate for the person when the following exists: (2-22-18)T

- 01. Legal Guardian Unable to Participate.** The person's legal guardian is unable or unwilling to

participate, or is unavailable after reasonable efforts to contact them for participation have been made. (2-22-18)T

02. Person Unable to Make Informed Decisions. A person “lacks capacity to make informed decisions” as defined in Section 66-402(9), Idaho Code. The IDT must determine and document in the person's record the specific impairment that has rendered the person incapable of understanding his own rights. (2-22-18)T

03. Requested by Person or Guardian. An advocate is requested by the person or his guardian. (2-22-18)T

04. Advocate Selection. The administrator must assure that all persons are represented only by individuals who are not employed by the facility and that a person’s preference is honored whenever possible and appropriate. The priority for selection of advocates will be in the following order: (2-22-18)T

a. Parent(s); (2-22-18)T

b. An interested family member; or (2-22-18)T

c. Other interested parties. (2-22-18)T

05. Advocate Limitations. A person's advocate cannot make legal or other decisions on behalf of the person. The role of the advocate is limited to assisting the person in exercising his rights within the facility and as a United States citizen. (2-22-18)T

302. RIGHTS, RESTRICTIONS, AND RULES OF THE FACILITY – DOCUMENTATION.

The facility must ensure each person, each person's legal guardian, and each person's advocate is provided with comprehensive facility information including each person’s rights, restrictions, rules, services available, and potential charges for care. If legal guardians wish for other members of the person's family to be informed, they must put this permission in writing. The fact that a person has been determined to be incompetent or incapable does not absolve the facility from providing the person with such information to the extent that the person is able to understand them. (2-22-18)T

01. Provided with Rights, Restrictions, and Rules. Upon admission, a notice communicating rights information must be provided verbally and in writing in the manner and language understood by the person and the person’s legal guardian, and the person’s advocate, who will also acknowledge receipt of this notice in writing. If the person refuses to acknowledge receipt of the notice, the staff member delivering the notice will note the refusal on the receipt. The signed receipt, or copy of refusal will be maintained in the person's record. At a minimum, the information on record at admission must include the following: (2-22-18)T

a. Documentation demonstrating the receipt and explanation of each person’s rights, including the person's right to participate in accordance with person-centered care principles and his right to be free from abuse, neglect, mistreatment, and suspicious injuries of unknown source; (2-22-18)T

b. Documentation demonstrating the receipt and explanation of written policies, procedures, or rules of the facility pertaining to the following: (2-22-18)T

i. Implementation and monitoring of trauma-informed care principles; (2-22-18)T

ii. For the management of conduct between staff and persons; (2-22-18)T

iii. For the management of maladaptive behavior; (2-22-18)T

iv. For the use of restraint during emergency situations and the facility's methods for the reduction and elimination of restraint use; (2-22-18)T

v. For suicide precautions; (2-22-18)T

vi. For filing a grievance; and (2-22-18)T

- vii. For appealing treatment and re-admission decisions. (2-22-18)T
- c. Contact information must be provided, including the phone number and mailing address for the following: (2-22-18)T
 - i. Facility personnel responsible for receiving allegations of abuse, neglect, and mistreatment and reporting suspicious injuries of an unknown source; (2-22-18)T
 - ii. Facility personnel responsible for receiving grievances and treatment appeals; and (2-22-18)T
 - iii. Adult Protection Services, the state protection and advocacy system, and the Department's Division of Licensing and Certification. (2-22-18)T

02. Written Interpretation of Evaluations. Upon request, a copy of the evaluation or a written interpretation of the evaluation that is conducted for the person must be provided to the person, the person's legal guardian, and the person's advocate within thirty (30) days of admission to the facility. Upon request, the administrator of the facility must provide a written interpretation of any and all subsequent evaluations. (2-22-18)T

03. Be Informed of Risks and Benefits. The facility must explain the relative risks and benefits of specific modes of treatment contained in each person's Individual Treatment Plan (ITP) to the person, the person's guardian, and the person's advocate. The attendant risks of treatment must describe the risk vs. risk and the risk vs. benefit associated with the treatment. These risks include possible side effects, other complications from treatments including medical and drug therapy, unintended consequences of treatment, or other behavioral or psychological ramifications arising from treatment. (2-22-18)T

04. Be Informed of Activities. Each person's legal guardian or the person's advocate must be informed of activities related to the person that may be of interest to them. (2-22-18)T

05. Notification of Significant Events. Each person's legal guardian or advocate must be notified in the event of any unusual occurrence or significant changes in the person's condition including serious injury, illness, or accident, impending death, or death. Notifications must be made as soon as possible, but must not exceed twenty-four (24) hours. (2-22-18)T

06. Communications. Each person's legal guardian or advocate must receive replies to any communication sent to the facility regarding the person within forty-eight (48) hours. (2-22-18)T

303. FACILITY ENVIRONMENTAL RESTRICTIONS.

01. Locked, Fenced, and Enclosed Grounds Accessible to Persons, Staff, and Authorized Individuals. The facility must develop, implement, and monitor policies and procedures governing the use of locked, fenced, and enclosed grounds. Policies must identify the circumstances under which fencing is to be unlocked and the procedures specifying how each person, staff, and authorized individuals will gain access. (2-22-18)T

02. Locked Residential Units. The facility must develop, implement, and monitor policies and procedures governing the use of locked residential units. Policies must identify the circumstances under which the units are to be unlocked and the procedures specifying how each person, staff, and authorized individuals will gain access to locked units. Locked units must not be used as a substitute for adequate staff, staff convenience, or a treatment plan. (2-22-18)T

03. Bedroom and Building Exit Alarms. The facility must develop, implement, and monitor policies and procedures governing the use of bedroom and building exit alarms. Policies must identify the circumstances under which the alarms are to be used. Alarms must not be used in lieu of sufficient staff, for staff convenience, or as a substitute for a treatment plan. (2-22-18)T

04. Video and Audio Monitoring. The facility must develop, implement, and monitor policies and procedures governing the use of video and audio monitoring. The facility may install video and audio equipment for

the purposes of monitoring persons in common areas only. Video and audio monitoring in bathrooms, bedrooms, or in areas where the person is visiting with his attorney, an employee at the attorney's firm, or a representative of the state protection and advocacy system is prohibited. Video and audio monitoring must not be used in lieu of sufficient staff, for staff convenience, or as a substitute for a treatment plan. (2-22-18)T

05. Restricted Access to Items That Could Be Used as Weapons. The facility must develop, implement, and monitor policies and procedures that restrict access to facility items and equipment that could be used as weapons. Facility policies must specify which items will be permanently restricted and which items may be temporarily restricted. For temporary restrictions, procedures must be established for the return of access based on individualized assessment. Restricted access to items must not be used in lieu of sufficient staff, for staff convenience, or as a substitute for a treatment plan. (2-22-18)T

304. RIGHTS THAT MAY NOT BE RESTRICTED.

01. Right to Care in a Safe Setting. Each person is entitled to humane care and treatment in the environment or setting that is least restrictive of personal liberties in which appropriate treatment can be provided. Each person is entitled to be diagnosed, cared for, and treated in a manner consistent with his legal rights and in a manner no more restrictive than necessary for his protection and the protection of others for a period no longer than reasonably necessary for diagnosis, care, treatment, and protection. (2-22-18)T

02. Right to Be Free from Abuse, Neglect, and Mistreatment. The facility must implement, through policies, oversight, and training, safeguards to ensure that each person is not subjected to abuse, neglect, or mistreatment by anyone including facility staff, consultants, contractors, staff of other agencies serving the person, family members, legal guardians, advocates, friends, other persons, themselves, or members of the public. The facility must adhere to the following: (2-22-18)T

a. The facility must prohibit the employment of individuals with a conviction or prior employment history of abuse, neglect, or mistreatment of a child or of a person residing in a care facility. (2-22-18)T

b. Through established procedures, the facility must ensure that all allegations of abuse, neglect, mistreatment, and suspicious injuries of unknown origin are reported immediately to the administrator and to other officials according to with state law, including law enforcement agencies and adult protective services under Section 39-5303, Idaho Code. (2-22-18)T

c. The facility must have evidence that all alleged violations are thoroughly investigated. (2-22-18)T

d. The facility must prevent further potential abuse while the investigation is in progress. (2-22-18)T

e. The results of all investigations must be reported to the administrator within five (5) business days of the investigation's start date. (2-22-18)T

f. If the alleged violation is verified, the person's trauma history must be immediately updated, the impacts of the trauma must be assessed, and the person's comprehensive functional assessment, Individual Treatment Plan (ITP), and programs must be reviewed and updated under Section 440 of these rules. All other appropriate corrective action must be taken as soon as is reasonable. (2-22-18)T

03. Right to Be Free from Unnecessary Drugs. All persons have the right to be free from unnecessary drugs. Drugs must not be used without indication, in excessive doses, or for excessive durations that interfere with the person's daily living activities. Chemical restraint imposed as a means of coercion, punishment, convenience, or retaliation by staff constitutes abuse. (2-22-18)T

04. Right to Be Free from Unnecessary Physical Restraint and Seclusion. All persons have the right to be free from seclusion and unnecessary physical restraint. Seclusion and prone restraint, supine restraint, and any other restraint that forces a person against a hard surface such as a wall, chair, or the floor is not allowed. Other physical restraints may only be used to ensure the immediate physical safety of the person, a staff member, or others, and must be discontinued at the earliest possible time based on an individualized person assessment and re-evaluation. Restraint of any form imposed as a means of coercion, punishment, convenience, or retaliation by staff

constitutes abuse. (2-22-18)T

05. Right to Free Access to Attorney and Advocacy. Every person in the facility must, at all times, have the right to visit and be visited by or to communicate by sealed mail, telephone, or otherwise with the person's attorney, an employee at the attorney's firm, or a representative of the state protection and advocacy system. Each person must have reasonable access to letter-writing material and postage for this purpose. (2-22-18)T

06. Right to Practice Religion. The facility must honor each person's religious preferences and practices, including providing religiously necessary food accommodations. If the person's right to participate in community activities has been restricted, according to Subsection 310.01 of these rules, the facility must make other arrangements such as telecommunication or in-person visits with religious personnel, necessary to ensure the person's rights to practice religion is upheld. (2-22-18)T

07. Right to Be Paid for Work Performed. A person must not be compelled to perform services for the facility. Persons who do work for the facility must be compensated for their efforts at prevailing wages. (2-22-18)T

08. Right to Voice Grievances. Each person and his representatives must be provided free access to established procedures to voice grievances and to recommend changes in policies and services being offered at the facility. The facility must have an established grievance process for prompt resolution of grievances and must inform each person whom to contact to file a grievance. At a minimum, the facility policy must include the following: (2-22-18)T

a. A clearly explained procedure for the submission of a person's written or verbal grievance to the facility; (2-22-18)T

b. Specific time frames for review of the grievance and the provision of a response; and (2-22-18)T

c. In its resolution of the grievance, the facility must provide the person or his representative with written notice of its decision that contains the name of the facility staff contact, the steps taken on behalf of the person to investigate the grievance, the results of the grievance process, and the date of completion. (2-22-18)T

09. Right to Appeal Treatment Decisions. The person, the person's attorney, and the person's legal guardian or advocate may appeal any treatment decisions that limit the person's rights to the facility's Human Rights Committee (HRC) within thirty (30) calendar days of receipt of the written statement and a notice of appeal rights, under Subsection 310.06 of these rules. (2-22-18)T

10. Right to Participate. Each person has the right to participate in the development of his Individual Treatment Plan (ITP). The ITP must be a person-centered plan of care, which ensures each person's rights to participate are upheld, including, the following: (2-22-18)T

a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings, and the right to request revisions to the ITP. (2-22-18)T

b. The right to participate in establishing the expected goals and outcomes of care, the type, amount frequency, and duration of care, and any other factors related to the effectiveness of the ITP. (2-22-18)T

c. The right to be informed, in advance, of changes to the ITP. (2-22-18)T

d. The right to receive the training and services included in the ITP. (2-22-18)T

305. – 309. (RESERVED)

310. RIGHTS THAT MAY BE RESTRICTED.

The decision to limit a person's rights must accord with Title 66, Chapter 14, Idaho Code. Limitations or any restrictive treatment that may infringe on person's rights, must be a clinical decision made as part of the person's

Individual Treatment Plan (ITP). The facility must seek the written informed consent of the person and the person's legal guardian. (2-22-18)T

01. Limitations on Communication, Visitation, and Participation in Social and Community Events. Except as provided in Subsections 304.05 and 304.06 of these rules, the facility may limit a person's rights to communicate with individuals inside or outside the facility or to receive visitors or associate freely with other individuals. (2-22-18)T

02. Limitations on Personal Possessions. The facility may permanently and temporarily restrict a person's right to keep and use the person's own personal possessions. (2-22-18)T

a. Permanent restrictions while the person resides at the facility may include the restriction of items that may be used as weapons such as knives, baseball bats, hammers, screwdrivers, rocks, weights, lighters, knitting needles, hand-held mirrors, CDs, DVDs, glass or porcelain nick-knacks, neckties, necklaces, nylons, and other items that are not considered supportive or adaptive equipment, communication devices, or basic clothing. (2-22-18)T

b. Temporary restrictions may include the restrictions of supportive or adaptive equipment, or basic clothing that may be used as weapons such as eye glasses, canes, walkers, belts, socks, and shoelaces. Removal of such items must only occur if the removal is necessary to ensure the immediate physical safety of the person, a staff member, or others. Any removal of supportive or adaptive equipment that compromises a person's mobility must be returned to the person immediately if the person indicates a desire to move through verbal, physical, or other means. All items must be returned as soon as the physical safety situation has been resolved. Removal of communication devices is not allowed. (2-22-18)T

03. Limitations on Financial Management. The facility may limit a person's rights to manage his financial affairs when a person chooses to purchase items, such as weapons, that are contraindicated in the person's Individual Treatment Plan (ITP). (2-22-18)T

