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**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES**

**12VAC35-107 – Residential Services Chapter**

**CHAPTER 107**

**GENERAL RULES AND REGULATIONS FOR LICENSING PROVIDERS BY THE  
DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES**

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## **Article 1. General Provisions.**

### **12VAC35-107-10. Definitions.**

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Allied health professionals" means professionals who are involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as certified substance abuse counselors, certified substance abuse counseling assistants, peer recovery support specialists, certified nursing assistants, and occupational therapists.

"ASAM" means the American Society of Addiction Medicine.

"Behavior intervention" means those practices utilized by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in an individualized and safe manner. Behavior intervention practices shall be utilized in accordance with the individualized services plan; the provider's written policies and procedures governing safety (crisis prevention and intervention); and service expectations. The plan shall utilize the least restrictive treatment possible, and shall be based upon practices that are effective, therapeutic, and informed by evidence.

"Behavioral treatment plan," "functional plan" or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of systematic data collection, which analyzes the variables that are maintaining challenging behavior, such as a functional behavior assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness through the development of new or currently underutilized skills;
2. Alleviation of symptoms of psychopathology; and
3. Reduction of challenging behaviors.

"Brain injury" as defined by §37.2-403 of the Code of Virginia means any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care" or "treatment" "or support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

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"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs and desires. Case management services include: identifying potential users of the service; assessing needs and planning services using a person centered approach; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery and revising the service plan as indicated; discharge planning; and monitoring and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential future service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Clinically managed high-intensity residential care" means a substance use treatment program that offers 24 hour supportive treatment of individuals with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. A clinically managed high-intensity residential care program provides treatment to individuals who present with significant challenges, such as physical, sexual, or emotional trauma; past criminal or antisocial behaviors, with a risk of continued criminal behavior; an extensive history of treatment; inadequate anger management skills; extreme impulsivity; and antisocial value system.

"Clinically managed low-intensity residential care" means providing an ongoing therapeutic environment for individuals requiring some structured support in which treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education, and family life, and adaptive skills that may not have been achieved or have been diminished during the individual's active addiction. Such programs must offer at least five hours per week of low-intensity treatment the focus of which is stabilizing the individual's substance use disorder. Clinically managed low-intensity residential care is also designed for the individual suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system. All individuals served by the residential care service shall have access to the substance use treatment program.

"Clinically managed high-intensity residential care" means a substance use treatment program that offers 24 hour supportive treatment of individuals with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. The individuals served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service. All individuals served by the residential care service shall have access to the substance use treatment program. A clinically managed high-intensity residential care program is particularly suitable for treatment of individuals who present with physical, sexual, or emotional trauma; a constellation of past criminal or antisocial behaviors; risk of continued criminal behavior;

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an extensive history of treatment; inadequate anger management skills; extreme impulsivity; and antisocial value system.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually age 65 or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health related services.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, substance abuse (substance use disorders), or brain injury.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board : (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed psychiatric clinical nurse specialist; (viii) a licensed psychiatric nurse practitioner; (ix) a licensed marriage and family therapist; (x) a licensed substance abuse treatment practitioner; (xi) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xii) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); (xiii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

"Department" means the Virginia Department of Behavioral Health and Developmental Services.

"Developmental disability" as defined by § 37.2-100 of the Code of Virginia means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas

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of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine years, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) of this definition if the individual, without services and supports, has a high probability of meeting those criteria later in life.

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

"Diagnostic and Statistical Manual of Mental Disorders" or "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, of the American Psychiatric Association.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling or compounding necessary to prepare the substance for that delivery (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency services (crisis intervention)" means unscheduled and sometimes scheduled crisis intervention, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services shall provide immediate mental health care in the most appropriate and least restrictive environment available to include the home or community to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention or experiencing crisis events originating from behavioral or mental health support needs. Emergency services shall include assessment, short-term counseling designed to stabilize the individual and care coordination. Emergency services also may include walk-ins, home visits, office visits, jail interventions, and preadmission screening activities associated with the judicial process or telephone contacts.

"Group home or community residential service" means a congregate service providing 24-hour direct awake supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

"Individual" or "individual receiving services" as defined by § 37.2-100 of the Code of Virginia means a current direct recipient of public or private mental health, developmental, or substance

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abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client." When the term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services. An assessment is not a service.

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and his authorized representative, as applicable, and the provider with the intent of empowering the individual and his authorized representative to make decisions that will lead to positive service outcomes.

"Initial individualized service plan" or "Initial ISP" means a written plan developed and implemented within 24 hours of admission to address immediate service, health, and safety needs as identified within the individual's initial assessment.

"Intellectual disability" as defined by § 37.2-100 of the Code of Virginia means a disability, originating before the age of 18 years, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

"Intensity of Service" means the number, type, and frequency of staff interventions and other services provided during treatment at a particular level of care.

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified

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psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

"Location" means a place where services are or could be provided.

"Medically managed intensive inpatient service" means an organized service delivered in an acute care general hospital, psychiatric unit in a general hospital, or a free-standing psychiatric hospital, which shall be available to all individuals within that setting. This level of care is appropriate for individuals whose acute biomedical and emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Services at this level of care are managed by a physician who is responsible for diagnosis, treatment and treatment plan decisions in collaboration with the individual.

"Medically monitored intensive inpatient treatment" means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical personnel. The care provided shall include directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. The care shall be available to all individual within the inpatient setting. The care provided may include the use of medication to systematically eliminate or reduce effects of substance use. This program is appropriate for an individual whose detoxification, withdrawal, and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment but who does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the legally permitted direct application of medications by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications, as enumerated by § 54.1-3408 of the Code of Virginia. .

"Medication assisted opioid\_treatment" means an intervention strategy that combines outpatient treatment with the administering or dispensing of synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

"Medication assisted treatment" or "MAT" means the use of FDA-approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication assisted treatment includes but not limited to medication assisted opioid treatment.

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

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"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Mental illness" as defined by § 37.2-100 of the Code of Virginia means a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Motivational enhancement" means a person-centered approach that is collaborative, employs strategies to strengthen motivation for change, increases engagement in substance use services, resolves ambivalence about changing substance use behaviors, and supports individuals to set goals to change their substance use.

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

"Provider" as defined by § 37.2-403 of the Code of Virginia means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601 and 54.1-3701 of the Code of Virginia.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, ICF/IID, sponsored residential homes, medical detoxification, neurobehavioral services, and substance abuse residential treatment for women and children.

"Residential treatment service" means providing an intensive and highly structured clinically based mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders in a residential setting, other than an inpatient service.

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"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for assessment.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave it. Seclusion shall only be utilized within an inpatient hospital and only in an emergency.

"Service" as defined by § 37.2-403 of the Code of Virginia means (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Specific high-intensity residential services" means a substance use treatment program that provides a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of individuals. The functional limitations of individuals who are placed within this level of care are primarily cognitive and can be either temporary or permanent.

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.

"Substance abuse (substance use disorders)" as defined by § 37.2-100 of the Code of Virginia means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse residential treatment for women with children service" means a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.

"Supervised living residential service" means the provision of direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence. Staff is available on a 24-hour basis and provides daily monitoring. Services are provided based on the needs of the individual in areas

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such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

### **12VAC35-107-20. Services.**

Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. The following services shall require a residential license:

1. Clinically managed high-intensity residential services ;
2. Clinically managed low-intensity residential services;
3. Clinically managed population-specific high-intensity residential services;
4. Community gero-psychiatric residential services;
5. Group home;
6. ICF/IDD;
7. Inpatient;
8. Medically managed intensive inpatient service;
9. Medically monitored intensive inpatient service;
10. Respite residential;
11. Substance abuse residential treatment for women with children service
12. Sponsored residential home; and
13. Supervised living.

### **12VAC35-107-30. Service descriptions.**

- A. Clinically managed high-intensity residential services includes services that provide 24-hour supportive treatment in an environment to initiate or continue a recovery process that has failed to progress. Clinically managed high-intensity residential services are characterized by their reliance on the treatment community as a therapeutic agent. These services include therapeutic community with appropriately clinically trained staff or a residential treatment center.
- B. Clinically managed low-intensity residential services includes low-intensity treatment of substance-related disorders. Treatment is characterized by services such as individual, group and family therapy; medication management; and psychoeducation. These services include halfway houses, group homes, and other supportive living environments with 24-hour staff and close integration with clinical services.
- C. Clinically managed population-specific high-intensity residential services include a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of patients to support recovery from substance related disorders. These services include therapeutic rehabilitations facilities and traumatic brain injury programs.
- D. Community gero-psychiatric residential services includes 24 hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually age 65 or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home.
- E. Group home services includes 24-hour direct awake supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living.

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- F. ICF/IDD includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status.
- G. Inpatient service includes intensive 24 hour medical, nursing, and treatment services provided to individuals with developmental disabilities, mental illness or substance use disorders in a hospital or in a special unit of a hospital.
- H. Medically managed intensive inpatient includes service delivered in an acute care inpatient setting. Such a program includes a regimen of medically directed evaluation and treatment services, provided in a 24-hour treatment setting. These services include acute care general hospitals, an acute psychiatric hospital or psychiatric unit within an acute care general hospital and a licensed addiction treatment specialty hospital with acute care medical and nursing staff.
- I. Medically monitored intensive inpatient includes planned and structured regimen of 24 hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. Medically monitored intensive inpatient includes an inpatient treatment center within the context of an acute care hospital or acute psychiatric unit, or a separate more intensive unit of a freestanding residential facility.
- J. Respite residential includes providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular care giver within a residential setting.
- K. Substance abuse residential treatment for women with children service includes 24-hour residential service providing an intensive and highly structure substance abuse service for women with children who live in the same facility.
- L. Sponsored residential home includes a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.
- M. Supervised living includes the provision of direct supervision and community support services to individuals living in apartments or other residential settings.