04. Limitations on Personal Privacy. The facility may limit a person's personal privacy in situations where a person must be continuously observed to ensure his safety, such as when a person is under suicide precautions. (2-22-18)T

05. Limitations on Access to Records. The facility may limit a person's access to his records when such access results in violent or self-destructive behavior or a deterioration in the person's mental health status. The reason for restricted access to records, including the person-centered Individual Treatment Plan (ITP) and all revisions must be clearly documented. The person's record must also clearly document any alternative measures the facility has taken to ensure the person's right to participate is upheld under Subsection 304.10 of these rules. Direct care staff may not limit access unless the restriction has been incorporated into the person's ITP as stated in Section 310 of these rules. (2-22-18)T

06. Right to Refuse or Revoke. The facility must inform each person, the person's legal guardian, and the person's advocate of the right to refuse treatment or revoke consent for treatment without fear of reprisal. (2-22-18)T

a. A person, or a person's legal guardian who refuses or revokes consent for a particular treatment, such as a behavior control measure, seizure control medication, a particular intervention strategy, or a specific mode of treatment or habilitation, either verbally or in writing, must be offered information about acceptable alternatives to the treatment, if acceptable alternatives are available. (2-22-18)T

b. The person's preference about alternatives are to be elicited and considered in deciding on the course of treatment. If the person or the person's legal guardian also refuses the alternative treatment, or if no alternative exists to the treatment, the facility must consider the effect this refusal may have on the health and safety of other persons and the person himself. (2-22-18)T

c. If treatment refusals or the revocation of consent presents a significant health and safety risk to other persons or the person himself, treatment may be given over the objections of the person and the person's legal guardian when allowable according to applicable law. The decision to limit a person's rights is a clinical decision

made by the Interdisciplinary Team (IDT) as part of the person's Individual Treatment Plan (ITP) and according to physicians' orders. (2-22-18)T

d. If treatment is given over an objection, a statement explaining the reasons for such limitations must be entered in to the person's record immediately. Copies of the statement and a notice of treatment decision appeal rights must be sent to the court that committed the person, the person's attorney, the person's legal guardian, the person's advocate, and the Human Rights Committee within one (1) business day of the Interdisciplinary Team's decision. The notice of treatment decision appeal rights must include the following: (2-22-18)T

- i.** A description of how to request an appeal; (2-22-18)T
- ii.** The deadline to request the appeal and what to do if the deadline is missed; and (2-22-18)T
- iii.** The contact information of the person designated to coordinate the appeal process. (2-22-18)T

311. – 319. (RESERVED)

320. WRITTEN INFORMED CONSENT REQUIRED.

The facility must provide each person and the person's legal guardian with the information required to make an informed decision about the person's care related to the person's medical condition, developmental status, mental health status, and behavioral status. When a person does not have a legal guardian, the person's advocate must be provided sufficient information necessary to assist the person in decision-making only. The person's advocate cannot make decisions or provide consent on the person's behalf. (2-22-18)T

01. Written Informed Consent Required for Proposed Restrictive Treatment. The facility must seek the written informed consent from the person and the person's legal guardian for any restrictive treatment and other practices that may infringe on person's rights. Consents must be obtained prior to the implementation of the proposed restriction. Experimental research is not allowed. Written informed consent must be time-limited and include the following: (2-22-18)T

- a.** The specific treatment; (2-22-18)T
- b.** The reason for treatment; (2-22-18)T
- c.** The attendant risks vs. benefits of the treatment; (2-22-18)T
- d.** Alternatives to the proposed treatment; (2-22-18)T
- e.** Right to refuse the proposed treatment without fear of reprisal; (2-22-18)T
- f.** The consequences associated with consent or refusal of the proposed treatment; and (2-22-18)T
- g.** The right to revoke consent without fear of reprisal. (2-22-18)T

321. FUNCTION OF THE HUMAN RIGHTS COMMITTEE.

01. Primary Function. The primary function of the Human Rights Committee is to protect a person's rights by monitoring facility practices and programs necessary to ensure that each person's rights are protected. There must be evidence that the committee members have been provided with initial, ongoing, and refresher training on trauma-informed care principles, person-centered care principles, methods to reduce and eliminate restraint use, rights of the people residing at the facility, what constitutes a restriction of a right, and the difference between punishment and training. Initial training must be provided prior to the HRC's review of facility policies and procedures, and interventions, appeals, and grievances for persons. Refresher training must be provided annually. (2-22-18)T

02. Policies and Role of the Committee. The facility will develop policies for the committee that includes the composition of the committee members, including qualifications and what number constitutes a quorum.

The role of the committee will be outlined to include the following: (2-22-18)T

a. Review and approval, prior to implementation, of any procedure or treatment that the person or the person's legal guardian has refused or revoked, for which there is no known acceptable alternative treatment, and for which the treatment team has presented a clinical decision to limit the rights; (2-22-18)T

b. Review facility policies and practices to ensure that they are consistent with trauma-informed care principles, person-centered care principles, applicable law, and these rules and present feedback to the facility on any concerns noted; (2-22-18)T

c. Review revisions of procedures and treatments that increases the level of intrusiveness of restrictive interventions the HRC previously approved; (2-22-18)T

d. Review appeals of treatment decisions; and (2-22-18)T

e. Participate in reviewing grievances under the grievance policy. (2-22-18)T

322. DOCUMENTATION OF HUMAN RIGHT COMMITTEE REVIEW, APPROVAL, AND MONITORING.

01. Documentation of Human Rights Committee Review and Approval. Documentation to verify that the committee completed a thorough, substantive review of all restrictive practices and interventions, except environmental restrictions outlined in Section 303 of these rules. Periodic monitoring by the committee must ensure trauma-informed principles and person-centered care principles are adhered to and include the following: (2-22-18)T

a. An assessment supporting the need for the restrictive intervention; (2-22-18)T

b. Evidence the intervention has been approved for use at the facility, under policy; (2-22-18)T

c. Evidence the severity of the behavior outweighs the risks of the proposed intervention; (2-22-18)T

d. Evidence that less restrictive interventions were considered; (2-22-18)T

e. Evidence that an individualized behavior plan to reduce the need for the restrictive intervention has been developed and implemented; (2-22-18)T

f. Evidence that replacement behavior training is present and functionally related to each maladaptive behavior; (2-22-18)T

g. Evidence that the committee ensured that the person, the person's legal guardian, and the person's advocate was actively involved in the development of the assessment, proposed intervention, alternatives, plan and written informed consent from the person's legal guardian was obtained; (2-22-18)T

h. Documentation of any changes required by the committee prior to approval; (2-22-18)T

i. The frequency of the committee's review of the person's progress and approval of the restrictive intervention; and (2-22-18)T

j. The time limit of the committee's approval. (2-22-18)T

02. Documentation of Objection of Restrictive Measures Overridden. According to Subsection 310.06 of these rules, the Interdisciplinary Team (ITD) may implement restrictive measures over the objection of the person and the person's legal guardian. In those situations, the Human Rights Committee (HRC) must review the interventions and the objection (if available) prior to giving approval. The Interdisciplinary Team will not implement restrictive measures over the objection of the HRC. (2-22-18)T

323. – 399. (RESERVED)

400. STANDARD OF LICENSURE: TREATMENT AND SERVICES.

The facility must implement a person-centered Individual Treatment Plan (ITP) that is developed and designed to achieve the person's discharge from the facility at the earliest possible time. (2-22-18)T

401. ADMISSION RECORDS.

Each person's record must clearly document admission to the facility was in conformance with all admission criteria found in Title 66, Chapter 14, Idaho Code. Each person's record must include the following: (2-22-18)T

01. Documentation of Basic Information. The person's name, age, level of intellectual or developmental disability, serious mental illness diagnosis, other relevant diagnoses, who to contact in case of an emergency, and other significant events must be documented. (2-22-18)T

02. Documentation of Court Findings. Documentation from the court regarding criminal adjudication and evaluation for competency or treatment to restore competency, civil commitment to the custody of the Department, or determination of the presence of a substantial threat to the safety others if not evaluated or treated in the facility. (2-22-18)T

402. ADMISSION PROCESS.

Upon admission, each person must be immediately evaluated to ensure safe and appropriate treatment is provided upon admission. The preliminary evaluation must contain background information obtained from the person and the person's guardian and the person's advocate that includes a comprehensive trauma history and de-escalation strategy information, as well as currently valid assessments of basic functioning. (2-22-18)T

01. Medical and Physical History Assessment. Upon admission, each person must have a comprehensive medical history and physical assessment completed by the physician. At a minimum, the assessment must include the following: (2-22-18)T

- a. A complete head to toe examination of all a person's body systems; (2-22-18)T
- b. Documentation of immunization status; (2-22-18)T
- c. An assessment for the risk to a person if they require restraint, including limitations on any restraint based on the person's needs and medical condition; (2-22-18)T
- d. Orders signed by the physician for all drugs and biologicals required by the person; (2-22-18)T
- e. Documentation of any medication allergies or adverse drug reactions the person has experienced; (2-22-18)T
- f. Documentation of any food allergies and a diet order signed by the physician. (2-22-18)T

02. Comprehensive Trauma History and De-escalation Strategy Information. Upon admission, the clinical case manager must complete a comprehensive trauma history and gather information regarding strategies that may be implemented to de-escalate the person during periods of agitation and distress. Information must be obtained from the person and the person's guardian and the person's advocate. (2-22-18)T

- a. At a minimum, the trauma history must include: (2-22-18)T
 - i. Physical abuse; (2-22-18)T
 - ii. Sexual abuse and rape; (2-22-18)T
 - iii. Victimization due to other crimes; (2-22-18)T
 - iv. Neglect; (2-22-18)T

- v. Acute trauma, such as a severe accident or natural disaster; (2-22-18)T
 - vi. Witnessing a death or violence toward someone else; (2-22-18)T
 - vii. Being subjected to seclusion, including the form, frequency, and duration of the seclusion, physical restraints, including the form, frequency, and duration of restraints used, and punishment, including the form, frequency, and duration of the punishment used; and (2-22-18)T
 - viii. As applicable, what trauma-related effects the person is experiencing, such as flashbacks, nightmares, insomnia, fearfulness, self-injury or aggression, and triggering events such as yelling, hearing loud noises, a certain time of day or year, a particular task or activity, or frequent prompts to engage in activities that results in increased difficulty for the person. (2-22-18)T
- b.** At a minimum, de-escalation information must include: (2-22-18)T
- i. Identification of strategies that have worked for the person in the past, such as taking a walk with staff, listening to music, talking with someone, or deep breathing; (2-22-18)T
 - ii. Identification of other individuals who have been helpful to the person during previous upsetting situations; and (2-22-18)T
 - iii. Identification of actions or events that may cause additional distress when the person is already upset, such as being touched, being isolated, being prompted to engage in tasks or activities, or being told to calm down. (2-22-18)T

03. Assessment of Abilities and Needs. At the time of admission and upon completion of the person's trauma history and de-escalation strategy information, the clinical case manager must assess each person's basic functioning abilities and needs. All assessments must include information obtained from the person, the person's guardian, and the person's advocate and identify those areas that are deemed to be important to the person. The assessment must also incorporate all relevant information obtained from the trauma history and de-escalation strategy information, including the identification of any task, activity or event that the person may find re-traumatizing, and the psychological impacts a re-traumatizing situation may have on the person. At a minimum, assessments must include the following areas: (2-22-18)T

- a.** Basic activity of daily living skills including toileting, personal hygiene, dental hygiene, dining, bathing, dressing, grooming, and self-administration of medication; (2-22-18)T
- b.** Receptive and expressive communication of basic needs, including the person's verbal and non-verbal expression of illness, pain, and discomfort; (2-22-18)T
- c.** Supportive or adaptive equipment needs; (2-22-18)T
- d.** Mental health and behavioral status, including the person's ability to recognize, report, and cope with any symptoms they may be experiencing, which intervention strategies are recommended, and which intervention strategies to avoid. If restrictive interventions are to be implemented upon admission, the assessment must clearly document the need for the interventions; (2-22-18)T
- e.** If physical restraint is to be used, the assessment must include a trauma history, documenting any past trauma, physical, sexual or psychological abuse, and the psychological effect that restraint may have by re-traumatizing the person. The assessment must include any restraints that will not be used based on past trauma. Aftercare instructions to staff must be provided; and (2-22-18)T
- f.** Any other pertinent information that contributes to an overall understanding of the person's level and quality of functioning. (2-22-18)T

403. FORMATION OF THE PRELIMINARY PLAN.

01. Preliminary Plan Required. Immediately following the basic admission assessments, the clinical case manager must formulate a preliminary plan for staff to follow in meeting each person's immediate needs. The preliminary plan must include input from the person and the person's guardian and the person's advocate. (2-22-18)T

02. What the Preliminary Plan Must Include. From the time of admission until the time the Individual Treatment Plan (ITP) is implemented, the facility must provide those services and activities determined to be essential to the person's daily functioning as specified on the person's preliminary plan. Staff must receive specific training on the preliminary plan prior to working with the person directly. The preliminary plan must incorporate all assessment recommendations, with particular emphasis given to those recommendations which the person and the person's guardian and the person's advocate deemed to be important and those that were based on the person's trauma history and de-escalation strategy information. At a minimum, the preliminary plan must include the following:
(2-22-18)T

a. Basic information including the person's name, age, level of intellectual or developmental disability, other relevant diagnoses, and information-related areas that were identified as important to the person;
(2-22-18)T

b. Basic physical health information, including any physical health-related concerns identified by the physician in the admission history and physical, medication allergies, adverse drug reactions, medications prescribed, and times of medication administration. If PRN medications are prescribed, information must include a specific set of symptoms which indicate the need for PRN medication;
(2-22-18)T

c. Staffing and specific supervision needs, including any enhanced supervision, such as line of sight during all hours, line of sight during all waking hours except when the person is engaged in independent personal care activities, or arm's length supervision;
(2-22-18)T

d. The level of assistance staff must provide the person to perform each basic activity of daily living, and to engage in interests, activities and hobbies;
(2-22-18)T

e. Information related to food allergies and any dietary restrictions or modifications;
(2-22-18)T

f. How to communicate with the person, including the person's verbal and nonverbal expression of illness, pain, discomfort, and distress;
(2-22-18)T

g. Signs and symptoms of mental illness the person displays, what may trigger an escalation of mental health symptoms, how to intervene, and what interventions to avoid;
(2-22-18)T

h. Maladaptive behaviors the person engages in what conditions, activities, tasks, and events may result in the person engaging in maladaptive behavior, how to intervene, and what interventions to avoid. If the physician or the clinical case manager has determined there is a health or psychological risk to utilizing restraint, the Interdisciplinary Team (IDT) must insure that the preliminary plan clearly states the prohibition of restraints and must identify alternative measures to use in an emergency situation;
(2-22-18)T

i. If physical restraint is to be used, the preliminary plan must include aftercare instructions to staff;
and
(2-22-18)T

j. Any other pertinent information that contributes to an overall understanding of the person's level and quality of functioning.
(2-22-18)T

404. – 409. (RESERVED)

410. COMPREHENSIVE FUNCTIONAL ASSESSMENT.

Within fourteen (14) calendar days after admission, the Interdisciplinary Team (IDT) must have completed assessments or reassessments as needed, to supplement the preliminary assessment completed upon admission. All assessments must include information obtained from the person, the person's guardian, the person's advocate, and identify those areas that are deemed to be important to the person. All assessments must incorporate all relevant information obtained from the trauma history and de-escalation strategy.
(2-22-18)T

01. Accurate Assessment. Assessments must be accurate and administered with appropriate adaptations such as specialized equipment, use of an interpreter, use of manual communication and tests designed to measure performance in the presence of visual disability. (2-22-18)T

a. Assessment data must be current, relevant, and valid. Assessment data from assessments completed in a previous placement or as part of the court's determination to place the person in the facility can be used to meet this requirement if those assessments were completed within the past six (6) months, and the assessments are reviewed and updated for relevance and validity. (2-22-18)T

b. Stated in specific functional terms, including specific information about the person's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment; (2-22-18)T

c. Identify skills, abilities, and training needs that correspond to the person's actual, observed status; and (2-22-18)T

d. Include conclusions and recommendations on which to base Individual Treatment Plan (ITP) priority decisions. (2-22-18)T

02. Assessments Completed by Appropriate Personnel. The separate components of the comprehensive assessment must be completed by appropriate personnel. Professional expertise may fall within the purview of multiple professional disciplines, based on overlapping training and experience. The facility's policies must specify which discipline or disciplines are responsible for completing each assessment area. All personnel must receive training on trauma-informed care principles and person-centered care under Subsection 204.02 of these rules, and review the person's trauma history and de-escalation strategy information prior to conducting his portion of the comprehensive functional assessment. (2-22-18)T

411. COMPONENTS OF THE COMPREHENSIVE FUNCTIONAL ASSESSMENT.

Assessments must include identification of those functional life skills in which the person needs to be more independent and those services needed for the person to more successfully manage maladaptive behaviors and mental health symptoms. All assessments must be consistent with trauma-informed care principles and person-centered care principles, and include recommendations that actively avoid re-traumatizing the person when applicable. Components of the comprehensive functional assessments must include the following: (2-22-18)T

01. Assessment of Placement. The assessment must include an evaluation of the circumstance under which the person was admitted to the facility and the specific barrier(s) that the person must overcome in order to be discharged to a less restrictive setting. (2-22-18)T

02. Assessment of Adaptive Behavior and Independent Living Skills. To the degree possible considering the limitations in the facility, the assessment must include the effectiveness or degree with which the person meets the standards of personal independence, social responsibility, and community orientation and integration expected of his age and cultural group. (2-22-18)T

03. Assessment of Presenting Problems and Disabilities and Their Causes. The assessment must include all of the person's diagnoses and intellectual or developmental deficits and the supporting information for each. (2-22-18)T

04. Assessment of Physical Development, Health Status, Strengths, and Needs. The assessment must include the person's developmental history, results of the history, and physical examination conducted by a licensed physician, health assessment data, including a medication and immunization history, and when available, a review and summary of all laboratory reports and reports of all specialist consultations. The assessment must include the person's skill level in the monitoring and supervision of one's own health status, and the ability to administer one's own medications and treatments. (2-22-18)T

05. Assessment of Sensorimotor Development. The assessment must include motor development that

addresses those behaviors that primarily involve muscular, neuromuscular, or physical skills and varying degrees of physical dexterity, and an assessment of perceptual skills, including auditory functioning and vision, that are involved in making sense of environmental stimuli. Identified sensory deficits will be evaluated in conjunction with the impact they will have on the person's life. (2-22-18)T

06. Assessment of Adaptive Equipment. For those motor areas that are identified by the assessment as limited, the assessment will specify the extent to which corrective, orthotic, prosthetic, or support devices would impact the person's functional status and the extent of time the device is to be used throughout the day. The assessment must include the specific accommodations that address the person's needs to ensure better opportunity for the person's success. The identified accommodations may be assistive technology that can help a person to learn, play, complete tasks, get around, communicate, hear or see better, control his own environment, and take care of his personal needs (e.g. door levers instead of knobs, plate switches, audio books, etc.). (2-22-18)T

07. Assessment of Cognitive Function and Developmental Status, Strengths, and Needs. The assessment must include the person's development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning and problem solving. It is also the identification of different learning styles the person has and those best used by the trainers. It is critical that the assessment address the individual learning style of the person in order to best direct the way the trainers will teach formal and informal programs. (2-22-18)T

08. Assessment of Nutritional Status, Strengths, and Needs. The assessment must include the person's height, weight, ideal body weight, the person's eating habits, religious preferences, and accommodations, favorite foods, determination of appropriateness of diet, including the person's desire to lose or the need to gain weight, adequacy of total food intake, bowel habits, means through which the person receives nutrition, and the skills associated with eating including chewing, sucking, and swallowing disorders. (2-22-18)T

09. Assessment of Speech and Language (Communication) Development. The assessment must address both verbal and nonverbal and receptive and expressive communication skills. Assessment data must identify the appropriate intervention strategy to be applied, and which augmentative or assistive devices, if any, will improve communication and functional status. Recommendations for intervention strategies must provide the person with a viable means of communication that is appropriate to his sensory, cognitive, and physical abilities. The assessment must identify if or how frustration caused by a lack of effective means to communicate contributes to the person's maladaptive behaviors. (2-22-18)T

10. Assessment of Mental Health. Each person must receive a psychiatric evaluation that includes the person's diagnosis and treatment, to include a history of when the person's symptoms presented, were diagnosed and if possible, by whom. Information related to the effectiveness of prior treatments and information necessary to support the person's current diagnosis and treatment must be present. In those cases where the mental status portion of the psychiatric evaluation is performed by a nonphysician, there is the expectation of evidence that the nonphysician is licensed and credentialed by the facility, legally authorized by the state to perform that function, and a physician review and countersignature is present, where required by facility policy or state law. (2-22-18)T

11. Assessment of Behavioral Status, Strengths, and Needs. The assessment must address and identify the skill deficits that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports are to be done within the context of the person's age, gender, and culture. (2-22-18)T

a. The assessment must include the development of behaviors that relate to the person's interests, attitudes, values, morals, emotional feelings, and emotional expressions. (2-22-18)T

b. The functional behavioral assessment must look beyond the behavior itself. The functional behavioral assessment must identify significant person-specific physical, social, affective, cognitive, and environmental factors associated with the occurrence (and nonoccurrence) of specific behaviors. The functional behavioral assessment must identify the purpose of the specific behavior(s) and recommend interventions to directly address the function of the behavior(s). (2-22-18)T

12. Assessment to Support the Need of Restrictions. If restrictive interventions are to be used, the

assessment must clearly document the behaviors the person engages in to support the need for the restriction. If the physician or the clinical case manager has determined there is a health or psychological risk to utilizing restraint, the Interdisciplinary Team (IDT) must ensure that the assessment clearly states the prohibition of restraints and must identify alternative measures to use in an emergency situation. (2-22-18)T

412. PROFESSIONAL SERVICES AVAILABLE.

The comprehensive functional assessment must identify the course of specific interventions recommended to meet the person's needs, both through direct professional services and nonprofessional services. The person's needs identified in the comprehensive functional assessment must guide the Interdisciplinary Team (IDT) in deciding if a particular professional's involvement is necessary and, if so, to what extent professional involvement must continue on a direct or indirect basis. (2-22-18)T

413. – 419. (RESERVED)

420. INDIVIDUAL TREATMENT PLAN (ITP).

The Interdisciplinary Team, including the person, the person's legal guardian, the person's advocate, and any other individual identified as important to the person, including those identified when gathering de-escalation information, must collaboratively develop the person's Individual Treatment Plan (ITP) treatment plan within five (5) calendar days of the completion of the Comprehensive Functional Assessment. When professional assessments have been completed, recommendations to address the person's needs must be presented to the Interdisciplinary Team (IDT) at the person's ITP meeting.

01. Mandatory Participation. Professional participation may be through written reports or verbally while attending the ITP meeting, in person, via telephone, or by other electronic means. This participation provides team members with the opportunity to review and discuss information and recommendations relevant to the person's needs, and to reach decisions as a team, rather than individually, on how best to address those needs. All recommendations must be incorporated into the person's ITP, with a current prioritized objective. ITP documentation must demonstrate the person's right to participate was upheld in accordance with Subsection 304.10 of these rules. (2-22-18)T

02. Clinical Case Manager Responsibilities. Each person's treatment program must be integrated, coordinated, and monitored by a clinical case manager. The clinical case manager is ultimately responsible for the overall responsiveness and effectiveness of each person's treatment program. (2-22-18)T

03. Development of the Individual Treatment Plan (ITP). Each person must receive a continuous treatment program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services. The Individual Treatment Plan (ITP) is the outline of what the facility has committed itself to do for the person, based on an assessment of the person's needs. The plan must be consistent with trauma-informed care principles and person-centered care principles and contain the following: (2-22-18)T

- a. The person's strengths, needs, areas deemed to be important by the person, and the person's trauma history, and de-escalation strategy information; (2-22-18)T
- b. Substantiated diagnoses; (2-22-18)T
- c. Short-term and long-range goals of the desired outcomes the person is trying to achieve and projected completion dates based on the person's rate of learning; (2-22-18)T
- d. Specific, separately stated, measurable priority and secondary objectives necessary to meet the person's training needs, as identified by the comprehensive assessment; (2-22-18)T
- e. Specific, separately stated, measurable priority and secondary objectives necessary to meet the person's service and support needs, as identified by the comprehensive assessment; (2-22-18)T
- f. Specific treatment modalities utilized, with the following requirements: (2-22-18)T

- i. The focus of the treatment must be included. Simply naming modalities such as individual therapy, group therapy, occupational therapy, and medication education is not acceptable. (2-22-18)T
- ii. Modality approaches must be specifically described in order to ensure consistency of approach. Simply stating modality approaches, such as set limits, encourage socialization, and discharge planning as needed is not acceptable. (2-22-18)T
- g. Any additional adaptive equipment, assistive technology, services and supports required to meet the person's needs; (2-22-18)T
- h. The specific steps and actions that will be taken to achieve the established objectives; (2-22-18)T
- i. The responsibilities of each member of the Interdisciplinary Team; and (2-22-18)T
- j. Adequate documentation to support the diagnosis and treatment activities carried out. (2-22-18)T

421. DEVELOPMENT OF INDIVIDUALIZED WRITTEN TRAINING AND SERVICE PROGRAMS.

01. Written Training and Service Programs. Written training and service programs must be developed for each priority objective identified in the Individual Treatment Plan (ITP). (2-22-18)T

02. Program Specifications. Each written training and service programs must specify the following: (2-22-18)T

- a. The specific methods or treatment modalities to be used and those that are specifically prohibited based on the person's trauma history and de-escalation information; (2-22-18)T
- b. The schedule for use of the methods or treatment modalities; (2-22-18)T
- c. The staff member responsible for the program and identification of staff who may implement the program; (2-22-18)T
- d. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives; (2-22-18)T
- e. Any triggers, mental health symptom(s), inappropriate behavior(s), including those identified in the person's trauma history and de-escalation information, that are specifically related to the program; (2-22-18)T
- f. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior with behavior that is adaptive or appropriate, including those identified in the person's de-escalation information; (2-22-18)T
- g. A description of relevant interventions to support the person toward independence, provide opportunities for personal choice and self-management, and include the areas identified as important to the person and the person's self-identified de-escalation strategies; (2-22-18)T
- h. Identify the location where program strategy information, that must be accessible to any person responsible for implementation, can be found; and (2-22-18)T
- i. Specific instructions to staff regarding how to respond if the person refuses to engage in the activities specified in the written program. (2-22-18)T

422. REQUIRED EQUIPMENT AND SUPPLIES.

01. Equipment and Supplies. The equipment and supplies needed to implement each written program, including adaptive equipment and mechanic supports must be identified to achieve proper body position, balance, or alignment. (2-22-18)T

- 02. Plan Specifications.** The plan must specify the following: (2-22-18)T
- a.** The reason for each support; (2-22-18)T
 - b.** The situations in which each is to be applied; and (2-22-18)T
 - c.** A schedule for the use of each support. (2-22-18)T

423. IMPLEMENTATION OF THE INDIVIDUAL TREATMENT PLAN (ITP).

As soon as the interdisciplinary team has formulated a person's Individual Treatment Plan (ITP), each person must receive a continuous treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the Individual Treatment Plan (ITP) in both structured and nonstructured situations. Staff must receive specific training on the implementation of the ITP at the time of implementation. (2-22-18)T