#### **12VAC35-107-40. Screening.**

- A. Providers shall implement screening policies and procedures that include:
  - 1. Identification, qualification, training and responsibilities of employees responsible for screening;
  - 2. Minimum required elements of screening for a residential setting including:
    - a. Date of contact;
    - b. Name, date of birth, biological sex and gender identity of the individual;
    - c. Address and telephone number of the individual, if applicable;
    - d. Reason why the individual is requesting services;
    - e. Current diagnoses;
    - f. Medical symptoms;
    - g. Psychoactive and other medications currently being used, including recent increases, decreases or discontinuation, misuse or overdose of prescription medication;
    - h. Recent or current substance use or dependence including risk for intoxication or substance withdrawal; and

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- i. Status of the individual including his referral to other services, further assessment, placement on a waiting list for service or admission to the service.
  3. Methods to assist individuals who are not admitted to identify other appropriate services.
- B. The provider shall retain documentation of the individual's screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service.

### **12VAC35-107-50. Secondary screening.**

A. In the event that an individual has been placed on a waitlist prior to receiving services a secondary screening shall be performed prior to admission to the service. The provider shall document:

1. Any changes to the individual's address and telephone since the individual's screening, if applicable;
2. Any changes to the individual's emergency contact;
3. Any changes to the reason why the individual is requesting services, since the individual's screening, if applicable;
4. Any changes or updates to the individual's current diagnoses, since the individual's screening;
5. Any changes or updates to the individual's medical symptoms, since the individual's screening;
6. Changes or updates to medications the individual has used since the individual's screening; and
7. Changes to the individual's substance use or dependence, including risk for intoxication or substance withdrawal, since the individual's screening.

B. The secondary screening shall be performed by qualified employees, as outlined in the provider's policy as required by 12VAC35-107-40.

C. Documentation shall be included in the individual's record.

### **12VAC35-107-60. Assessment.**

A. The provider shall implement a written assessment policy. The policy shall define how assessments will be conducted and documented.

B. The provider shall actively involve the individual and authorized representative, if applicable, in the preparation of initial and comprehensive assessments. In these assessments, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The assessment policy shall designate appropriately qualified employees or contractors who are responsible for conducting, obtaining or updating assessments and medical screenings. These employees or contractors shall have experience in working with the needs of individuals

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who are being assessed, the assessment tool or tools being utilized, and the provision of services that the individuals may require.

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history.

E. Providers shall utilize standardized state or federally sanctioned assessment tools as approved by the department, or utilize their own assessment tools that shall meet the requirements laid out in subsection F for an initial assessment, and subsection G for a comprehensive assessment.

F. 1. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall complete, or obtain information from other qualified providers in order to complete, an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service. The initial assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's:

- a) Diagnosis;
- b) Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs;
- c) Current medical issues;
- d) Current medications;
- e) Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders;
- f) At-risk behavior to self and others; and
- g) Risk factors that will impact the individual's ability to seek treatment or continue to participate in services.

2. For providers treating substance use disorder, at the time of the initial assessment the provider shall:

- a) Identify individuals with a high-risk for medical complications or who may pose a danger to themselves or others;
- b) Assess substances used and time of last use;
- c) Document time of last meal;
- d) Analyze blood alcohol content or administer a breathalyzer; and
- e) Record vital signs.

3. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements noted within subsection G. In the event a comprehensive assessment is completed at the time of an initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

G. A comprehensive assessment shall update and finalize the initial assessment, unless the comprehensive assessment is completed at the time of initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for providers of mental health and

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substance abuse services and 60 days after admission for providers of developmental services. It shall address:

1. Onset and duration of needs;
2. Social, behavioral, developmental, and family history and supports;
3. Cognitive functioning including strengths and weaknesses;
4. Employment, vocational, and educational background;
5. Previous interventions and outcomes;
6. Financial situation, financial resources, financial support and benefits, and whether the individual has the means to meet their financial needs;
7. Health history and current medical care needs, to include:
  - a. Allergies;
  - b. Recent physical complaints and medical conditions;
  - c. Nutritional needs;
  - d. Chronic conditions;
  - e. Communicable diseases;
  - f. Restrictions on physical activities if any;
  - g. Restrictive protocols or special supervision requirements;
  - h. Past serious illnesses, serious injuries, and hospitalizations;
  - i. Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and
  - j. Current and past substance use including alcohol, prescription and nonprescription medications, and illicit drugs.
8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues;
9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma;
10. Legal competency status including authorized representative, commitment, and representative payee status;
11. Relevant criminal charges or convictions and probation or parole status;
12. Daily living skills;
13. Housing arrangements;
14. Ability to access services including transportation needs; and
15. As applicable, fall risk, communication methods or needs, and mobility and adaptive equipment needs.

H. The provider shall retain documentation of the individual's assessments in the individual's record for six years after the individual's discharge in accordance with § 54.1-2910.4 of the Code of Virginia.

**12VAC35-107-70. Individualized services plan (ISP)/individualized supports plan/ service planning.**

- A. The provider shall actively involve the individual and authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors.

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1. Providers of developmental services shall develop and implement a plan for supports, which is a component of the comprehensive individual support plan, 24 hours after admission. The initial plan for supports shall address immediate health and safety needs, may include assessment activities, and shall continue in effect until the ongoing comprehensive plan of supports is developed or the individual is discharged, whichever comes first. Providers shall collaborate with the individual's planning team to develop and implement this initial person-centered plan for supports, which may include assessment activities for the first 60 days. An ongoing comprehensive plan for supports shall be completed after 60 days. A provider may complete an ongoing comprehensive plan for supports prior to 60 days.
  2. Providers of mental health and substance abuse services shall develop and implement the initial ISP 24 hours after admission to address immediate service, health, and safety needs and shall continue until the comprehensive ISP is developed or the individual is discharged, whichever comes first. The provider shall develop and implement an initial person-centered ISP for the first 30 days.
- B. Providers of developmental services shall collaborate with the individual's support coordinator to develop and implement an initial person-centered ISP for the first 60 days. Providers of mental health and substance abuse services shall develop and implement a person-centered ISP for the first 30 days. The initial ISP shall be obtained, developed and implemented 24 hours after admission to address immediate service, health, and safety needs and shall continue in effect until the comprehensive ISP is developed or the individual is discharged, whichever comes first.
- C. The provider shall implement a person-centered comprehensive ISP as soon as possible after admission based upon the nature and scope of services but no later than 30 days after admission for providers of mental health and substance abuse services and 60 days after admission for providers of developmental services. Providers of short-term intensive services, such as inpatient, that are typically provided for less than 30 days shall implement a comprehensive ISP no later than 48 hours after admission.
- D. The initial ISP and the comprehensive ISP shall be developed based on the respective assessment with the participation and informed choice of the individual receiving services.
1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or his authorized representative, as applicable, in a reasonable and comprehensible manner:
    - a) The proposed services to be delivered;
    - b) Any alternative services that might be advantageous for the individual; and
    - c) Any accompanying risks or benefits of the proposed alternative services.
  2. If no alternative services are available to the individual, it shall be clearly documented within the ISP or within documentation attached to the ISP, that alternative services were not available as well as any steps taken to identify if alternative services were available.

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3. Whenever there is a change to an individual's ISP it shall be clearly documented within the ISP or within documentation attached to the ISP that:
  - a. The individual participated in the development of or revision to the ISP;
  - b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative, and;
  - c. The reasons the individual or the individual's authorized representative chose the option included in the ISP.

### **12VAC35-107-80. ISP requirements.**

- A. The initial ISP shall be based on the individual's immediate service, health, and safety needs identified in the initial assessment. The initial ISP shall include:
  1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's assessment. This includes documentation that the individual's needs require a provider operated home and non-center based setting;
  2. Services and supports and frequency of services required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, medical, medical, rehabilitation, training, and nursing needs and supports;
  3. The role of the individual and others, including the individual's family if appropriate in implementing the service plan;
  4. Target dates for accomplishment of goals and objectives; and
  5. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies.
- B. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the comprehensive assessment. The ISP shall include:
  1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's assessment. This includes documentation that the individual's needs require a provider operated residential setting;
  2. Services and supports required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, medical, rehabilitation, training, and nursing needs and supports;
  3. The frequency at which services and supports must be provided to accomplish the individual's goals;
  4. The role of the individual and others, including the individual's family if appropriate, in implementing the ISP;
  5. A communication plan for individuals with communication barriers, including language barriers;
  6. A behavioral support or treatment plan, if applicable;
  7. A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;
  8. A crisis or relapse plan, if applicable;
  9. Target dates for accomplishment of goals and objectives;
  10. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies;

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11. A transportation plan, if applicable;
  12. Recovery plans, if applicable;
  13. Services the individual elects to self direct, if applicable; and
  14. Projected discharge plan and estimated length of stay.
- C. Both the initial and comprehensive ISP shall be signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services or the authorized representative in order to document agreement.
1. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason why he was unable to obtain it. The provider shall continue to make attempts to obtain the necessary signature for the length of time the ISP is in effect. An attempt to obtain the necessary signature shall occur, at a minimum each time the provider reviews the ISP as required by 12VAC35-107-90 (F).
  2. The ISP shall be distributed to the individual and others authorized to receive it, prior to the implementation of the ISP. The provider shall document that the ISP was distributed within the individual's record.
- D. The provider shall designate a person who shall be responsible for developing, implementing, reviewing, and revising each individual's ISP in collaboration with the individual or authorized representative, as appropriate.
- E. Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.
1. Providers shall educate and train employees or contractors who are responsible for implementing the ISP on the objectives and strategies contained within the individual's current ISP;
  2. After each training, providers shall test the employee's or contractor's knowledge, competency or both, and retain documentation of the test of the employee's or contractor's knowledge, competency or both within the employee or contractor's personnel file.
  3. When changes occur to an individual's ISP, employees or contractors who are responsible for implementing the ISP shall be made aware of changes, and shall be competent to implement the revised ISP.
- F. When a provider provides more than one service to an individual the provider may maintain a single ISP document that contains individualized objectives and strategies for each service provided.
- G. Whenever possible the identified goals in the ISP shall be written in the words of the individual receiving services.
- H. The provider shall use signed and dated progress notes to document the implementation of the goals and objectives contained within the ISP.
- I. The individual's most current ISP shall be located at the individual's residential setting.