01. Individualized Treatment Schedules. The facility must develop and implement a treatment schedule that outlines the person's treatment program, that must be readily available for review by relevant staff. Each person must be actively involved in the development of his schedule in accordance with Subsection 304.10 of these rules. (2-22-18)T

02. Professional and Licensed Staff Services. The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions under the stated objectives of each person's Individual Treatment Plan (ITP). (2-22-18)T

a. Each person must receive the professional program services needed to implement the treatment program defined by each person's Individual Treatment Plan (ITP). Professional program staff must work directly with each person. For those services that must be provided by a professional due to law, licensure, or registration, the person must receive the services directly from the professional. (2-22-18)T

b. Professional program staff must work directly with paraprofessional, nonprofessional, and other professional program staff who work directly with the person. Professionals may deliver services through the supervision and direction of subordinates where provided by law. (2-22-18)T

03. Unlicensed Staff Responsibilities. Except for those facets of the Individual Treatment Plan (ITP) that must be implemented only by licensed personnel, each person's ITP must be implemented by all staff who work with the person, including professional, paraprofessional, and nonprofessional staff. (2-22-18)T

a. An Individual Treatment Plan (ITP) may not require that professional staff perform all of the services as outlined by the ITP; and (2-22-18)T

b. Direct Care Staff may be trained by the professional staff to safely and effectively carry out the written program. In these situations, the appropriate professional must evaluate the staff's competencies in plan delivery at periodic intervals. (2-22-18)T

424. – 429. (RESERVED)

430. DATA COLLECTION.

Documentation. Each person's record must be a comprehensive, accurate representation of the person's status, care, and treatment. (2-22-18)T

01. Documented Program Data. Program data must be documented in measurable terms and collected in the form and at the frequency specified on each written program; (2-22-18)T

02. Documentation Requirements. Documentation must ensure that all therapeutic efforts received by the person are included; and (2-22-18)T

03. Significant Events. Significant events that are related to the person's Individual Treatment Plan (ITP) and assessments that contribute to an overall understanding of the person's ongoing level and quality of functioning must be documented. For all traumatic significant events, the person's trauma history must be immediately updated, the impacts of the trauma must be assessed, and the comprehensive functional assessment, ITP, and programs must be reviewed and updated under Section 440 of these rules. (2-22-18)T

431. CHRONIC, PERVASIVE REFUSALS TO PARTICIPATE.

01. Active Engagement. The facility must actively attempt to engage persons to participate in activities specified in their Individual Treatment Plans (ITPs). (2-22-18)T

02. Refusal Policies and Procedures. The facility must develop, implement, and monitor policies and procedures that address a person's chronic, pervasive pattern of refusals to participate in treatment. Policies must address the following: (2-22-18)T

a. Refusals that do not impact the person's health and safety, such as refusing to engage in housekeeping activities; and (2-22-18)T

b. Refusal that may impact a person's health and safety, such as refusing to eat, refusing to take medications, refusing vaccinations, and refusing to engage in personal and dental hygiene. (2-22-18)T

i. The facility's policies must address the circumstances under which forced compliance will be implemented, such as when a person refuses to take medications, and how forced compliance will be achieved. The person's physician must document the reason why the task or activity is necessary and critical to the person's health and safety prior to the use of forced compliance. (2-22-18)T

ii. The facility's policies must address the circumstance in which the facility must consider alternative placement options due to a person's persistent refusals to participate that jeopardizes the health and safety of the person or others or significantly impedes the facility's ability to meet the person's treatment needs. Discharge and transfer policies must adhere to Section 441 of these rules. (2-22-18)T

432. – 439. (RESERVED)

440. PROGRAM MONITORING AND CHANGE.

01. Clinical Case Manager Review and Revision. The person's comprehensive functional assessment, and Individual Treatment Plan (ITP) must be reviewed and updated by the clinical case manager at least monthly and as necessary, including situations in which: (2-22-18)T

a. The person has successfully completed an objective or objectives identified in the Individual Treatment Plan (ITP); (2-22-18)T

b. The person has regressed or lost skills already gained; (2-22-18)T

c. The person has failed to progress toward identified objectives after reasonable efforts have been made; (2-22-18)T

d. The person is being considered to work toward new objectives; or (2-22-18)T

e. The comprehensive assessment of the person's strengths and needs has changed based on the occurrence of a significant event. For all traumatic significant events, the person's comprehensive functional assessment, ITP, and programs must be reviewed and updated by the appropriate professional personnel to address the impacts of the new traumatic event. The person's record must include documentation that all changes have been communicated and discussed with the interdisciplinary team, including the person, prior to the change being made. (2-22-18)T

02. Interdisciplinary Team Review and Revision. The person's comprehensive functional assessment

and Individual Treatment Plan (ITP) must be reviewed at least every ninety (90) days by Interdisciplinary Team (IDT) and revised as necessary. The IDT review must include participation of the person, the person's guardian, and the person's advocate. (2-22-18)T

03. Interdisciplinary Team 90-Day Review. Upon completion, the IDT's 90-day review must be immediately forwarded to the Director to determine whether the person continues to meet facility criteria under Subsection 441.02 of these rules. The IDT review must include the following: (2-22-18)T

a. Documentation of review and discussion of the person's current status and significant events, including traumatic significant events and how those events have impacted the person; (2-22-18)T

b. Documentation of review and discussion of the person's progress toward all objectives and documentation of any recommendations and changes to be made to the person's treatment program; (2-22-18)T

c. Documentation of a re-evaluation of all restrictive interventions and documentation of any recommendations and changes to be made to the person's restrictive interventions; and (2-22-18)T

d. Documentation of a re-evaluation of placement at the facility. (2-22-18)T

i. Documentation must include the specific criteria supporting the continued placement of the person at the facility; or (2-22-18)T

ii. Documentation of any recommendations and changes to be made to the person's living situation, including transfer and discharge from the facility. (2-22-18)T

441. TRANSFER OR DISCHARGE FROM THE FACILITY.

Except in emergencies, the Director must have documentation in the person's record that the person was transferred or discharged for good cause. (2-22-18)T

01. Transfer or Discharge Based on Emergent Needs. If a person is deemed to need medical care or acute psychiatric care, it is the responsibility of the facility to ensure a timely transfer based on the urgent or emergency nature of symptoms or injury presentation. The person's legal guardian, advocate, and the Director must be immediately notified of the transfer or discharge based on the person's emergent needs. (2-22-18)T

a. The facility must have a transfer agreement for the immediate transfer to a hospital for persons requiring emergency medical care beyond the capabilities of the facility. (2-22-18)T

b. The facility must have a transfer agreement for the transfer to a hospital with psychiatric services for persons requiring psychiatric care beyond the capabilities of the facility. (2-22-18)T

02. Non-Emergency Discharge. Upon receipt of the Interdisciplinary Team's 90-day review under Subsection 440.03 of these rules, the Director must determine and document whether the person continues to meet secure facility program criteria. If the person no longer meets the program criteria, the Director must redispotion the person, under Section 66-1405, Idaho Code. If a person is to be either transferred or discharged, the facility must ensure the following: (2-22-18)T

a. Discharge for Good Cause. The facility must have documentation in the person's record that the person was transferred or discharged for good cause; and (2-22-18)T

b. Reasonable Preparation Time. The facility must provide a reasonable time to prepare the person, the person's legal guardian, and the person's advocate for the transfer or discharge, except in emergencies; and (2-22-18)T

c. Information Provided. At the time of transfer or discharge, medical and other information needed for care of the person in light of such a transfer, will be exchanged between the institutions according to federal and state medical privacy law, including: (2-22-18)T

- i. Any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and (2-22-18)T
- ii. A post-discharge plan of care that will assist the person to adjust to the new living environment. (2-22-18)T

442. – 499. (RESERVED)

500. STANDARD OF LICENSURE: BEHAVIOR AND FACILITY PRACTICES.

The facility must provide each person with training, and services and supports to increase his independence in the self-management of maladaptive behavior and mental health symptoms. (2-22-18)T

501. PROHIBITIONS.

The facility must not, under any circumstances, use interventions including: (2-22-18)T

- 01. Seclusion.** (2-22-18)T
- 02. Aversive Conditioning.** Adverse conditioning, including painful or noxious stimuli; (2-22-18)T
- 03. Barred Enclosures.** Barred or other enclosures that do not meet the construction requirements of a time-out room under Subsection 502.02 of these rules; (2-22-18)T
- 04. Forced Compliance.** Forced compliance for tasks and activities not related to health and safety; (2-22-18)T
- 05. Prone and Supine Restraints.** Prone, supine, and any other restraint that forces a person against a hard surface such as a wall, chair, or the floor. (2-22-18)T
- 06. Physical Interventions and Hyperextension.** Physical interventions that hyper-extend of any part of the body such as limbs, joints, fingers, and thumbs; (2-22-18)T
- 07. Physical Interventions and Pressure.** Physical interventions that include pressure points, joint or skin twisting, or applying pressure or weight to the chest, lungs, sternum, diaphragm, back, abdomen, neck, throat, any major artery, or on the back of a person's neck or head, obstructing circulation or the person's airway; (2-22-18)T
- 08. Techniques Involving the Head.** Any technique that involves using a person's head to control movement such as half nelsons, full nelsons, and headlocks; (2-22-18)T
- 09. High Risk Techniques.** Any technique that involves substantial risk of injury such as wrestling holds and take downs; (2-22-18)T
- 10. Tie-Down Devices to Stationary Objects.** Any tie-down device designed to secure a person to a stationary object, such as a bed or chair; (2-22-18)T
- 11. Law Enforcement Restraint Devices.** Any use of law enforcement restraint devices, such as handcuffs, manacles, shackles, or other chain type restraint devices; (2-22-18)T
- 12. Law Enforcement Weapons or Devices.** Any use of law enforcement weapons or devices used to subdue persons such as pepper spray, mace, nightsticks, tasers, cattle prods, stun guns, and riot gear; (2-22-18)T
- 13. Other Techniques.** Any techniques imposed as a means of coercion, punishment, convenience or retaliation by staff, or as a substitute for a treatment plan; and (2-22-18)T
- 14. Behavior Interventions.** The use of standing or as needed behavior interventions. (2-22-18)T

502. POLICIES, PROCEDURES, AND PRACTICES TO MANAGE MALADAPTIVE BEHAVIOR.

The facility must develop, implement, and monitor all practices and individualized interventions to ensure restrictive

techniques are employed with sufficient safeguards to protect each person's health, safety, and rights. Any use of restrictive interventions that is not consistent with facility policy and these rules constitutes abuse and must be immediately reported to the facility administrator under Subsection 304.02 of these rules. The failure of staff to intervene to ensure a person's health and safety constitutes neglect and must also be immediately reported to the facility administrator under Subsection 304.02(b) of these rules. All policies, procedures, and practices used to manage a person's maladaptive behavior or mental health symptoms must be approved by facility administration and reviewed by the Human Rights Committee. Policies must be available to each person, staff, guardian, and advocate and must address the following: (2-22-18)T

01. Conduct. The facility must develop, implement, and monitor written policies and procedures for the management of conduct between staff and persons. These policies and procedures must be consistent with trauma-informed care principles and person-centered care principles in creating a culture that actively supports people in having control over their own treatment throughout all levels of the facility. These policies and procedures must: (2-22-18)T

- a. Promote the growth, development, and independence of each person; (2-22-18)T
- b. Specify conduct by a person to be allowed or not allowed; and (2-22-18)T
- c. Be available to each person, staff, guardian, and advocate. (2-22-18)T

02. Interventions Approved for Use. The facility must develop, implement, and monitor written policies and procedures that identify all behavior interventions approved for use at the facility. These policies and procedures must designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive to least positive or most intrusive, and address the following: (2-22-18)T

a. Time-out room use. Exclusionary time-out procedures may include the use of a time-out room, from which egress is prevented only if the following conditions are met: (2-22-18)T

- i. The placement is part of a systematic time-out program; (2-22-18)T
- ii. Emergency placement of a person into a time-out room is not allowed unless the person's behavior places the person, staff, or others at immediate risk for harm and all other less-intrusive behavior interventions have been tried. (2-22-18)T

iii. The person is under the direct constant supervision of designated staff and the time-out is immediately discontinued if the person has an emergent need, such as needing to use the bathroom, or displays any physical signs or symptoms of distress such as seizure-like activity or labored breathing; (2-22-18)T

iv. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged; (2-22-18)T

v. Placement of a person in a time-out room does not exceed one (1) hour; (2-22-18)T

vi. Each person placed in a time-out room must be protected from hazardous conditions including the presence of sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets; (2-22-18)T

vii. A record of time-out activities must be kept; and (2-22-18)T

viii. Using a person's bedroom as a time-out room is not allowed. (2-22-18)T

b. Physical restraint use; (2-22-18)T

c. The use of drugs to manage inappropriate behavior; and (2-22-18)T

d. Forced compliance for health and safety related tasks and activities. The person's physician must document the reason why the task or activity is necessary and critical to the person's health and safety prior to the use

of forced compliance. (2-22-18)T

03. Sufficient Safeguards and Supervision. The facility must develop, implement, and monitor written policies and procedures that ensure all interventions to manage each person's inappropriate behavior or mental health symptoms are employed with sufficient safeguards and supervision to ensure that the safety, welfare, and civil and human rights of the person are adequately protected. Monitoring of all intervention strategies must be an integral part of the facility's Quality Assessment Performance Improvement Program under Section 901 of these rules. These policies and procedures must: (2-22-18)T

- a. Identify the staff members who may authorize the use of specified interventions; (2-22-18)T
- b. Include a mechanism for monitoring and controlling the use of interventions; and (2-22-18)T
- c. Include mechanisms for increased monitoring during the use of concurrent restrictive interventions such as chemical restraints used while a person is in physical restraint. (2-22-18)T

04. Incorporated into Individual Treatment Plans (ITPs). The facility must develop, implement, and monitor written policies and procedures that ensure the systematic use of behavior interventions to manage inappropriate behavior are sufficiently incorporated into each person's Individual Treatment Plan (ITP). These policies and procedures must: (2-22-18)T

- a. Specify the use of the person's individualized trauma history, de-escalation strategy, information, and mental health and behavior assessments in the development of all behavior management programs; (2-22-18)T
- b. Specify expectation for the use of less restrictive interventions; (2-22-18)T
- c. Specify restrictive programming must be designed to lead to less restrictive means of managing and eliminating the behavior for which the restriction is applied; and (2-22-18)T
- d. Specify the identification and use of replacement behaviors that are clearly related to the function of the inappropriate behavior. (2-22-18)T

503. EMERGENCY USE OF RESTRICTIVE INTERVENTION FOR EMERGENCY MENTAL HEALTH AND BEHAVIORAL REASONS.

The facility must develop, implement, and monitor written policies and procedures that govern the use of restrictive interventions in cases of emergency. These policies and procedures must be consistent with physician's orders and must: (2-22-18)T

01. Specify Restrictive Interventions. Specify which restrictive interventions may be used in the event of a behavioral or mental health emergency; (2-22-18)T

02. Ensure Appropriate Emergency Interventions. Ensure emergency interventions are only employed when absolutely necessary to protect the person or others from injury when the person is exhibiting behaviors that he has not exhibited before and were not identified in the person's mental health or behavioral assessments; (2-22-18)T

03. Specify Reporting and Documentation Requirements. Specify reporting and documentation requirements for each emergency intervention use; (2-22-18)T

04. Specify Required Re-evaluation. Specify required re-evaluation of the person's trauma history, mental health and behavioral assessments, Individual Treatment Plan (ITP), and behavior programming after each emergency intervention is used; and (2-22-18)T

05. Establish Criteria. Establish criteria to ensure interventions are incorporated into a person's Individual Treatment Plan (ITP) when it can be reasonably anticipated the intervention will be regularly used. (2-22-18)T

504. EMERGENCY USE OF RESTRICTIVE INTERVENTION FOR PHYSICAL MEDICAL EMERGENCIES AND TREATMENT.

The facility must develop, implement, and monitor written policies and procedures that govern the use of restrictive interventions for physical medical emergencies and treatment. These policies and procedures must ensure health-related protections and monitoring are prescribed by a physician, and used only if absolutely necessary for the person's protection during the time that a medical condition exists. (2-22-18)T

505. – 509. (RESERVED)

510. SUICIDE PRECAUTIONS.

The facility must develop, implement, and monitor written policies and procedures that govern the management of people who are suicidal. (2-22-18)T

01. Suicidal Ideation Indicators. The facility policies and procedures must include information to staff regarding verbal and nonverbal indicators of a person engaging in suicidal ideation. (2-22-18)T

02. Immediate Action Taken. The facility policies and procedures must address what immediate actions are to be taken in the event of suicidal ideation, threats, or attempt without significant injury, including: (2-22-18)T

- a. Increased level of supervision and monitoring; (2-22-18)T
- b. Room and property searches; (2-22-18)T
- c. Body searches; and (2-22-18)T
- d. Inventory and storage of any removed items. (2-22-18)T

03. Notifications. The facility policies and procedures must include who must be notified and documentation requirements. (2-22-18)T

04. Suicide Risk Assessment. The facility policies and procedures must include the facility's expectations for the completion of a suicide risk assessment. The policy must specify the following: (2-22-18)T

- a. The qualifications and training required to complete suicide risk assessments; (2-22-18)T
- b. When and how the initial risk assessment is to be completed; (2-22-18)T
- c. Actions to be taken in response to assessment findings; (2-22-18)T
- d. Frequency of re-evaluation; (2-22-18)T
- e. Specific criteria and documentation for decreasing supervision and monitoring; and (2-22-18)T
- f. Specific criteria and documentation for the return of any items taken. (2-22-18)T

05. Documentation. The facility policies and procedures must specify, that the person's mental health and behavioral assessment, Individual Treatment Plan (ITP), and programs must include comprehensive information and specific individualized intervention strategies for each person known to engage in suicidal ideation, or threats or actions that are person-centered and consistent with trauma-informed care principles. (2-22-18)T

06. Action for Injury or Death. The facility policies and procedures must address what immediate actions are to be taken in the event of a suicide attempt with significant injury or an actual suicide. (2-22-18)T

511. PHYSICAL RESTRAINT USE.

Restraint must only be used for the management of violent or self-destructive behavior after less restrictive interventions have failed. The use of any restraint must be immediately reported to the facility's administrator or

designee. (2-22-18)T

01. Prohibitions. All persons require a physician and a clinical case manager to assess the risk to a person if they require restraint. If the physician or the clinical case manager identifies any risk to utilizing the restraint, Interdisciplinary Team (IDT) must ensure that the Individual Treatment Plan (ITP) identifies alternative measures to use in place of physical restraint. (2-22-18)T

02. Conditions for Use. Restraint must not be used unless the use of restraint is necessary to ensure the immediate physical safety of the person, a staff member, or others. The use of restraint must be discontinued as soon as possible based on an individualized assessment and re-evaluation of the person. (2-22-18)T

a. Restraints must be designed and used so as not to cause physical injury to the person and to cause the least possible discomfort. (2-22-18)T

b. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the person, a staff member, or others from harm. (2-22-18)T

c. The use of restraint must be implemented under safe and appropriate restraint techniques by trained staff. No less than two (2) staff must be physically present for continuous visual monitoring whenever restraint is employed. The use of excessive force, unapproved restraints, or improper restraint technique constitutes abuse and must be immediately reported to the administrator under Subsection 304.02(b) of these rules. (2-22-18)T

d. If the person being restrained has an emergent need, such as needing to use the bathroom or displays any physical signs or symptoms of distress, such as labored breathing, blue color of the lips or mouth, flushing of the face or neck, pale skin color, excessive perspiration, or muscle spasms must be taken out of restraint immediately and the facility's registered nurse must be immediately notified. (2-22-18)T

e. A person must be released from physical restraint as quickly as possible. Restraints cannot be in effect longer than two (2) consecutive hours. (2-22-18)T

f. Except in emergencies, restraint must be used as an integral part of an Individual Treatment Plan (ITP) that is intended to lead to less restrictive means of managing the behavior or mental health symptoms for which restraint is used. Restraint must only be implemented according to a person's behavior management program that provides a clear description of the violent or self-destructive behavior the person engages that would warrant the need for restraint. The program must specify the following; (2-22-18)T

i. A description of the person's behavior that would indicate the need for restraint; (2-22-18)T

ii. Person-specific behavioral changes that indicate restraint is no longer necessary; and (2-22-18)T

iii. Aftercare instructions to staff regarding how to respond to and support the person after the restraint is released. (2-22-18)T

03. Monitoring and Documentation. The use of restraints and related monitoring of the person must be documented in the person's record. (2-22-18)T

a. The condition of the person who is restrained must be continuously visually monitored, in person, by no less than two (2) trained staff that have completed the training criteria specified in Subsection 204.02 of these rules. Video monitoring of restraint is not allowed. Monitoring documentation must include the following;(2-22-18)T

i. An evaluation of the person's circulation, skin integrity, hydration needs, elimination needs, breathing, level of distress, and agitation; and (2-22-18)T

ii. Entries every fifteen (15) minutes describing the continuous visual monitoring of a person in restraints. (2-22-18)T

b. Within twenty-four (24) hours or sooner as indicated by need, the nurse must complete a head to

toe examination of any person placed in restraint. Any injuries noted must be immediately reported to the facility's administrator. (2-22-18)

04. Utilization Review. An interdisciplinary team review and debriefing must be completed and documented within seventy-two (72) hours of each restraint use. If the person refuses the opportunity to participate in the restraint debriefing, the refusal must be documented. All restraint use must be reviewed in conjunction with the person's trauma history, all applicable assessments, the Individual Treatment Plan (ITP), and programs. Review must include the following: (2-22-18)T

a. An analysis of triggers, antecedent behaviors, alternative behaviors, least restrictive or alternative interventions attempted, including identification of the person's de-escalation preferences must be included. The restraint uses and any injuries noted in the nursing assessment must also be evaluated as well as the effectiveness of the aftercare the person received. A plan of correction must be developed, implemented, and monitored for any identified concerns and the person's trauma history, assessments, Individual Treatment Plan (ITP), and programs must be updated as needed. (2-22-18)T

b. An interdisciplinary team comprehensive 90-day restraint review must be completed to identify patterns and trends in restraint use, including patterns in triggering events, in times of day, or staff involved. A plan of correction must be developed, implemented, and monitored for any identified concerns and the person's trauma history, assessments, Individual Treatment Plan (ITP), and programs must be updated as needed; (2-22-18)T

c. The Human Rights Committee must review the interdisciplinary team's 90-day restraint review findings and any corrective actions taken as a result of the review. The Human Rights Committee must document agreement with the actions taken or make additional recommendations; and (2-22-18)T

d. All restraint data, including the Interdisciplinary Team (IDT) and Human Rights Committee review, must be an integral part of the facility Quality Assessment and Performance Improvement Program to reduce restraint frequency and duration and improve safety. (2-22-18)T

512. – 519. (RESERVED)

520. DRUGS USED TO MANAGE MENTAL HEALTH SYMPTOMS OR MALADAPTIVE BEHAVIOR. The facility must develop, implement and monitor policies and procedure governing the use of all drugs used for the management of mental health symptoms or maladaptive behavior, including the use of routine medications, PRN medication, and the use of emergency chemical restraints. (2-22-18)T

01. Prohibitions. Drugs used for the management of mental health symptoms or maladaptive behaviors must not be used: (2-22-18)T

a. Without justification; (2-22-18)T

b. For excessive durations that interfere with the person's daily living activities; and (2-22-18)T

c. Until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. (2-22-18)T

02. Conditions for Use. Medications used for the management of mental health symptoms or inappropriate behavior must be prescribed by a physician and administered as prescribed by trained staff who have been delegated the authority. (2-22-18)T

a. The facility must ensure emergency chemical restraints are only used when absolutely necessary to protect the person or others from injury when the person is exhibiting behaviors of a severity and intensity that he has not exhibited before. (2-22-18)T

i. The facility's registered nurse must assess the person before contacting the physician to request an emergency chemical restraint; and (2-22-18)T

ii. The physician must be contacted each time an emergency chemical restraint is requested. Standing or repeat chemical restraint orders are not allowed. (2-22-18)T

b. Except in emergencies, medications used for the management of mental health symptoms or inappropriate behavior must be approved by the Interdisciplinary Team (IDT) and be used only as an integral part of the person's behavior management program. The program: (2-22-18)T

i. Must be an integral part of the person's Individual Treatment Plan (ITP) that is directed toward the reduction of the mental health symptoms or maladaptive behavior for which the drugs are employed; (2-22-18)T

ii. Must include, for all PRN medication use, the person's ability to self-report a need for PRN medication and include PRN administration criteria based on the person's specific behavior or signs and symptoms of mental distress; and (2-22-18)T

iii. Must include specific behavioral criteria for when each medication will be increased or decreased based on the person's progress or regression towards the objectives establish in the person's Individual Treatment Plan (ITP). (2-22-18)T

03. Monitoring and Documentation. All drugs used for the management of mental health symptoms or inappropriate behavior must be documented in the person's record. (2-22-18)T

a. Drugs must be monitored closely for desired responses and adverse consequences by facility staff and in conjunction with the physician and the pharmacist. (2-22-18)T

b. If an emergency chemical restraint or PRN medication is given while a person is in physical restraint, documentation of the emergency chemical restraint or PRN effects must be completed every five (5) minutes until the physical restraint is discontinued. (2-22-18)T

c. The effectiveness of any emergency chemical restraint or PRN medication must be documented one (1) hour after the medication's administration and as needed based on peak onset of the drug. At a minimum, documentation must include pre- and post-behavior or mental health symptoms and pre- and post-assessment of the person's circulatory, respiratory, and neurological status at intervals appropriate to the drug administered. (2-22-18)T

04. Utilization Review. All emergency chemical restraint or PRN medication use must be reviewed. (2-22-18)T

a. An Interdisciplinary Team (IDT) review must be completed and documented within seventy-two (72) hours of each emergency chemical restraint or each PRN medication use to evaluate the events before, during, and after the use. If the person refuses the opportunity to participate in the review, the refusal must be documented. All chemical restraint and PRN medication use must be reviewed in conjunction with the person's trauma history, all applicable assessments, the Individual Treatment Plan (ITP), and programs. A plan of correction must be developed, implemented, and monitored for any identified concerns; (2-22-18)T

b. In conjunction with the physician, an Interdisciplinary Team (IDT) comprehensive 90-day emergency chemical restraint and PRN medication review must be completed to identify patterns and trends in use, including patterns in triggering events, in times of day, staff involved, or need to re-evaluate the person's drug regimen. A plan of correction must be developed, implemented, and monitored for any identified concerns; (2-22-18)T

c. The Human Rights Committee (HRC) must review the Interdisciplinary Team (IDT) 90-day emergency chemical restraint and PRN medication review with the drug regimen re-evaluation. The HRC must document agreement with the actions taken, or make additional recommendations; and (2-22-18)T

d. All emergency chemical restraint and PRN medication data, including the Interdisciplinary Team (IDT) and Human Rights Committee (HRC) review must be an integral part of the facility Quality Assessment and Performance Improvement Program. (2-22-18)T

521. – 599. (RESERVED)

600. STANDARD OF LICENSURE: HEALTH CARE SERVICES.

The facility must provide each person with health care services to ensure optimal levels of wellness. (2-22-18)T

601. PHYSICIAN SERVICES.

The facility must ensure the availability of physician services twenty-four (24) hours a day. (2-22-18)T