**12VAC35-107-90. Reassessments and ISP reviews.**

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- A. Reassessments shall be completed at least annually and any time there is a need based on changes in the medical, psychiatric, behavioral, or other status of the individual. Reassessments shall include documented justification that the individual's needs continue to require a provider operated residential setting.
- B. The provider shall actively involve the individual and authorized representative, if applicable, in reassessments. The provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.
- C. Individuals who receive medication-only services shall be reassessed at least annually to determine whether there is a change in the need for additional services and the effectiveness of the medication.
- D. Providers shall complete changes to the ISP, if necessary or if desired by the individual, as a result of a reassessment. If a reassessment indicates no changes to the ISP are necessary the provider shall document that no changes are necessary and the reasoning.
- E. If necessary as a result of reassessment, providers shall complete changes to medical protocols, or collaborate with other providers to ensure changes to medical protocols are made. This shall include medical equipment protocols if appropriate.
- E. The provider shall complete quarterly reviews in writing of the ISP at least every three months from the date of the implementation of the comprehensive ISP or whenever there is a reassessment.
1. A review of the ISP, shall evaluate the individual's progress toward meeting the ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.
  2. A review of the ISP, shall document evidence of or lack of progression toward or achievement of a specific targeted outcome for each goal and objective.
  3. For goals and objectives that were not accomplished by the identified target date, or goals and objectives the individual has not made progression toward, the provider and any appropriate team members, i.e. other service providers and support members, shall meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. The provider shall retain documentation of this meeting and the individual's informed choice within the individual's record. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.
  4. A review of the ISP, shall note the individual's family involvement, if any, in the individual's treatment;
  5. A review of the ISP, shall note the individual's progress towards discharge; and
  6. A review of the ISP, shall note the status of the individual's discharge planning.
- G. After each reassessment the provider shall ensure that the individual's most current ISP is located at the individual's residential setting.

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**12VAC35-107-100. Progress notes or other documentation.**

- A. The provider shall have a policy or process to ensure that progress notes are consistent in format across the provider's service(s).
- B. The provider shall use signed and dated progress notes or other documentation to document the services provided. Progress notes shall at a minimum:
  - 1. Be consistent across the provider's services;
  - 2. Be legible and readable;
  - 3. Record events of the individual's interaction with the clinical staff writing the progress note, including care provided and events relevant to diagnosis and treatment or care of the individual;
  - 4. Have a narrative component;
  - 5. Include next steps related to treatment or care of the individual; and
  - 6. Be signed and dated by the clinical staff entering the progress note.
- C. The provider shall make documentation should the individual no longer need the intensity of care provided within a residential setting.
- D. Progress notes shall be entered into the individual's record at a minimum once per shift as defined by the provider by the provider's policies and procedures.
- E. Communication logs and supervision notes shall not be considered progress notes.

**12VAC35-107-110. Discharge planning.**

- A. Providers shall implement policies and procedures that include:
  - 1. Identification, qualification, training, and responsibilities of employees responsible for discharge planning.
  - 2. Completion of a discharge plan prior to an individual's discharge that:
    - a. Involves the individual or his authorized representative and reflects the individual's preferences to the greatest extent possible consistent with the individual's needs.
    - b. Involves mental health, developmental disability, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the individual will need upon discharge into the community or to another provider and identifies the public or private agencies or persons that have agreed to provide them.
    - c. Providers of short-term intensive services, such as inpatient, that are typically provided for less than 30 days shall develop a discharge plan no later than 48 hours prior to discharge. Providers of all other residential services, shall develop a discharge plan 7 days prior to discharge.
- B. Providers shall follow the elements of the General Chapter 12VAC35-106-450 for Discharge.

**12VAC35-107-120. Emergency preparedness and response plan.**

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- A. The scope of emergency preparedness in relation to this section applies to disasters as defined by §44.146.16 of the Code of Virginia.
- B. The provider shall develop a written emergency preparedness and response plan for all of its services and locations. This plan shall include specifics for each location. This plan shall include the following:
1. An analysis and prioritization of vulnerability of all services and locations to various hazards that may impact the provider. Vulnerability is a combination of the likelihood and severity of hazard occurrence.
  2. A base-level response plan that is applicable to all hazards and includes:
    - a. Documentation of preparedness activities such as emergency planning team meetings, incident reviews, plan revisions, etc.
    - b. Maintenance of a 24-hour phone line which can be used for communication during emergencies.
    - c. Documented procedure for activation of the emergency plan including a description of various triggers for activation, who may activate, and overall situation assessment, response escalation, situation stabilization, and life and property preservation as first priority during any response.
    - d. Documented procedure to notify the department of activation of the emergency plan as soon as possible, but no later than 24 hours after incident occurrence.
    - e. Documented polices, outlining specific responsibilities for incident command and the necessary incident management team including operations, logistics, planning and finance.
    - f. Documented policies and procedures to ensure, to the extent possible, the life safety of employees, contractors, volunteers, visitors, and individuals
    - g. Policy and procedures for building access and security to include both provision of a secure building under adverse circumstances and appropriate access to the building by emergency responders.
    - h. Documented policies and procedures for the resumption of normal activities following service disruption by and emergency including any necessary site inspections required before repatriation can take place.
    - i. Documented identification, consideration and mitigation activities related to high-priority vulnerabilities as identified by a vulnerability analysis.
  3. An evacuation plan which includes:
    - a. Documented, current consideration of local/regional sites that could function as evacuation locations or stop-over points, including documentation of any arrangements the provider has made with such local/regional sites.
    - b. Policy and procedure for executing an evacuation or individual relocation to include individual and staff tracking and preservation of all critical services (pharmacy, feeding, etc.).
    - c. Policy and procedure for handling PHI during an evacuation or relocation to ensure the PHI is both properly secured and accessible at the new location (or by new service providers) to allow for proper continuity of care.
- C. The provider shall develop a written communication plan detailing:

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1. The process for notifying local and state authorities of an emergency.
  2. The process for notifying and communicating with staff, employees, contractors, volunteers and community responders during emergencies.
  3. The process for warning, notifying, and communicating with individuals receiving services.
  4. The process for notifying and communicating with family members or authorized representatives; during emergencies.
- D. The provider shall develop a written Continuity of Operations Plan detailing:
1. Delegation of authority under emergency conditions.
  2. Succession planning for emergency conditions.
  3. The plan should clearly indicate which services are critical to the health and well-being of the individual(s) being served and therefore must be continued, which services are less critical and may be delayed, which services are ancillary and may be discontinued during emergency circumstances, and triggers with regard to the continuity of these services. Documented plans for continuity of activities related to the provision of care, treatment, and services including scheduling, modifying, or discontinuing services, PII and PHI access and security, providing medication and transportation services.
  4. The plan shall documented plans for supply chain disruption for critical supplies to include pharmaceuticals, food, water, toiletries, linens, and any other supplies required for subsistence.
- E. Providers shall ensure a three-day supply of emergency food and water for all individuals and staff. Emergency food caches should include food that is easily prepared and does not need to be cooked. One gallon of potable water per person, per day is required.
1. The emergency food cache shall not include expired food.
  2. The emergency food cache shall be appropriate for the population the provider serves.
  3. The provider shall ensure any tools needed to prepare the emergency food supply (i.e. can openers, portable blender, etc) are included in the emergency food cache.
  4. The emergency food cache shall be separate from the provider's day to day food supply. The emergency food cache shall be packed and ready for transport in case of emergency.
- F. The provider shall maintain documentation of collaborative outreach to local emergency officials to include local emergency managers at least annually. The outreach shall address local disaster risks and community wide plans to address different disasters and emergency situations.
- G. The provider shall implement annual emergency preparedness and response training for all employees, contractors, students, and volunteers pursuant to 12VAC35-106-290 (B). This training shall also be provided during the onboarding of new employees. This training shall include:
1. Activation and notification for the emergency plan
  2. Evacuation procedures that include of individuals with functional and access needs.
  3. Use, maintenance, and operations of any emergency equipment.
  4. Medical record stewardship during emergencies.
  5. Utilization of community support services in emergencies.

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H. The provider shall document review of the emergency preparedness plan and continuity of operations annually and make necessary revisions. Such revisions shall be communicated to employees, contractors, students, volunteers, and individuals receiving services and incorporated into training for employees, contractors, students, and volunteers and into the orientation of individuals to services.