01. Physician Participation in Plan. A physician must participate in the establishment of each newly admitted person's initial Individual Treatment Plan (ITP) and, if appropriate, review and update the plan as necessary. (2-22-18)T

02. Use of Physician Assistants and Nurse Practitioners. With the exception of newly admitted persons, under Subsection 601.01 of this rule and to the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this Section. (2-22-18)T

03. Care Required. The facility must provide or obtain preventative and general care, including: (2-22-18)T

a. A complete history and physical examination upon admission, under Subsection 402.01 of these rules and no less than annually thereafter; (2-22-18)T

b. An evaluation of vision and hearing; (2-22-18)T

c. Immunizations as recommended by the Centers for Disease Control and Prevention; (2-22-18)T

d. Routine screening laboratory examinations as determined necessary by the physician; (2-22-18)T

e. Special studies when needed; and (2-22-18)T

f. Screening for tuberculosis appropriate to the facility's population. (2-22-18)T

602. NURSING SERVICES.

The facility must develop, implement, and monitor policies and procedures that delineate a person's care responsibilities for all nursing service personnel. Nursing services must be provided according to recognized standards of practice, state law, and according to each person's needs. (2-22-18)T

01. Participate in Treatment Planning. Licensed nursing staff must participate as appropriate in the development, review, and update of each person's Individual Treatment Plan (ITP) as part of the Interdisciplinary Team (IDT). (2-22-18)T

02. Quarterly Examinations. The registered nurse must review each person's health status by a direct physical examination on a quarterly or more frequent basis depending on the person's needs. The review must: (2-22-18)T

a. Be recorded in the person's record; and (2-22-18)T

b. Result in any necessary action, including referral to a physician to address health problems. (2-22-18)T

03. Provide Other Nursing Care. Nursing care will need to be completed as prescribed by the physician or identified by the person's needs and according to recognized standards of practice and state law. (2-22-18)T

04. Training. Nursing staff are to actively participate in the instruction to each person and staff in methods of infection control, in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs. (2-22-18)T

05. License to Practice. Nurses providing services in the facility must have a current license to practice in the state. (2-22-18)T

06. Sufficient for Needs. The facility must employ or arrange for licensed nursing services sufficient to care for each person's health needs. A licensed nurse, who is trained in the use of the facility's emergency equipment, must be available for emergency treatment, whenever there is a person in the facility. (2-22-18)T

07. Licensed Registered Nurses (RNs). The facility must utilize licensed registered nurses (RNs) as appropriate and required by state law to perform the health services specified in this Section. (2-22-18)T

08. Consultation. If the facility utilizes licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a licensed registered nurse (RN) to be available for verbal or onsite consultation to the licensed practical or vocational nurse. (2-22-18)T

09. Unlicensed Nursing Personnel. Unlicensed personnel who provide health care services must do so under the supervision of licensed personnel. (2-22-18)T

603. – 609. (RESERVED)

610. DENTAL SERVICES.

The facility must provide or arrange for diagnostic and treatment services for each person from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. The facility must ensure comprehensive dental treatment services that include: (2-22-18)T

01. Emergency Treatment. The availability for emergency dental treatment on a 24-hour a day basis by a licensed dentist; (2-22-18)T

02. General Dental Care. Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health; and (2-22-18)T

03. Diagnostic Services. Comprehensive dental diagnostic services must include: (2-22-18)T

a. A complete extra-oral and intra-oral examination, using all diagnostic aids necessary to properly evaluate the person's condition not later than one (1) month after admission to the facility; (2-22-18)T

b. Periodic examination and diagnosis performed at least annually; (2-22-18)T

c. Radiographs when indicated and detection of manifestations of systemic disease; and (2-22-18)T

d. A review of the results of the examination and entry of the results in the person's dental record. (2-22-18)T

611. PHARMACY SERVICES.

The facility must provide or arrange for the provision of routine and emergency drugs and biologicals for each person. Drugs and biologicals may be obtained from community or contract pharmacists. (2-22-18)T

01. Drug Regimen Review. A pharmacist with input from the Interdisciplinary Team (IDT) must review the drug regimen of each person at least quarterly. The pharmacist must: (2-22-18)T

a. Report any irregularities, black box warnings, and off-label uses in each person's drug regimens to the prescribing physician and Interdisciplinary Team (IDT); (2-22-18)T

b. Prepare a record of each person's drug regimen reviews, which must be obtained by the facility; and (2-22-18)T

c. Participate, as appropriate, in the development, implementation, and review of each person's

Individual Treatment Plan (ITP) either in person or through written report to the Interdisciplinary Team (IDT). (2-22-18)T

02. Medication Administration Record. An individual medication administration record must be maintained for each person. (2-22-18)T

03. Organized System. The facility must have an organized system for drug administration that identifies each drug up to the point of administration. The system must ensure the following: (2-22-18)T

a. All drugs are administered in compliance with the physician's orders; (2-22-18)T

b. All drugs, including those that are self-administered, are administered without error; (2-22-18)T

c. Unlicensed personnel administer only those forms of medication that state law permits; and (2-22-18)T

d. Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician. (2-22-18)T

04. Drug Storage. The facility must store drugs under proper conditions of sanitation, temperature, light, and humidity. (2-22-18)T

05. Drug Security. The facility must keep all drugs and biologicals secured according to federal and state law, except when being prepared for administration. Only authorized personnel may have access to the keys to the drug storage area. (2-22-18)T

06. Controlled Drugs. The facility must maintain records of the receipt and disposition of all controlled drugs. The facility must follow federal and state requirements for the reconciliation of controlled drugs. (2-22-18)T

07. Drug Labeling. Labeling of drugs and biologicals must be based on currently accepted professional principles and practices and include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. (2-22-18)T

08. Drugs Removed from Use. The facility must ensure outdated drugs and drug containers with worn, illegible, or missing labels are removed from use. (2-22-18)T

09. Discontinued Drugs. Drugs and biologicals packaged in containers designated for a particular person must be immediately removed from the person's current medication supply if discontinued by the physician. (2-22-18)T

10. Self-Administration of Medication. Each person is taught to administer his own medications if the Interdisciplinary Team (IDT) determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. (2-22-18)T

a. The person's physician must be informed of the Interdisciplinary Team's decision that self-administration of medications is an objective for the person; and (2-22-18)T

b. No person self-administers medication until he demonstrates the competency to do so. (2-22-18)T

612. LABORATORY SERVICES. The facility must arrange for the provision of laboratory services. (2-22-18)T

01. Certification Required. Laboratory services must be provided from a laboratory certified in the appropriate specialties and subspecialties of service necessary to meet each person's needs. (2-22-18)T

02. Waived Tests. A facility performing any laboratory service or test must have applied to and

received a Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. (2-22-18)T

613. – 699. (RESERVED)

700. STANDARD OF LICENSURE: DIETETIC SERVICES.

Each person must receive a nourishing, well-balanced diet including modified and specially prescribed diets. Unless otherwise specified by medical needs, the diet must be prepared at least according to the latest edition of the recommended dietary allowances of the Idaho Diet Manual as incorporated in Section 004 of these rules, adjusted for age, sex, disability, religious belief, and activity. Food purchase, storage, preparation, and service may be provided directly by the facility or under a written agreement with an outside service provider. If provided according to written agreement, the facility must ensure the outside service provider complies with all applicable rules. (2-22-18)T

701. QUALIFIED DIETICIAN.

A qualified dietitian must be employed full-time, part-time, or on a consultant basis at the facility's discretion. If a qualified dietitian is not employed full-time, the facility must designate a staff member to serve as the director of food services, who is a certified food protection manager. (2-22-18)T

702. MENUS.

The dietitian must ensure menus are prepared in advance, provide a variety of foods at each meal, be different for the same days of each week and adjusted for seasonal changes, and include average portion sizes for menu items. Records of food actually served must be kept on file for thirty (30) days. (2-22-18)T

703. PURCHASING AND STORAGE OF FOOD.

Food provided directly or under written agreement must be purchased and stored, as follows: (2-22-18)T

01. Food Source. All food and drink must be obtained from an approved source identified in IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments"; (2-22-18)T

02. Record of Food Purchases. At a minimum, a record of food purchases that includes invoices for the preceding thirty (30) day period must be kept; and (2-22-18)T

03. Temperature Requirements. Each refrigerator and freezer must be equipped with a reliable, easily read thermometer to ensure the following guidelines are met: (2-22-18)T

a. Refrigerators must be maintained at forty-one (41°F) degrees Fahrenheit or below; and (2-22-18)T

b. Freezers must be maintained at ten (10°F) degrees Fahrenheit or below. (2-22-18)T

704. DIET ORDERS.

The person's Interdisciplinary Team (IDT), including a qualified dietitian and physician must prescribe: (2-22-18)T

01. Modified and Special Diets. All modified and special diets, including those used as a part of a program to manage inappropriate behavior; and (2-22-18)T

02. Proposed Foods for Reinforcement of Adaptive Behavior. Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the person's nutritional status and needs. (2-22-18)T

705. FOOD PREPARATION.

Food provided directly or according to written agreement must be prepared in a safe and sanitary manner and comply with IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." Food provided directly may be prepared in a location adjacent to the facility, away from care areas. (2-22-18)T

706. FOOD SERVICE.

Each person must receive at least three (3) meals daily and nourishing snacks, at regular times comparable to normal mealtimes in the community. Food service may be provided directly or according to written agreement. (2-22-18)T

01. Food to Be Served. (2-22-18)T

- a. In appropriate quantity; (2-22-18)T
 - b. At appropriate temperature; (2-22-18)T
 - c. In a form consistent with the developmental level of the person; and (2-22-18)T
 - d. In a palatable and attractive manner. (2-22-18)T
- 02. Refusal of Food.** If a person refuses the food served, substitutions must be made within the same food group. (2-22-18)T
- 03. Uneaten Food Served.** Food served to each person individually and uneaten must be discarded. (2-22-18)T

707. DINING AREAS, EQUIPMENT, AND SUPERVISION.

Unless otherwise specified by the physician or IDT in the person's ITP, each person must receive meals in appropriately equipped dining areas. The facility must: (2-22-18)T

- 01. Provide Table Service.** Provide table service for each person who can and will eat at a table, including people who use wheelchairs; (2-22-18)T
- 02. Provide Proper Equipment and Furniture.** Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental, behavioral, and mental health needs of each person; and (2-22-18)T
- 03. Provide Sufficient Staff.** Provide sufficient staff to ensure the following: (2-22-18)T
 - a. Supervise and direct self-help dining procedures; (2-22-18)T
 - b. Ensure that each person receives enough food; (2-22-18)T
 - c. Ensure that each person eats in a manner consistent with his developmental level; and (2-22-18)T
 - d. Ensure that each person eats in an upright position. (2-22-18)T

708. – 799. (RESERVED)

800. STANDARD OF LICENSURE: PHYSICAL ENVIRONMENT.

The requirements of Sections 800 through 899 of these rules are in addition to the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety." In addition to compliance with the standards set forth herein, the facility must comply with all building codes, ordinances, and regulations that are enforced by city, county, or other local jurisdictions in which the facility is located, or will be located. (2-22-18)T

801. ENVIRONMENTAL SANITATION STANDARDS.

The facility must ensure that its environment promotes the health, safety, and treatment of each person in the facility. (2-22-18)T

802. ENVIRONMENTAL STANDARDS – WATER, SEWER, AND GARBAGE.

- 01. Water Supply.** The facility must have a water supply that is adequate, safe, and of a sanitary quality. The water supply must be from an approved public or municipal water supply. (2-22-18)T
- 02. Adequate Water Supply.** The facility must have a sufficient amount of water under adequate pressure to meet sanitary and fire sprinkler system requirements of the facility at all times, according to the requirements in IDAPA 07.02.06, "Rules Concerning Idaho State Plumbing Code," and the NFPA Life Safety Code incorporated in Section 004 of these rules. (2-22-18)T

03. Sewage Disposal. The facility must discharge all sewage and liquid wastes into a municipal sewage system. (2-22-18)T

04. Garbage and Refuse Disposal. The facility must provide garbage and refuse disposal at its facility that meets the following requirements: (2-22-18)T

a. The premises and all buildings must be kept free from accumulation of weeds, trash, and rubbish; (2-22-18)T

b. Materials not directly related to the maintenance and operation of the facility must not be stored on the premises; (2-22-18)T

c. All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material, and must not leak. Containers must be provided with tight-fitting lids unless stored in a vermin-proof room or enclosure; (2-22-18)T

d. Garbage containers must be maintained in a sanitary manner. Sufficient containers must be afforded to hold all garbage and refuse that accumulates between periods of removal from the facility; and (2-22-18)T

e. Storage areas must be kept clean and sanitary. (2-22-18)T

803. ENVIRONMENTAL STANDARDS – CHEMICALS AND PESTICIDES.

01. Rodent and Pest Control. The facility must be maintained free from insects, rodents, vermin, and other pests. (2-22-18)T

a. Chemicals and pesticides must be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer that is registered with the Idaho Department of Agriculture; and (2-22-18)T

b. Chemicals and pesticides used in the facility's pest control program must be used and stored to meet local, state, federal requirements, and must be stored outside of the facility. (2-22-18)T

02. Chemical Storage. All toxic chemicals must be properly labeled and stored outside of the building in a secured shed when not in use. Toxic chemicals must not be stored in individual areas, with drugs, or in any area where food is stored, prepared, or served. (2-22-18)T

804. ENVIRONMENTAL STANDARDS – LINENS AND LAUNDRY SERVICES.

01. Linens Provided. The facility must have available at all times a quantity of linens sufficient for the proper care and comfort of its persons according to their ITPs. The linens must: (2-22-18)T

a. Be of good quality, not threadbare, torn, or badly stained; and (2-22-18)T

b. Be handled, processed, and stored in an appropriate manner that prevents contamination. (2-22-18)T

02. Laundry Facilities. The facility must have adequate laundry facilities for the sanitary washing and drying of the linens and other washable goods laundered in the facility. A person's personal laundry must be collected, sorted, washed, and dried in a sanitary manner, and must not be washed with the general linens. The laundry area must: (2-22-18)T

a. Be situated in an area separate and apart from where food is stored, prepared, or served;(2-22-18)T

b. Be well-lighted and ventilated; (2-22-18)T

c. Be adequate in size for the needs of the facility; (2-22-18)T

- d. Be maintained in a sanitary manner; and (2-22-18)T
- e. Be kept in good repair. (2-22-18)T

805. ENVIRONMENTAL STANDARDS – HOUSEKEEPING SERVICES.

The facility must have sufficient housekeeping and maintenance personnel and equipment to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. (2-22-18)T

01. Facility Interior. Floors, walls, ceilings, and other interior surfaces, equipment, and furnishings must be maintained in a clean and sanitary manner. (2-22-18)T

02. Housekeeping Procedures. The facility must have written procedures for cleaning surfaces and equipment that is explained to each person engaged in housekeeping duties. (2-22-18)T

03. Requirements after Discharge. After discharge of a person, the facility must ensure that the person's room is thoroughly cleaned, including the bed, bedding, linens, and furnishings. (2-22-18)T

04. Deodorizers. Deodorizers and other products must not be used to cover odors caused by poor housekeeping or unsanitary conditions. (2-22-18)T

05. Housekeeping Equipment. All housekeeping equipment must be in good repair and maintained in a clean and sanitary manner. (2-22-18)T

806. – 829. (RESERVED)

830. PHYSICAL FACILITY STANDARDS CONSTRUCTION REQUIREMENTS.

The facility must comply with IDAPA 07.03.01, “Rules of Building Safety,” or with locally adopted code when more stringent. In addition to the construction and the physical facility standards for new construction, a facility must also comply with applicable Sections of these rules. Additions to existing facilities and portions of facilities undergoing remodeling or alterations other than repairs, must meet the NFPA Life Safety Code, as incorporated in Section 004 of these rules. (2-22-18)T

831. REQUIREMENTS FOR BUILDING CONSTRUCTION AND PHYSICAL STANDARDS.

The goals of these rules are to provide an environment for the occupants that are reasonably safe from fire and similar emergencies. (2-22-18)T

01. Facility Life Safety Code Requirements. (2-22-18)T

a. The facility must meet the provisions of the NFPA Life Safety Code as incorporated in Section 004 of these rules, applicable to facility. (2-22-18)T

b. The facility must be constructed to house persons and staff on the first floor only. (2-22-18)T

02. Plans and Specifications. Plans and specifications for the proposed new facility construction, any addition or remodeling are governed by the following: (2-22-18)T

a. Plans must be prepared by an architect or engineer licensed in the state of Idaho. A variance of this requirement may be granted by the Licensing and Survey Agency when the size of the project does not necessitate involvement of an architect or engineer; (2-22-18)T

b. Plans and specifications must be submitted to the Licensing and Survey Agency to ensure compliance with applicable construction standards, codes, and regulations; (2-22-18)T

c. Plans must be drawn to scale but not less than a scale of one-eighth (1/8) inch to one (1) foot; (2-22-18)T

- d. Plans may be submitted electronically; (2-22-18)T
- e. Plans must use the physical address as approved by the city; (2-22-18)T
- f. Plans must include life safety plans; (2-22-18)T
- g. Plans must include fire alarm shop drawings; and (2-22-18)T
- h. Plans must include fire sprinkler system drawings and calculations. (2-22-18)T

03. Approval by Department's Division of Licensing and Certification. The Department's Division of Licensing and Certification will review and approve plans and specifications to ensure compliance with the applicable construction standards, codes, rules, and regulations prior to beginning any construction work. (2-22-18)T

04. Toilet and Bathrooms. The facility must provide sanitary facilities that prevent self-harm to persons and include at least one (1) public toilet, tub or shower, and lavatory in each building. (2-22-18)T

- a. A toilet and bathroom for person use must be arranged so that it is not necessary for an individual to pass through another person's room to reach the toilet or bath; (2-22-18)T
- b. Solid walls must separate each toilet and bathroom from all adjoining rooms; (2-22-18)T
- c. Floors must be seamless and sealed; (2-22-18)T
- d. Mechanical ventilation must vent to the outside; (2-22-18)T
- e. Touch-tap systems must be installed for sinks; (2-22-18)T
- f. Water shutoff valve must be located outside the rooms; (2-22-18)T
- g. All light switches must be automatic; (2-22-18)T
- h. Toilet must have no exposed piping; (2-22-18)T
- i. Toilets must be of an electronic type with flood control devices; (2-22-18)T
- j. Toilets must have fixed seats; (2-22-18)T
- k. Lavatories must have solid surface material with an integral sink; (2-22-18)T
- l. Shower controls must be recessed stainless steel panels; (2-22-18)T
- m. Accessible (ADA) showers must have a dual head; (2-22-18)T
- n. Showers must be designed to prevent the need for shower curtains; and (2-22-18)T
- o. Floor drains must be sealed. (2-22-18)T

05. Electrical Installations and Emergency Lighting. Electrical installations and emergency lighting must be installed according to the manufacturer's specification and NFPA Life Safety Code and mandatory references therein, incorporated in Section 004 of these rules. (2-22-18)T

- a. Maintain all electrical equipment in good repair and safe operating condition; (2-22-18)T
- b. Electrical Panels installed inside the facility must be secured with a suitable keyed locking device and the keys must be accessible only to authorized personnel only; (2-22-18)T

c. The use of any type of extension cords, relocatable power taps, outlet strips, multi-plug adapters are strictly prohibited inside or outside the facility or facility grounds; (2-22-18)T

d. Emergency power must be arranged to provide the required power automatically in the event of any interruption of normal power; and (2-22-18)T

e. The emergency power must be arranged to automatically operate within ten (10) seconds upon failure of normal power and to maintain the necessary power source for a minimum of ninety (90) minutes. (2-22-18)T

06. Lighting. The facility must provide adequate lighting in all person's sleeping rooms, dining rooms, living rooms, recreation rooms, and hallways. (2-22-18)T

07. Ventilation. The facility must be ventilated and precautions must be taken to prevent offensive odors. (2-22-18)T

08. Plumbing. All plumbing in the facility must comply with local and state codes. All plumbing fixtures must be easily cleanable and maintained in good repair. The temperature of hot water at plumbing fixtures used by persons must be between one hundred five degrees (105°F) Fahrenheit and one hundred twenty degrees (120°F) Fahrenheit. (2-22-18)T

09. Heating, Air Conditioning, and Ventilation. Heating, air conditioning, piping, boilers, and ventilation equipment must be furnished, installed, and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes. (2-22-18)T

832. – 839. (RESERVED)

840. STRUCTURE, MAINTENANCE, EQUIPMENT TO ENSURE SAFETY.

The facility must be structurally sound, maintained, and equipped to ensure the safety of persons, personnel, and the public must be in compliance with the NFPA Life Safety Code incorporated in Section 004 of these rules. In addition, the following special requirements for secured facilities must be provided: (2-22-18)T

01. Doors. Doors must be made of a material that cannot be easily damaged by pulling off pieces that could be used for harmful purposes and must meet the requirements of the NFPA Life Safety Code and include the following requirements: (2-22-18)T

a. Door must be swing outward with hinges mounted on outside; (2-22-18)T

b. Solid core wood or steel; (2-22-18)T

c. Door handles (if applicable) must be located on the exterior of the door; (2-22-18)T

d. Lock with keyed (manual or electronic) entry only and that is equipped with a device that automatically disengages in case of an emergency; (2-22-18)T

e. All doors will limit the passage of smoke; and (2-22-18)T

f. Doors must be ligature-resistant. (2-22-18)T

02. Portable Heating Devices. Portable heating devices of any kind are prohibited to include portable electric space heaters, movable fuel-fired heaters, electric fire places, and heating pads or blankets. (2-22-18)T

03. Wall Projections. Placement of items on the wall must prohibit ligature. (2-22-18)T

a. Drinking fountains are to be secured to the wall and visible to staff; and (2-22-18)T

b. Wall mounted thermostat must not be placed in a person's room. (2-22-18)T

04. Light Fixtures. Light fixture coverings must be secure and of break-resistant material. Tamper-resistant screws or attachment devices must be used, and the light fixtures are not to create an anchor point. Lighting and other ceiling mounted items are to be recessed or surface mounted to the ceiling with vandal-resistant fixtures, pull chains are not permitted. (2-22-18)T

a. Except for emergency egress lighting, all artificial lighting must be controllable by switches or automatic sensors; (2-22-18)T

b. Lighting must be provided for all rooms and include safety features; (2-22-18)T

c. Staff must have the ability to dim the light rather than turning on a full overhead light in the room to observe the person; and (2-22-18)T

d. Light switches must be located on the outside of the person's sleeping room. (2-22-18)T

05. Window Frames. Frames must be tamper-resistant and shatter-resistant and tested to make sure that they cannot be broken apart. (2-22-18)T

06. Window Coverings. Shades or blinds must: (2-22-18)T

a. Be located inside of window panes; (2-22-18)T

b. Not contain attached cords or ropes, and curtains must not be used; (2-22-18)T

c. Have hardware that is flush with the wall; and (2-22-18)T

d. Be tamper-proof. (2-22-18)T

07. Dietary Facilities. The food service facilities and equipment must comply with IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments," and food service facilities must be designed and equipped to meet the requirements of the facility. These may consist of an onsite conventional food preparation system, a convenience food service system, or an appropriate combination thereof. (2-22-18)T

08. Functional Elements for Food Services. The following facilities must be provided and be appropriately sized to implement the type of food service system selected: (2-22-18)T

a. Control station for receiving food supplies; (2-22-18)T

b. Storage space to accommodate a one (1) week supply of staple foods and a two (2) day supply of perishable foods; (2-22-18)T

c. Food preparation facilities as required by the program. Conventional food preparation systems require space and equipment for preparing, cooking, and baking. Convenience food service systems such as frozen prepared meals, bulk-packaged entrées, individually packaged portions, or systems using contractual commissary services will require space and equipment for thawing, portioning, cooking or baking, or both; (2-22-18)T

d. Handwashing station in the food preparation area; (2-22-18)T

e. Meal service space including facilities for tray assembly and distribution; (2-22-18)T

f. Warewashing in a room or an alcove separate from food preparation and serving areas. This must include commercial type dishwashing equipment. Space must also be provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using area. Handwashing facilities must be conveniently available; (2-22-18)T

g. Pot washing facilities; (2-22-18)T

- h.** Waste storage facilities that are easily accessible for direct pickup or disposal; (2-22-18)T
- i.** Office or suitable work space for the dietitian or food service supervisor; (2-22-18)T
- j.** Toilets for dietary staff with handwashing facility immediately available; and (2-22-18)T
- k.** Janitor's closet located within the dietary department. The closet must contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. (2-22-18)T
- 09. Dining Areas.** The facility must provide one (1) or more attractively furnished, multi-purpose areas of an adequate size for person's dining, diversional, and social activities. Each area must be: (2-22-18)T

 - a.** Well-lighted; (2-22-18)T
 - b.** Ventilated; and (2-22-18)T
 - c.** Equipped with tables and chairs that are secured or heavy enough to prevent from lifting and have easily cleanable surfaces. (2-22-18)T
- 10. Bathroom Accessories.** (2-22-18)T

 - a.** Mirrors in a person's bathrooms must be reflective polycarbonate with a stainless steel frame firmly anchored to the wall. No shelf is to be part of this frame assembly; (2-22-18)T
 - b.** Toilet paper holder must be ligature-resistant spindle button recessed; (2-22-18)T
 - c.** Grab bars, as required for accessible rooms, must be fixed to the wall with a welded horizontal plate on the bottom of the bar. No swinging grab bars are to be used; (2-22-18)T
 - d.** Clothing or towel hooks must be designed to collapse when any weight above four (4) pounds; (2-22-18)T
 - e.** Paper towel dispensers, if installed, must be recessed; and (2-22-18)T
 - f.** Soap dispensers must be wall-mounted with sloped tops or a suitable recessed dispenser. (2-22-18)T
- 11. Storage Areas.** The facility must provide general storage areas. (2-22-18)T

 - a.** Suitable storage must be provided for personal clothing, possessions, and individual adaptive equipment; (2-22-18)T
 - b.** Safe and adequate storage space must be provided for medical supplies and an area appropriate for the preparation of medications; and (2-22-18)T
 - c.** Medical gases must be stored and labeled in racks or fastenings to protect cylinders from accidental damage or dislocation. (2-22-18)T
- 12. Accessibility for Persons with Mobility and Sensory Impairments.** For persons with mobility or sensory impairments, the facility must provide a physical environment that meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. Construction must meet the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities must comply, to the maximum extent feasible, with 28 CFR Sections 36.304 and 36.305 regarding removal of barriers according to the Americans with Disabilities Act, without creating an undue hardship or burden on the facility, and must provide as required, the necessary accommodations: (2-22-18)T

a. Ramps for persons who require assistance with ambulation must comply with the requirements of the ADAAG; and (2-22-18)T

b. Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the ADAAG 4.13. (2-22-18)T

13. Emergency Medical Equipment. The facility medical staff and program administration must develop, implement, and monitor policies and procedures to specify the types of emergency equipment required for use in the facility and must be immediately available for use during emergency situations and be appropriate for the facility's population. The facility as a minimum must be able to provide a suction machine, AED, and crash cart. (2-22-18)T

841. PHYSICAL FACILITY STANDARDS – PROTECTION.

The facility must meet the provisions of NFPA Life Safety Code, as incorporated in Section 004 of these rules, applicable to facility. In addition, the following special requirements for the facility must be included: (2-22-18)T