**12VAC35-107-130. Health care policy.**

A. The provider shall implement a policy that addresses provision of adequate and appropriate medical care. This policy shall describe how:

1. Medical care needs will be assessed including circumstances that will prompt the decision to obtain a medical assessment.
2. ISPs will address any medical care needs appropriate to the scope and level of service.
3. The provider will provide or arrange for the provision of medical and dental services identified at admission;
4. The provider will provide or arrange for the provision of routine ongoing and follow-up medical and dental services after admission;
5. The provider will communicate the results of any physical examinations, medical assessments, and any diagnostic tests, treatments or examinations to the individual and authorized representative, as appropriate.
6. The provider will keep accessible to staff and contractors on duty the names, addresses, and phone numbers of the individual's medical and dental providers.
7. The provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests, when services cannot be provided on site.
8. The provider will ensure the provision of emergency medical services for each individual.

B. The provider shall implement written policies to identify any individuals who are at risk for falls and develop and implement a fall prevention and management plan and program for each at risk individual.

C. Providers shall provide or arrange for the provision of appropriate medical care.

D. The provider shall implement written infection control measures including the use of universal precautions.

E. The provider shall report outbreaks of infectious diseases to the Department of Health pursuant to § 32.1-37 of the Code of Virginia.

**12VAC35-107-140. Written policies and procedures for crisis or emergency interventions; required elements.**

A. The provider shall implement written policies and procedures, as approved by the department, for prompt intervention in the event of a crisis or a behavioral, medical, or psychiatric emergency that may occur during screening and referral, at admission, or during the

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period of service provision. A crisis, behavioral, medical or psychiatric emergency as referred to in this section is a situation that poses an imminent risk to the individual or others and cannot be addressed within the scope of the provider's services, this does not include events that require the use of behavior intervention and supports as discussed within 12VAC35-106-520.

B. The policies and procedures shall include:

1. The provider's definition of a crisis or behavioral, medical, or psychiatric emergency;
2. Procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency;
3. Employee or contractor responsibilities; and
4. Location of the face sheets with emergency medical information as required by 12VAC35-106-480.

#### **12VAC35-107-150. Staffing.**

**(This is currently a placeholder section – The Department encourages input into staffing requirements to include within this section for each of the services)**

- A. Clinically managed high-intensity residential services shall meet the following staffing requirements:
- B. Clinically managed low-intensity residential services shall meet the following staffing requirements:
- C. Clinically managed population-specific high-intensity residential services shall meet the following staffing requirements:
- D. Community gero-psychiatric residential services shall meet the following staffing requirements:
- E. Group homes shall meet the following staffing requirements:
- F. ICF/IDDs shall meet the following staffing requirements:
- G. Inpatient services shall meet the following staffing requirements:
- H. Medically managed intensive inpatient services shall meet the following staffing requirements:
- I. Medically monitored intensive inpatient services shall meet the following staffing requirements:
- J. Respite residential shall meet the following staffing requirements:
- K. Substance abuse residential treatment for women with children services shall meet the following staffing requirements:
- L. Sponsored residential homes shall meet the following staffing requirements:
- M. Supervised living shall meet the following staffing requirements:

#### **12VAC35-107-160. Provider staffing plan.**

A. The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the:

1. Needs of the individuals receiving services;

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2. Types of services offered;
  3. Service description;
  4. Number of individuals to receive services at a given time; and
  5. Adequate number of staff required to safely evacuate all individuals during an emergency.
- B. The provider shall develop a written transition staffing plan for new services, added locations, and changes in capacity.
- C. The provider shall meet the following staffing requirements related to supervision.
1. The provider shall describe how employees, volunteers, contractors, and student interns will be supervised in the staffing plan and how that supervision will be documented.
  2. Supervision of employees, volunteers, contractors, and student interns shall be provided by persons who have experience in working with individuals receiving services and in providing the services outlined in the service description.
  3. Supervision shall be appropriate to the services provided and the needs of the individual. Supervision shall be documented.
  4. Supervision shall include responsibility for approving assessments and individualized services plans, as appropriate. This responsibility may be delegated to an employee or contractor who meets the qualification for supervision as defined in this section.
  5. Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions.
  6. Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation or mental health supports, shall be provided by a QMHP-A, a licensed mental health professional, or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. An individual who is a QMHP-E may not provide this type of supervision.
  7. Supervision of developmental services shall be provided by a person with at least one year of documented experience working directly with individuals who have developmental disabilities and holds at least a bachelor's degree in a human services field such as sociology, social work, special education, rehabilitation counseling, nursing, or psychology. Experience may be substituted for the education requirement.
  8. Supervision of brain injury services shall be provided at a minimum by a clinician in the health professions field who is trained and experienced in providing brain injury services to individuals who have a brain injury diagnosis including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a psychiatrist who is a doctor of medicine or osteopathy specializing in psychiatry and licensed in Virginia; (iii) a psychologist who has a master's degree in psychology from a college or university with at least one year of clinical experience; (iv) a social worker who has a bachelor's degree in human services or a related field (social work, psychology, psychiatric evaluation, sociology, counseling, vocational rehabilitation, human

Underlined = new language.

services counseling, or other degree deemed equivalent to those described) from an accredited college or university with at least two years of clinical experience providing direct services to individuals with a diagnosis of brain injury; (v) a Certified Brain Injury Specialist; (vi) a registered nurse licensed in Virginia with at least one year of clinical experience; or (vii) any other licensed rehabilitation professional with one year of clinical experience.

D. The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals receiving services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary.

E. Providers of brain injury services shall employ or contract with a neuropsychologist or licensed clinical psychologist specializing in brain injury to assist, as appropriate, with initial assessments, development of individualized services plans, crises, staff training, and service design.

F. Staff in direct care positions providing brain injury services shall have at least a high school diploma and two years of experience working with individuals with disabilities or shall have successfully completed an approved training curriculum on brain injuries within six months of employment.

**12VAC35-107-170. Nutrition.**

A. The provider shall implement a protocol for the provision of food services, which ensures access to nourishing, well-balanced, varied, and healthy meals which shall at a minimum:

1. Ensure that each individual's dietary needs, as reflected within their ISP, are fulfilled
2. Provide methods to learn the cultural background, personal preferences, and food habits and that meet the dietary needs of the individuals served and ensure meals are prepared in a manner that considers these preferences; and
3. List steps to be taken to assist individuals who require assistance feeding themselves in a manner that effectively addresses any deficits.

B. The provider shall have menus. Menus shall:

1. Meet the nutritional needs of individuals as indicated within the individual's ISP;
2. Be prepared in advance;
3. Be followed;
4. Reflect based on a provider's reasonable efforts, the religious, cultural and ethnic needs of individuals served;
5. Be updated periodically;
6. Be retained for a period of six months; and
7. Nothing in this subsection should be construed to limit the individual's right to make personal dietary choices.

Underlined = new language.

C. The provider shall implement protocols to monitor each individual's food consumption and nutrition for:

1. Warning signs of changes in physical or mental status related to nutrition; and
2. Compliance with any needs determined by the ISP or prescribed by a physician, nutritionist, or health care professional.

D. Each individual shall be provided a daily diet that consists of at least three nutritionally balanced meals and includes an adequate variety and quantity of food for the age of the individual and meets minimum nutritional requirements and the U.S. Department of Health and Human Services and U.S. Department of Agriculture Dietary Guidelines for Americans. Children's residential service providers shall also provide each individual with an evening snack.

### **12VAC35-107-180. Community participation.**

A. Individuals served shall be afforded opportunities to participate in community activities and utilize community resources that are based on their personal interests or preferences. The provider shall:

1. Document efforts made to learn the individual's served preferred community activities;
2. Document that opportunities for participation in community activities were made available to individual's served;
3. Ensure that individuals are afforded opportunities for community participation on an individual basis; and
4. Ensure that the frequency of opportunities are afforded to individual's consistent with their ISP.

B. The provider shall have and implement written policies regarding opportunities for individuals to participate in religious activities.

C. The provider's policies on religious participation shall be available to individuals, and their authorized representatives, if applicable. The policies shall also be available to any individual, or authorized representative, if applicable, considering admission to a residential service, as well as any agency considering placement of a child into a children's residential facility.

D. Individuals shall not be coerced to participate in religious activities.

E. Children's residential providers shall develop and implement written policies and procedures for evaluating persons or organizations in the community who wish to associate with individuals on the premises or take individuals off the premises. The procedures shall cover how the facility will determine if participation in such community activities or programs would be in the individuals' best interest.

F. Each children's residential provider facility shall have a staff community liaison who shall be responsible for facilitating cooperative relationships with neighbors, the school system, local law enforcement, local government officials, and the community at large.

Underlined = new language.

G. Each children's residential provider shall develop and implement written policies and procedures for promoting positive relationships with the neighbors that shall be approved by the department.

**12VAC35-107-190. Medication management.**

A. All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer medication.

B. The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by individuals. The policies shall address:

1. Identification of the staff member responsible for routinely communicating to the prescriber the effectiveness of prescribed medications; and any adverse reactions, or any suspected side effects;

2. Training for individuals served in the self administration of medication and recognition of side effects; and

3. Training for individuals served who self administer medication on the methods for storage and safekeeping of medication.

C. Individuals shall be taught how to administer their own medications if the individual's ISP indicates self administration as an appropriate objective:

1. No individual shall be permitted to self-administer medications until he demonstrates the competency to do so. Competency shall be defined by the provider's policies and procedures; and

2. The provider shall have a procedure to follow regarding the daily medication log for each individual that self administers. The procedure shall be reflected within the individual's ISP.

D. Individuals who self administer their own medications shall be assessed for competency to self administer during each reassessment, as governed by 12VAC35-107-90.

E. Drugs designated for a particular individual shall be immediately removed from the individual's current medication supply if discontinued by the individual's physician or other prescriber.

F. The provider shall ensure that all prescribed pro re nata (PRN) medications are present within the individual's medication supply.

1. Providers shall ensure that all PRNs administered by staff have specific indications for use. This may require that the provider discuss the parameters of administering the PRN with the prescriber.