01. Manual Fire Alarm Pull Stations. Manual fire alarm pull stations can be permitted to be locked, provided that staff is present within the area when it is occupied and staff has keys readily available to unlock the boxes. (2-22-18)T

02. Alarm Notification. Alarm notification (audible and visible) must be provided throughout the entire facility and must be ceiling-mounted. (2-22-18)T

03. Fire Sprinkler Systems. For the purpose of this rule, the facility must meet the provisions of NFPA Life Safety Code, as incorporated in Section 004 of these rules, as applicable to facility. (2-22-18)T

04. Portable Fire Extinguishers. For the purposes of this rule, the facility must meet the applicable provisions of NFPA Life Safety Code, as incorporated in Section 004 of these rules. In addition, the facility must meet the following special requirements: (2-22-18)T

a. Access to portable fire extinguishers must be locked and key must be with all staff members; (2-22-18)T

b. Portable fire extinguishers can be permitted to be located at staff locations and be provided locked and keyed; and (2-22-18)T

c. All staff members must be instructed in the proper use of portable fire extinguishers and other manual fire suppression equipment annually and new staff promptly upon commencement of duty. (2-22-18)T

05. Generators. The facility must ensure that the building generator is designed to meet the applicable codes in NFPA Life Safety code, NFPA 99, Health Care Facilities Code, and NFPA Standard # 110, Standard for Emergency and Standby Power Systems 2010 Edition, as incorporated in Section 004 of these rules, applicable to this facility. (2-22-18)T

842. PHYSICAL FACILITY STANDARDS – INDIVIDUAL SLEEPING ROOMS AND ACCOMMODATIONS REQUIREMENTS.

The facility must furnish and maintain in good repair accommodations for each person as incorporated in Section 004 of these rules, applicable to this facility. In addition, the facility must meet the following special requirements: (2-22-18)T

01. Personal Rooms. Personal sleeping rooms are not in attics, stairs, halls, or any other room commonly used for other than bedroom purposes, and must have direct access to an exit corridor; (2-22-18)T

02. Bed Requirements. (2-22-18)T

a. Beds must have a mattress and be low-profile type so that it cannot be used by the person to reach the ceiling. (2-22-18)T

- b.** Beds must be a heavy-duty platform bed with rounded edges and bolted to the floor and must be of proper size and height for convenience of person; (2-22-18)T
- c.** Beds and bedding must be clean and appropriate to weather and climate; (2-22-18)T
- d.** Beds must not contain anchor points or floor guards that can be removed by persons and used as a weapon or for self-harm; (2-22-18)T
- e.** Pillows and mattresses must not have covers that can be easily removed by the person and used for suffocation; and (2-22-18)T
- f.** Beds must have nonelastic fitted sheets or a standard flat bed sheet. (2-22-18)T
- 03. Closet Requirements.** Closets must contain racks, shelves accessible to persons, secured with tamper-resistant fasteners, and designed so they cannot be used as an anchor point. (2-22-18)T
- 04. Activity Areas.** The facility must provide recreational space. (2-22-18)T

 - a.** Equipment used by persons while supervised, such as computer equipment, and other facility equipment, must be located in rooms that can be locked when not in use. (2-22-18)T
 - b.** Activity areas must be free of all protrusions, sharp corners, hardware, fixtures, or other devices. (2-22-18)T
- 05. Outdoor Environment.** Security and safety for outdoor spaces used by persons are as follows: (2-22-18)T

 - a.** A courtyard is preferred over fenced areas for aesthetic, privacy, and security reasons. If a fence is utilized, it is to be securely anchored at the bottom; (2-22-18)T
 - b.** A minimum enclosure height of fourteen (14) feet (4.27 meters), if applicable; (2-22-18)T
 - c.** Exits, service gates, or doors are to be strong enough to withstand force and are to be locked and alarmed; (2-22-18)T
 - d.** Trees within the area must not facilitate climbing over a wall or fence; (2-22-18)T
 - e.** Shrubs are to be small and low enough that a person cannot hide behind them; (2-22-18)T
 - f.** Do not use rocks, gravel, dirt, and other planting bed or pathway materials that could be used as a weapon; (2-22-18)T
 - g.** Outdoor furniture will either be anchored to concrete pads or too heavy to be moved and must be located to prevent escape; (2-22-18)T
 - h.** All exposed fasteners in the courtyard area must receive tamper-resistant screws; and (2-22-18)T
 - i.** Exterior light poles must be prohibited near the exterior perimeter of the enclosed yard or courtyard. (2-22-18)T

843. FIRE AND LIFE SAFETY STANDARDS – EMERGENCY EGRESS AND RELOCATION. Emergency egress and relocation standards must be maintained according to the code and mandatory references therein, incorporated in Section 004 of these rules. In addition, the facility must meet the following special requirements: (2-22-18)T

- 01. Exits.** All exits must discharge into a fenced or walled courtyard, provided that not more than two

(2) walls of the courtyard are the building walls from which egress is being made. (2-22-18)T

02. Enclosed Yards or Courtyards. Courtyards used for exit discharge must be of sufficient size to accommodate all occupants at a distance of not less than fifty (50) feet. (2-22-18)T

03. Furnishings, Decorations, or Other Objects. No items may be placed to obstruct exit access, exits, or exit discharge; (2-22-18)T

04. Access. Doors leading to the exterior must be permitted to be locked with key locks. The keys to unlock such doors must be maintained and available at the facility at all times, and the locks must be operable from the outside. (2-22-18)T

a. All keys necessary for unlocking doors installed in a means of egress must be individually identified by both touch and sound. (2-22-18)T

b. Where egress doors are locked with key-operated locks, doors and door hardware used for egress must be inspected monthly. (2-22-18)T

c. A manual release is required on both sides of the locked doors. (2-22-18)T

844. FIRE AND LIFE SAFETY STANDARDS – OPERATING FEATURES.

Operating feature standards must be maintained according to the code and mandatory references therein, incorporated in Section 004 of these rules. In addition, the facility must meet the following special requirements: (2-22-18)T

01. Emergency Plans. The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters. (2-22-18)T

a. The written emergency plan for the facility must contain a diagram of the building showing emergency protection equipment, evacuation routes, exits, and assembly points. This diagram must be conspicuously posted in a common area within the facility. An outline of emergency instructions must be posted with the diagram. (2-22-18)T

b. A written fire safety plan must provide for all of the following: (2-22-18)T

i. Use of alarms; (2-22-18)T

ii. Transmission of alarms to fire department; (2-22-18)T

iii. Emergency phone call to fire department; (2-22-18)T

iv. Response to alarms; (2-22-18)T

v. Isolation of fire; (2-22-18)T

vi. Evacuation of immediate area; (2-22-18)T

vii. Evacuation of smoke compartment (if applicable); (2-22-18)T

viii. Preparation of floors and building for evacuation; and (2-22-18)T

ix. Extinguishment of fire. (2-22-18)T

c. The facility must periodically review the written emergency plan and thoroughly test it to ensure rapid and efficient function of the plan. (2-22-18)T

d. The facility must hold unannounced evacuation drills at least quarterly for each shift of personnel for a total of no less than twelve (12) per year. The evacuation drills must be irregularly scheduled throughout all

shifts and under varied conditions. The facility must actually evacuate persons into the secured courtyard or secured fenced area during at least one (1) drill each shift for each month. (2-22-18)T

e. The facility must document evacuation drills, cite the problems investigated, and take the appropriate corrective action for the identified problems. (2-22-18)T

02. Report of Fire. The facility must submit to the Department's Division of Licensing and Certification a separate report of each fire incident that occurs within the facility within ten (10) days of the occurrence. The facility must use the Department's Division of Licensing and Certification's reporting form, "Facility Fire Incident Report," available online at: <http://www.facilitystandards.idaho.gov>. The facility must provide all specific data concerning the fire including the date, origin, extent of damage, method of extinguishment, and injuries, if any, for each fire incident. A reportable fire incident is when the facility has an incident that: (2-22-18)T

a. Causes staff to activate the facility emergency plan, in whole, or in part; (2-22-18)T

b. Causes an alarm throughout, causing staff or persons to activate the facility emergency plan, in whole, or in part; (2-22-18)T

c. Causes a response by the fire department or emergency services to investigate an alarm or incident; (2-22-18)T

d. Is unplanned in which persons are evacuated, prepared to evacuate, partially evacuated, or protected in place, due to smoke, fire, unknown gases/odors, or other emergency; or (2-22-18)T

e. Results in an injury, burn, smoke inhalation, death, or other fire or emergency-related incident. (2-22-18)T

03. Fire Watch. The facility must institute a fire watch during any time the fire alarm, smoke detection system is inoperable for greater than four (4) hours in a twenty-four (24) hour period, or during any time the fire sprinkler system is out of service for more than ten (10) hours in a twenty-four (24) hour period, or both. (2-22-18)T

04. Smoking Regulations. Facility policies and procedures must include whether smoking is allowed. If the facility policy allows smoking, smoking regulations must be adopted and must include the following provisions: (2-22-18)T

a. Smoking must be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas must be posted with signs that read "NO SMOKING" or must be posted with the international symbol for no smoking. (2-22-18)T

b. Smoking by persons classified as not responsible must be under direct supervision of a staff member. (2-22-18)T

c. Ashtrays of noncombustible material and safe design must be provided in all areas where smoking is permitted. (2-22-18)T

d. Metal containers with self-closing cover devices into which ashtrays can be emptied must be readily available to all areas where smoking is permitted. (2-22-18)T

845. – 859. (RESERVED)

860. VEHICLES.

The facility must develop, implement, monitor, and maintain a written vehicle safety policy for each vehicle owned, leased, or used. The facility must have vehicle safety equipment, policies, and staffing requirements that meet the following requirements: (2-22-18)T

01. Preventative Maintenance Program. The establishment of a preventative maintenance program

for each vehicle; (2-22-18)T

02. Vehicle Inspections. Vehicle inspections and other regular maintenance needed to ensure person's safety; (2-22-18)T

03. Accessory Inspections. Inspection of wheelchair lifts, securing devices, and other devices necessary to ensure person's safety. (2-22-18)T

04. Fire Extinguishers, Maintenance, and Inspections. Vehicle mounted fire extinguishers must be inspected when initially placed in service and in thirty (30) day intervals, and must be subject to maintenance at intervals of not more than one (1) year. (2-22-18)T

05. Staff Requirement. There must be two (2) staff members assigned for transport of each person; and (2-22-18)T

06. Driver. One (1) driver. (2-22-18)T

861. – 869. (RESERVED)

870. INFECTION CONTROL.

The facility must provide a sanitary environment to avoid sources and transmission of infections. The facility must provide the following: (2-22-18)T

01. Active Program Requirement. Develop, implement, and monitor an active program for the prevention, control, and investigation of infection and communicable diseases; (2-22-18)T

02. Implement Corrective Action. Implement successful corrective action in affected problem areas; (2-22-18)T

03. Record of Incidents and Corrective Action. Maintain a record of incidents and corrective actions related to infections; (2-22-18)T

04. Employee with Signs of Illness. Prohibit employees with symptoms or signs of a communicable disease from direct contact with persons and their food; and (2-22-18)T

05. Reportable Diseases. Report diseases as required according to state law. (2-22-18)T

871. – 899. (RESERVED)

900. STANDARD OF LICENSURE: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT.

The facility must develop, implement, and maintain an ongoing and data-driven Quality Assessment and Performance Improvement (QAPI) program. (2-22-18)T

901. PROGRAM SCOPE AND DATA COLLECTION.

The program must be ongoing and demonstrate measurable improvement in a person's outcomes and safety by using quality indicators or performance measures. (2-22-18)T

01. Data Collection. The facility must collect quality indicator data in sufficient form and frequency to determine the quality of services and identify opportunities for improvement. Quality indicators must include: (2-22-18)T

a. Quality of services provided directly and under agreement including an adherence to trauma informed care principals and person centered care principals; (2-22-18)T

b. Incidents and accidents; (2-22-18)T

- c.** Grievances; (2-22-18)T
- d.** Allegations of abuse, neglect, and mistreatment; (2-22-18)T
- e.** Physical restraint use, including emergency use; (2-22-18)T
- f.** Medication to manage mental health or inappropriate behavioral use, including emergency chemical restraints and as needed medications; and (2-22-18)T
- g.** Areas identified by the facility as high-risk, high-volume, or problem-prone based on the prevalence and severity of incidents and negative impacts to a person's safety and quality of care. (2-22-18)T
- 02. Establish Measurable Goals.** The facility must establish measurable goals for all quality indicators that are being tracked. (2-22-18)T
- 902. PROGRAM DATA ANALYSIS.**
Quality indicator data must be regularly analyzed to: (2-22-18)T

 - 01. Monitor Effectiveness and Safety.** Monitor the effectiveness and safety of the facility's services and quality of care; and (2-22-18)T
 - 02. Identify Opportunities.** Identify opportunities that could lead to improvements and changes in a person's care that include those areas that are not meeting established goals. (2-22-18)T
- 903. IMPLEMENTING AND MONITORING CHANGES MADE AS A RESULT OF DATA ANALYSIS.**
Based on the data analysis, the facility must: (2-22-18)T

 - 01. Develop Changes.** Develop and implement changes in areas identified in need of improvement (2-22-18)T
 - 02. Monitor to Ensure that Changes Were Effective.** Monitor to ensure the changes were effective in achieving established goals; and (2-22-18)T
 - 03. Monitor to Ensure Changes Are Sustained.** Monitor to ensure that improvements are sustained over time. (2-22-18)T
- 904. PERFORMANCE IMPROVEMENT PROJECTS.**
A distinct improvement project must be conducted annually. The facility must document: (2-22-18)T

 - 01. The Projects.** The project(s) that are being conducted; (2-22-18)T
 - 02. The Reasons.** The reason(s) for implementing the project; and (2-22-18)T
 - 03. Description.** A description of the project's results. (2-22-18)T
- 905. – 999. (RESERVED)**