2. The provider shall follow up with the individual's prescriber in the event that a PRN medication is not effective, or if the prescription is no longer necessary.

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G. Syringes and other medical implements used for injecting or cutting skin shall be locked. Containers for used sharps shall be locked. Disposal of used sharps shall comply with the Virginia Regulated Medical Waste Management Regulations (9VAC20-120).

H. Providers shall ensure all medication is securely locked and properly labeled.

**12VAC35-107-200. Medication errors and drug reactions.**

In the event of a medication error or adverse drug reaction:

1. First aid shall be administered if indicated.
2. Employees or contractors shall promptly contact a poison control center, pharmacist, nurse or physician and shall take actions as directed.
3. The individual's physician shall be notified as soon as possible unless the situation is addressed in standing orders.
4. All actions taken by employees or contractors shall be documented.
5. The provider shall review medication errors at least quarterly as part of the quality assurance in 12VAC35-106-590.
6. Medication errors and adverse drug reactions shall be recorded in the individual's medication log.

**12VAC35-107-210. Medication administration and storage or pharmacy operation.**

A provider responsible for medication administration and medication storage or pharmacy operations shall comply with:

1. The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia);
2. The Virginia Board of Pharmacy regulations;
3. The Virginia Board of Nursing regulations; and
4. Applicable federal laws and regulations relating to controlled substances.

**12VAC35-107-220. Physical examination.**

A. The provider shall administer or obtain results of physical exams within 30 days of an individual's admission. Providers of inpatient services shall administer physical exams within 24 hours of an individual's admission. Should a provider obtain results of a physical exam rather than administer them, the examination must have been conducted within one year of admission to the service. Providers of children's residential services shall have a physical examination by or under the direction of a licensed physician no earlier than 90 days prior to admission to the facility or no later than seven days following admission, except (i) the report of an examination within the preceding 12 months shall be acceptable if a child transfers from one residential facility licensed or certified by a state agency to another; and (ii) a physical examination shall be conducted within 30 days following an emergency admission if a report of physical examination is not available.

B. Within seven days of placement, each individual shall have had a screening assessment for tuberculosis as evidenced by the completion of a screening form containing, at a minimum, the elements found on the Report of Tuberculosis Screening form published by the Virginia Department of Health. The screening assessment may be no older than 30 days. A screening assessment shall not be required for a new individual separated from a service with another

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licensed provider with a break in service of six months or less or who is transferred from another DBHDS licensed provider.

C. A physical examination shall include, at a minimum:

1. General physical condition (history and physical);
2. Evaluation for communicable diseases;
3. Allergies, chronic conditions, and physical disabilities if any;
4. Nutritional requirements, including special diets, if any;
5. Restrictions on physical activities, if any;
6. Recommendations for further diagnostic tests and treatment, if appropriate;
7. Other examinations that may be indicated;
8. . The date of examination; and
9. The signature of a qualified practitioner.

D. An individual with a communicable disease shall not be admitted unless a licensed physician certifies that:

1. The facility is capable of providing care to the individual without jeopardizing individuals and staff; and
2. The facility is aware of the required treatment for the individual and the procedures to protect individuals and staff.

E. Locations designated for physical examinations shall ensure individual privacy.

F. The provider shall review and follow-up with the results of the physical examination and of any follow-up diagnostic tests, treatments, or examinations and provide documentation of the provision of follow-up care in the individual's record.

G. Each individual's health record shall include notations of health and dental complaints and injuries and shall summarize symptoms and treatment given.

H. Each individual's health record shall include or document the facility's efforts to obtain treatment summaries of ongoing psychiatric or other mental health treatment and reports.

I. The provider shall develop and implement written policies and procedures that include use of standard precautions and address communicable and contagious medical conditions. These policies and procedures shall be approved by a medical professional.

J. A physical examination of an individual served at a children's residential provider shall include all of the provisions in subsection C and also include:

1. Immunizations administered at the time of the exam;

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2. A vision screening; and

3. a A hearing screening.

K. Children's residential providers shall ensure each individual's health record shall include written documentation of (i) the initial physical examination; and (ii) an annual physical examination by or under the direction of a licensed physician, including any recommendation for follow-up care.

L. Each children's residential provider shall include in each individual's record written documentation of (i) an annual examination by a licensed dentist and (ii) follow-up dental care recommended by the dentist or as indicated by the needs of the individual. This requirement does not apply to respite care facilities or short term intensive services that are typically provided for less than 30 days.

**12VAC35-107-230. Seclusion, restraint, and time out.**

A. The use of seclusion, restraint, and time out shall comply with applicable federal and state laws and regulations and be consistent with the provider's policies and procedures.

B. Devices used for mechanical restraint shall be designed specifically for emergency behavior management of human beings in clinical or therapeutic programs. Individuals being mechanically restrained shall be continuously observed face to face by a staff member who shall conduct a status check every 15 minutes. During status checks the staff will determine and, if necessary, respond to needs for hygiene, elimination and hydration. Children's residential providers are prohibited from utilizing mechanical restraints except as permitted by other applicable state regulations or as ordered by a court of competent jurisdiction.

C. Application of time out, seclusion, or restraint shall be documented in the individual's record and include the following:

1. Physician's order for seclusion or mechanical restraint or chemical restraint;
2. Date and time;
3. Employees or contractors involved;
4. Circumstances and reasons for use including other behavior management techniques attempted;
5. Duration;
6. Type of technique used; and
7. Outcomes, including documentation of debriefing of the individual and staff involved following the incident.

D. Children's residential providers are prohibited from use of pharmacological restraints.

**12VAC35-107-240. Requirements for seclusion room.**

A. Seclusion may only be used in children's residential facilities and inpatient hospitals and only in case of emergency. Seclusion shall comply with the provisions related to seclusion

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within the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Behavioral Health and Developmental Services, 12VAC35-115-110.

- B. The room used for seclusion shall meet the design requirements for buildings used for detention or seclusion of individuals.
- C. The seclusion room shall be at least six feet wide and six feet long with a minimum ceiling height of eight feet.
- D. The seclusion room shall be free of all protrusions, sharp corners, hardware, fixtures or other devices which may cause injury to the individual.
- E. Windows in the seclusion room shall be so constructed as to minimize breakage and otherwise prevent the individual from harming himself.
- F. Light fixtures and other electrical receptacles in the seclusion room shall be recessed or so constructed as to prevent the individual from harming himself. Light controls shall be located outside the seclusion room.
- G. Doors to the seclusion room shall be at least 32 inches wide, shall open outward and shall contain observation view panels of transparent wire glass or its approved equivalent, not exceeding 120 square inches but of sufficient size for someone outside the door to see into all corners of the room.
- H. The seclusion room shall contain only a mattress with a washable mattress covering designed to avoid damage by tearing.
- I. The seclusion room shall maintain temperatures appropriate for the season.
- J. All space in the seclusion room shall be visible through the locked door, either directly or by mirrors.

**12VAC35-107-250. Medication assisted treatment.**

All providers of medication assisted treatment shall comply with provisions 12VAC35-xxx-xxx through 12VAC35-xxx-xxx of the Center Based Chapter.

**12VAC35-107-260. Security of common residential hazards.**

- A. The provider shall secure opioid agonist medication supplies by:
  - 1. Restricting access to medication areas to medical or pharmacy personnel;
  - 2. Reconciling the medication inventory monthly;
  - 3. Keeping inventory records, including the monthly reconciliation, for three years; and
  - 4. Maintaining a current plan to control the diversion of medication to unprescribed or illegal uses.
- B. The provider shall secure all cleaning products and other household chemicals by:
  - 1. Ensuring all cleaning products are kept in their original bottles;
  - 2. Household cleaning products shall be kept out of sight and in a secure area, individuals capable of utilizing household cleaning products shall return products to the secure area after use;
  - 3. Laundry and dishwasher supplies shall be kept out of sight and in a secure area; and

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4. Car supplies and gardening products shall be kept out of reach, in a securely locked area, and stored according to package instructions.

**12VAC35-107-270. Beds.**

A. The provider shall arrange for each individual to have a bed.

B. The provider shall not operate more beds than the number for which its service location or locations are licensed.

C. An ICF/IID may not have more than 12 beds at any one location, as required by §32.1-102.1:3 of the Code of Virginia. This applies to new applications for services and not to existing services or locations licensed prior to December 7, 2011.

D. Beds and bed linens shall be clean, comfortable and well maintained.

E. Beds shall be equipped with a clean mattress, clean pillow, clean blankets, and clean bed linens. When a bed is soiled, providers shall assist individuals with bathing as needed, and provide clean clothing and bed linen. Children's residential providers shall provide a clean waterproof mattress cover, if needed.

F. Providers of children's residential services shall change bed linens at least every seven days and more often if needed.

G. Providers of children's residential services shall provide mattresses which are fire retardant as evidenced by documentation from the manufacturer. Except in buildings equipped with an automated sprinkler system as required by the Virginia Statewide Building Code (13VAC5-63).

H. Providers of children's residential services shall provide cribs for individuals under two years of age.

F. Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

**12VAC35-107-280. Bedrooms.**

A. Bedrooms shall meet the following square footage requirements:

1. Single occupancy bedrooms shall have no less than 80 square feet of floor space.
2. Multiple occupancy bedrooms shall have no less than 60 square feet of floor space per individual.
3. This subsection does not apply to community gero-psychiatric residential services. Requirements regarding community gero-psychiatric residential services are within 12VAC35-107-700 et. seq.

B. No more than four individuals shall share a bedroom, except in group homes where no more than two individuals shall share a room. This does not apply to group home locations licensed prior to December 7, 2011.

Underlined = new language.

C. Each individual shall have adequate private storage space accessible to the bedroom for clothing and personal belongings, except in secure custody facilities.

D. Every sleeping area shall have a door that may be closed for privacy or quiet and this door shall be readily opened in case of fire or other emergency.

E. The environment of sleeping areas shall be conducive to sleep and rest.

F. Providers of children's residential services shall provide separate sleeping areas for boys and girls for individuals four years of age or older.

G. Providers of children's residential services shall ensure beds are at least three feet apart at the head, foot, and sides and double-decker beds shall be at least five feet apart at the head, foot, and sides.

H. This section does not apply to correctional facilities and jails. Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

#### **12VAC35-107-290. Physical environment**

A. The physical environment, design, structure, furnishings, and lighting shall be appropriate to the individuals served and the services provided.

B. The physical environment shall be accessible to individuals with physical and sensory disabilities, if applicable.

C. The physical environment and furnishings shall be clean, dry, free of foul odors, safe, and well-maintained.

D. Floor surfaces and floor coverings shall promote mobility in areas used by individuals and shall promote maintenance of sanitary conditions. There shall be clear pathways of egress through the residential setting, free of tripping hazards, to ensure that all individuals can move about the setting safely.

1. Any electrical cords, extension cords or power strips utilized by the provider shall be properly secured and not be placed anywhere that the cord can cause trips or falls.

E. Heat shall be evenly distributed in all rooms occupied by individuals such that a temperature no less than 68 degrees Fahrenheit is maintained, unless otherwise mandated by state or federal authorities. Natural or mechanical ventilation to the outside shall be provided in all rooms used by residents. Individual or mechanical ventilating systems shall be provided in all rooms occupied by individuals when the temperature in those rooms exceeds 80 degrees Fahrenheit. If a provider is supplying heat throughout the residential setting by means of a wood stove or fireplace the provider shall:

1. Ensure that the wood stove or fireplace is operated safely, this includes storing fuel and disposing of ashes; and

2. Ensure the wood stove or fire place is clean and well maintained.

F. Plumbing shall be maintained in good operational condition. Adequate hot and cold running water of a safe and appropriate temperature shall be available. Hot water accessible to individuals being served shall be maintained within a range of 100-120° Fahrenheit. Precautions shall be taken to prevent scalding from running water.

G. Adequate provision shall be made for the collection and legal disposal of garbage and waste materials.

Underlined = new language.

H. The physical environment, structure, furnishings, and lighting shall be kept free of vermin, rodents, insects, and other pests.

I. If smoking is permitted, the provider shall make provisions for alternate smoking areas that are separate from the service environment. This subsection does not apply to home-based services.

J. For all program areas added after September 19, 2002, minimum room height shall be 7-1/2 feet.

K. Bedroom, bathroom and dressing area windows and doors shall provide privacy.

L. Bathrooms intended for use by more than one individual at the same time shall provide privacy for showers and toilets.

M. No required path of travel to the bathroom shall be through another bedroom. Each individual's room shall have direct access to a corridor, living area, dining area, or other common area.

N. The provider shall ensure that a house number for the residential location can be identified clearly from the road.

O. Above ground and in-ground swimming pools shall be inspected annually by the state or local health authorities or by a swimming pool business.

P. Each provider shall make available at least one toilet, one hand basin, and shower or bath for every four individuals. Providers of children's residential services shall:

1. Make available at least one toilet, one hand basin, and one shower or bathtub in each living unit;

2. Make available at least one bathroom equipped with a bathtub in each facility;

3. Make available at least one toilet, one hand basin, and one shower or tub for every eight individuals for facilities licensed before July 1, 1981;

4. Make available one toilet, one hand basin and one shower or tub for every four individuals in any building constructed or structurally modified after July 1, 1981, except secure custody facilities. Facilities licensed after December 28, 2007, shall comply with the one-to-four ratio; and

5. The maximum number of staff members on duty in the living unit shall be counted in determining the required number of toilets and hand basins when a separate bathroom is not provided for staff.

Q. Providers of children's residential services shall be provide privacy from routine sight supervision by staff members of the opposite gender while bathing, dressing, or conducting toileting activities. This subsection does not apply to medical personnel performing medical procedures, staff providing assistance to infants, or staff providing assistance to individuals who's physical or mental disabilities dictate the need for assistance with these activities as justified in the individual's record.

R. This section does not apply to correctional facilities and jails. Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

### **12VAC35-107-300. Building inspection and classification.**

All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose. The provider shall submit a copy of the Certificate of Use and Occupancy to the department for new locations. This section

Underlined = new language.

does not apply to correctional facilities. Sponsored residential service providers shall certify that their sponsored residential homes comply with this regulation.

#### **12VAC35-107-310. Fire inspections.**

The provider shall document at the time of its original application and annually thereafter that buildings and equipment in residential service locations serving more than eight individuals are maintained in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-51). This section does not apply to sponsored residential home services.

#### **12VAC35-107-320. Building and grounds.**

A. The interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. This includes, but is not limited to, required locks, mechanical devices, indoor and outdoor equipment, and furnishings.

B. The provider shall have policies for infrastructure concerns including utility shut-off.

#### **12VAC35-107-330. Floor plan and building modifications.**

A. All services shall submit floor plans with room dimensions to the department for new locations. New locations require a service modification application to be submitted to the department as required by 12VAC35-106-80 at least 45 days prior to opening the new location.

B. Within the service modification application to be submitted to the department as required by 12VAC35-106-80, the provider shall submit building plans and specifications for any planned construction at a new location, changes in the use of existing locations, and any structural modifications or additions including renovations to existing locations where services are provided. This section does not apply to correctional facilities.

C. The provider shall submit an interim plan to the department addressing the health and safety of individuals and continued service delivery if new construction involving structural modifications or additions or renovations to existing buildings is planned. The interim plan shall be submitted along with the service modification application which is required by 12VAC35-106-80.

#### **12VAC35-107-340. Lighting.**

A. Artificial lighting shall be by electricity.

B. All areas within buildings shall be lighted for safety and the lighting shall be sufficient for the activities being performed.

C. Lighting in halls shall be adequate at night

D. Operable flashlights or battery-powered lanterns shall be available for each staff member on the premises between dusk and dawn to use in emergencies.

E. Outside entrances and parking areas shall be lighted as appropriate for protection against injuries and intruders.

#### **12VAC35-107-350. Sewer and water inspections.**

A. Service locations shall be on a public water and sewage system or on a nonpublic water and sewage system. Prior to a location being licensed, the provider shall obtain the report from the building inspector pertaining to the septic system and its capacity. Nonpublic water and sewer systems shall be maintained in good working order and in compliance with local and state laws.

Underlined = new language.

B. Service locations that are not on a public water system shall have a water sample tested prior to being licensed and annually by an accredited, independent laboratory for the absence of coliform. The water sample shall also be tested for lead or nitrates if recommended by the local health department. Documentation of the three most recent inspections shall be kept on file.

**Article 2. Children's residential facilities.**

**12VAC35-107-360. Children's residential facilities – interstate compact on the placement of children.**

A. Documentation of the prior approval of the administrator of the Virginia Interstate Compact on the Placement of Children, Virginia Department of Social Services, shall be retained in the record of each individual admitted from outside Virginia. The requirements of this section shall not apply to a facility providing documentation that the administrator of the Virginia Interstate Compact has determined the facility is statutorily exempt from the compact's provisions.

B. Documentation that the provider has sent copies of all serious incident reports regarding any child placed through the Interstate Compact to the administrator of the Virginia Interstate Compact on the Placement of Children shall be kept in the individual's record.

C. No later than five days after an individual has been transferred to another facility operated by the same sponsor, the individual's record shall contain documentation that the administrator of the Virginia Interstate Compact on the Placement of Children was notified in writing of the individual's transfer.

D. No later than 10 days after discharge, the individual's record shall contain documentation that the administrator of the Virginia Interstate Compact on the Placement of Children was notified in writing of the discharge.

E. The provider shall not discharge or send out-of-state youth in the custody of out-of-state social services agencies and courts to reside with a parent, relative, or other individual who lives in Virginia without the approval of the administrator of the Virginia Interstate Compact on the Placement of Children.

**12VAC35-107-370. Children's residential facilities – admission procedures.**

A. The facility shall have written criteria for admission that shall include:

1. A description of the population to be served including the age and gender of individuals to be served;

2. A description of the types of services offered;

3. Intake and admission procedures;

4. Exclusion criteria to define those behaviors or problems that the facility does not have the staff with experience or training to manage; and

5. Description of how educational services will be provided to the population being served.

Underlined = new language.

B. The facility shall accept and serve only those children whose needs are compatible with the services provided through the facility unless a child's admission is ordered by a court of competent jurisdiction.

C. Acceptance of a child as eligible for respite care by a facility approved to provide residential respite care is considered admission to the facility. Each individual period of respite care is not considered a separate admission.

D. Each facility shall provide documentation showing proof of contractual agreements or staff expertise to provide educational services, counseling services, psychological services, medical services, or any other services needed to serve the individuals in accordance with the facility's program description as defined by the facility's criteria of admission.

**12VAC35-107-380. Children's residential facilities – types of admission.**

A. Children shall be accepted only by court order or by written placement agreement with legal guardians.

B. Providers accepting emergency or self-admissions shall:

1. Develop and implement written policies and procedures governing such admissions that shall include procedures to obtain (i) a written placement agreement signed by the legal guardian prior to admission or (ii) the order of a court of competent jurisdiction;

2. Place in each individual's record the order of a court of competent jurisdiction, a written request for care, or documentation of an oral request for care; and justification of why the individual is to be admitted on an emergency basis; and

3. Clearly document in written assessment information gathered for the emergency admission that the individual meets the facility's criteria for admission.

**12VAC35-107-390. Children's residential facilities – application for admission.**

A. Admission shall be based on evaluation of an application for admission. The requirements of this section do not apply to court-ordered placements or transfer of an individual between residential facilities located in Virginia and operated by the same sponsor.

B. Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile information necessary to determine:

1. The educational needs of the individual;

2. The mental health, emotional, and psychological needs of the individual;

3. The physical health needs, including the immunization needs, of the individual;

4. The protection needs of the individual;

5. The suitability of the individual's admission;

6. The behavior support needs of the individual;

Underlined = new language.

7. Family history and relationships;

8. Social and development history;

9. Current behavioral functioning and social competence;

10. History of previous treatment for mental health, intellectual disability, substance abuse, brain injury, and behavior problems; and

11. Medication and drug use profile, which shall include:

a. History of prescription, nonprescription, and illicit drugs that were taken over the six months prior to admission;

b. Drug allergies, unusual and other adverse drug reactions, and ineffective medications; and

c. Information necessary to develop an ISP and a behavior support plan.

C. The individual's record shall contain a completed assessment at the time of a routine admission or within 30 days after an emergency admission.

D. Each facility shall develop and implement written policies and procedures to assess each individual as part of the application process to ensure that:

1. The needs of the individual can be addressed by the facility's services;

2. The facility's staff are trained to meet the individual's needs; and

3. The admission of the individual would not pose any significant risk to (i) the individual or (ii) the individuals served by the facility or staff.

**12VAC35-107-400. Children's residential facilities – written placement agreement.**

A. The facility, except a facility that accepts admission only upon receipt of the order of a court of competent jurisdiction, shall develop a written placement agreement that:

1. Authorizes the individual's placement;

2. Addresses acquisition of and consent for any medical treatment needed by the individual;

3. Addresses the rights and responsibilities of each party involved;

4. Addresses financial responsibility for the placement;

5. Addresses visitation with the individual;

Underlined = new language.

6. Addresses the education plan for the individual and the responsibilities of all parties; and

7. Addresses the individual's discharge criteria

B. Each individual's record shall contain, prior to a routine admission, a completed placement agreement signed by a facility representative and the parent, legal guardian, or placing agency.

C. The individual record of each person admitted based on a court order shall contain a copy of the court order.

**12VAC35-107-410. Children's residential facilities – transfer between residential facilities located in virginia and operated by the same sponsor.**

A. Except when transfer is ordered by a court of competent jurisdiction, the receiving provider shall document at the time of transfer:

1. Preparation through sharing information with the individual, the family, if appropriate, the legal guardian, and the placing agency about the facility, the staff, the population served, activities, and criteria for admission;

2. Notification to the family, if appropriate; the individual, the placement agency, and the legal guardian;

3. Receipt from the sending facility of a written summary of the individual's progress while at the facility, justification for the transfer, and the individual's current strengths and needs; and

4. Receipt of the individual's record.

B. The sending facility shall retain a copy of the emergency face sheet, as required by 12VAC35-106-480, and a written summary of the child's progress while at the facility and shall document the date of transfer and the name of the facility to which the individual has been transferred.

**12VAC35-107-420. Children's residential facilities – facilities that serve persons over the age of 17.** Facilities that are approved to serve persons over the age of 17 years shall comply with these regulations for all occupants regardless of age, except when it is determined by the department that housing, programs, services, and supervision for such persons are provided separately from those for the other individuals.

**12VAC35-107-430. Children's residential facilities – additional requirements for residential facilities for individuals with brain injury.**

The provider of brain injury services shall employ or contract with a neuropsychologist or licensed clinical psychologist specializing in brain injury to assist, as appropriate, with initial assessments, development of individualized service plans, crises, staff training, and service design.

**12VAC35-107-440. Children's residential facilities – independent living programs.**

Underlined = new language.

A. Each independent living program must demonstrate that a structured program using materials and curriculum is being used to teach independent living skills. The curriculum shall be submitted and approved by the department during the application process, required by 12VAC35-106-40, or the service modification process, described within 12VAC35-106-80. The curriculum shall include information regarding each of the following areas:

1. Money management and consumer awareness;
2. Food management;
3. Personal appearance;
4. Social skills;
5. Health/sexuality;
6. Housekeeping;
7. Transportation;
8. Educational planning/career planning;
9. Job-seeking skills;
10. Job maintenance skills;
11. Emergency and safety skills;
12. Knowledge of community resources;
13. Interpersonal skills and social relationships;
14. Legal skills;
15. Leisure activities; and
16. Housing.

B. In addition to the assessment requirements within 12VAC35-107-60 the provider shall assess the individual's strengths and needs, of the individual's life skills using an independent living assessment tool approved by the department. The assessment shall cover the areas addressed within the provider's independent living curriculum listed within subsection A.

C. The individual's ISP shall, in addition to the requirements found in 12VAC35-107-80, address each of the areas addressed within the provider's independent living curriculum listed within subsection A.

D. Each independent living program shall develop and implement policies and procedures to train all direct care staff within 14 days of employment on the content of the independent living

Underlined = new language.

curriculum, the use of the independent living materials, the application of the assessment tool, and the documentation methods used. Documentation of the orientation shall be kept in the employee's personnel record.

E. Each independent living program shall develop and implement written policies and procedures that ensure that each individual is receiving adequate nutrition as required in 12VAC35-107-170.

**12VAC35-107-450. Children's residential facilities – Mother and baby programs.**

A. Each provider shall develop and implement written policies and procedures to orient direct care staff within 14 days of hire regarding the following:

1. Responsibilities of mothers regarding the child;
2. Child development including age-appropriate behavior for each stage of development;
3. Appropriate behavioral interventions for infants and toddlers;
4. Basic infant and toddler care including but not limited to nutritional needs, feeding procedures, bathing techniques; and
5. Safety issues for infants and toddlers.

B. Each direct care worker shall have certification in infant CPR and first aid prior to working alone with infants or toddlers.

C. A placement agreement shall be signed by the legal guardian for the adolescent mother and a separate placement agreement shall be signed for the adolescent mother's child at the time of admission.

D. In addition to the requirements of 12VAC35-107-390 the application for admission for the adolescent mother's child must include:

1. The placement history of the child;
2. The developmental milestones of the child; and
3. The nutritional needs of the child.

E. In addition to the requirements of 12VAC35-106-480, the face sheet for adolescent mother's child shall also include:

1. Type of delivery;
2. Weight and length at birth;
3. Any medications or allergies; and
4. Name and address, if known, of the biological father.

F. A combined service plan following the requirements of 12VAC35-107-80 must be written for the adolescent mother and her child within 30 days of the admission of the adolescent mother's child.

Underlined = new language.

G. There shall be a combined documented review of the adolescent mother's and her child's progress, which shall follow the requirements of the 12VAC35-107-90(F). The first review shall occur 60 days after the first combined service plan and within each 90-day period thereafter.

H. The developmental milestones of the adolescent's child must be documented in each quarterly progress report.

I. The record of each child 18 months or younger shall include the child's feeding schedule and directions for feeding. This information shall be posted in the kitchen.

J. The provider shall develop and implement written policies and procedures for tracking:

1. What a child 18 months or younger is eating;

2. How much a child 18 months or younger is eating; and

3. The response to newly introduced foods of the child 18 months or younger.

K. The provider shall ensure that when an adolescent mother is in school or is working, her child is appropriately cared for, either in a licensed child day program or at the facility.

L. A daily activity log must be kept for each child of the adolescent mother showing what activities the child actually participated in during the day. The daily log must show that children have the opportunity to participate in sensory, language, manipulative, building, large muscle, and learning activities.

M. The provider shall develop and implement written policies and procedures regarding health care of the adolescent's child including:

1. Obtaining health care;

2. Ensuring follow-up care is provided;

3. Ensuring adolescent mothers administer to their children only prescription and nonprescription medication authorized by a health care professional licensed to prescribe medication; and

4. Medication administration.

N. Adolescent mothers and their babies may share a bedroom as allowed by 12VAC35-107-280, but shall not share a room with other adolescents or their children.

O. Pregnant adolescents may share a room as allowed by 12VAC35-107-280.

P. Providers shall develop and implement written policies and procedures to protect infants, toddlers, and young children from dangers in their environment. The policies and procedures must include but not be limited to protection from:

1. Electrocutation;

2. Falling down steps or ramps or gaining access to balconies, porches, or elevated areas; and

3. Poisons, including poisonous plants.

Underlined = new language.

Q. The provider shall comply with all elements of the Standards for Licensed Child Day Centers (22VAC40-185).

**12VAC35-107-460. Children's residential facilities – campsite programs or adventure activities.**

A. All wilderness campsite programs and providers that take individuals on wilderness/adventure activities shall develop and implement policies and procedures that include:

1. Staff training and experience requirements for each activity;
2. Individual training and experience requirements for each activity;
3. Specific staff-to-individual ratio and supervision plan appropriate for each activity; including sleeping arrangements and supervision during night time hours;
4. Plans to evaluate and document each participant's physical health throughout the activity;
5. Preparation and planning needed for each activity and time frames;
6. Arrangement, maintenance, and inspection of activity areas;
7. A plan to ensure that any equipment and gear that is to be used in connection with a specified wilderness/adventure activity is appropriate to the activity, certified if required, in good repair, in operable condition, and age and body size appropriate;
8. Plans to ensure that all ropes and paraphernalia used in connection with rope rock climbing, rappelling, high and low ropes courses, or other adventure activities in which ropes are used are approved annually by an appropriate certifying organization, and have been inspected by staff responsible for supervising the adventure activity before engaging residents in the activity;
9. Plans to ensure that all participants are appropriately equipped, clothed, and wearing safety gear, such as a helmet, goggles, safety belt, life jacket, or a flotation device, that is appropriate to the adventure activity in which the individual is engaged;
10. Plans for food and water supplies and management of these resources;
11. Plans for the safekeeping and distribution of medication;
12. Guidelines to ensure that participation is conducted within the boundaries of the individual's capabilities, dignity, and respect for self-determination;
13. Overall emergency, safety, and communication plans for each activity including rescue procedures, frequency of drills, individual accountability, prompt evacuation, and notification of outside emergency services; and
14. Review of trip plans by the trip coordinator.

B. All wilderness campsite programs and providers that take individuals on wilderness/adventure activities must designate one staff person to be the trip coordinator who will be responsible for all facility wilderness or adventure trips.

Underlined = new language.

1. This person shall have experience in and knowledge regarding wilderness activities and be trained in wilderness first aid. The individual shall also have at least one year experience at the facility and be familiar with the facility procedures, staff, and individuals served.

2. Documentation regarding this knowledge and experience shall be found in the individual's personnel record.

3. The trip coordinator shall review all trip plans and procedures and shall ensure that staff and individuals meet the requirements as outlined in the facility's policy regarding each wilderness/adventure activity to take place during the trip.

C. The trip coordinator shall conduct a post trip debriefing within 72 hours of the group's return to base to evaluate individual and group goals as well as the trip as a whole.

D. The trip coordinator shall be responsible for writing a summary of the debriefing session and shall be responsible for ensuring that procedures and policies are updated to reflect improvements needed.

E. A trip folder shall be developed for each wilderness/adventure activity conducted away from the facility and shall include:

1. Medical release forms including pertinent medical information on the trip participants;

2. Phone numbers for administrative staff and emergency personnel;

3. Daily trip logs;

4. Incident reports;

5. Swimming proficiency list if trip is near water;

6. Daily logs;

7. Maps of area covered by the trip; and

8. Daily plans.

F. Initial physical forms used by wilderness campsite programs and providers that take individuals on wilderness or adventure activities shall include:

1. A statement notifying the doctor of the types of activities the individual will be participating in; and

2. A statement signed by the doctor stating the individual's health does not prevent him from participating in the described activities.

G. First aid kits used by wilderness campsite programs and providers that take individuals on adventure activities shall be activity appropriate and shall be accessible at all times.

H. Direct care workers hired by wilderness campsite programs and providers that take individuals on wilderness/adventure activities shall be trained in a wilderness first aid course.

I. The provider shall ensure that before engaging in any aquatic activity, each individual shall be classified by the trip coordinator or designee according to swimming ability in one of two

Underlined = new language.

classifications: swimmer and nonswimmer. This shall be documented in the individual's record and in the trip folder.

J. The provider shall ensure that lifesaving equipment is provided for all aquatic activities and is placed so that it is immediately available in case of an emergency. At a minimum, the equipment shall include:

1. A whistle or other audible signal device; and
2. A lifesaving throwing device.

K. A separate bed, bunk, or cot shall be made available for each person.

L. A mattress cover shall be provided for each mattress.

M. Sleeping areas shall be protected by screening or other means to prevent admittance of flies and mosquitoes.

N. Bedding shall be clean, dry, sanitary, and in good repair.

O. Bedding shall be adequate to ensure protection and comfort in cold weather.

P. Sleeping bags, if used, shall be fiberfill and rated for 0°F.

Q. Linens shall be changed as often as required for cleanliness and sanitation but not less frequently than once a week.

R. Each individual shall be provided with an adequate supply of clean clothing that is suitable for outdoor living and is appropriate to the geographic location and season.

S. Sturdy, water-resistant, outdoor footwear shall be provided for each individual.

T. Each individual shall have adequate personal storage area.

U. Fire extinguishers of a 2A 10BC rating shall be maintained so that it is never necessary to travel more than 75 feet to a fire extinguisher from combustion-type heating devices, campfires, or other source of combustion.

V. Artificial lighting shall be provided in a safe manner.

W. All areas of the campsite shall be lighted for safety when occupied by individuals.

X. Staff of the same sex may share a sleeping area with the individuals.

Y. A telephone or other means of communication is required at each area where individuals sleep or participate in programs.

### **12VAC35-107-470. Children's residential facilities – service requirements.**

A. The provider shall have and implement written policies and procedures for the on-site provision of a structured program of care or treatment of individuals with mental illness, developmental disability, substance abuse, or brain injury. The provision, intensity, and frequency of mental health, developmental disability, substance abuse, or brain injury

Underlined = new language.

interventions shall be based on the assessed needs of the individual. These interventions, applicable to the population served, shall include, but are not limited to:

1. Individual counseling;
2. Group counseling;
3. Training in decision making, family and interpersonal skills, problem solving, self-care, social, and independent living skills;
4. Training in functional skills;
5. Assistance with activities of daily living (ADL's);
6. Social skills training in therapeutic recreational activities, e.g., anger management, leisure skills education and development, and community integration;
7. Providing positive behavior supports;
8. Physical, occupational, and/or speech therapy;
9. Substance abuse education and counseling; and
10. Neurobehavioral services for individuals with brain injury.

B. Each provider shall have formal arrangements for the evaluation, assessment, and treatment of the mental health, developmental disability, substance abuse or brain injury needs of the individual.

C. The provider shall have and implement written policies and procedures that address the provision of:

1. Psychiatric care;
2. Family therapy; and
3. Staffing appropriate to the needs and behaviors of the individuals served as determined by the individuals ISPs. The policies and procedures shall document how the staffing provided is appropriate to the needs and behaviors of the individuals served.

**12VAC35-107-480. Children's residential facilities – structured program of care.**

A. There shall be evidence of a structured program of care designed to:

1. Meet the individuals' physical and emotional needs as outlined within the individual's ISP;
2. Provide protection, guidance, and supervision; and
3. Meet the objectives of any required ISP.

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B. There shall be evidence of a structured daily routine designed to ensure the delivery of program services. Documentation of the routine shall be readily available for the individuals served or their authorized representative.

C. A daily communication log shall be maintained to inform staff of significant happenings or problems experienced by individuals. The identity of the individual making each entry in the daily communication log shall be recorded.

D. Health and dental complaints and injuries shall be recorded and shall include the (i) individual's name, complaint, and affected area; (ii) time of the complaint; and (iii) plan to provide appropriate treatment or care. E. Routines shall be planned to ensure that each individual receives the amount of sleep and rest appropriate for his age and physical condition.

F. Staff shall promote good personal hygiene of individuals by monitoring and supervising hygiene practices each day and by providing instruction when needed.

G. The structured daily routine shall comply with any facility and locally imposed curfews.

**12VAC35-107-490. Children's residential facilities – participation of individuals in human research.**

The provider shall:

1. Implement a written policy stating that individuals will not be used as subjects of human research; or

2. Document approval, as required by the department for each research project using individuals as subjects of human research, unless such research is exempt from review. The provider may participate in human research activity when such activity has been considered and approved by a university institutional review board (IRB) that complies with the relevant requirements of § 32.1-162.19 of the Code of Virginia as required by 12VAC35-180-40.

**12VAC35-107-500. Children's residential facilities – physical or mental health of personnel.**

A. The provider or the department may require a report of examination by a licensed physician or mental health professional when there are indications that an individual's physical, mental, or emotional health may jeopardize the care of individuals.

B. An individual who is determined by a licensed physician or mental health professional to show an indication of a physical or mental condition that may jeopardize the safety of individuals served or that would prevent the performance of duties shall be removed immediately from contact with individuals served and food served to individuals until the condition is cleared as evidenced by a signed statement from the physician or mental health professional.

**12VAC35-107-510. Children's residential facilities – suspected child abuse or neglect.**

A. Written policies and procedures related to child abuse and neglect shall be distributed and reviewed as part of the orientation to all staff members in addition to the requirements of 12VAC35-106-290. These shall include procedures for:

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1. Handling accusations against staff; and

2. Promptly referring, consistent with requirements of the Code of Virginia, suspected cases of child abuse and neglect to the local child protective services unit and for cooperating with the unit during any investigation.

B. Any case of suspected child abuse or neglect shall be reported to the local child protective services unit as required by the Code of Virginia.

C. Any case of suspected child abuse or neglect occurring at the facility, on a facility-sponsored event or excursion, or involving facility staff shall be reported immediately to (i) the Office of Human Rights and placing agency; and (ii) either the individual's parent or legal guardian, or both, as appropriate.

D. When a case of suspected child abuse or neglect is reported to child protective services, the individual's record shall include:

1. The date and time the suspected abuse or neglect occurred;

2. A description of the suspected abuse or neglect;

3. Action taken as a result of the suspected abuse or neglect; and

4. The name of the person to whom the report was made at the local child protective services unit.

**12VAC35-107-520. Children's residential facilities – staff quarters.**

A. A separate, private bedroom shall be provided for staff and their families when a staff member is on duty for 24 consecutive hours or more.

B. A separate private bathroom shall be provided for staff and their families when there are more than four persons in the living unit and the staff person is on duty for 24 consecutive hours or more.

C. Staff and members of their families shall not share bedrooms with individuals served.

**12VAC35-107-530. Children's residential facilities. Staff supervision of individuals.**

A. No member of the child care staff shall be on duty more than six consecutive days without a rest day, except in an emergency or as approved by the department for live-in staff.

B. Child care staff shall have an average of at least two rest days per week in any four-week period. Rest days shall be in addition to vacation time and holidays.

C. Child care staff other than live-in staff shall not be on duty more than 16 consecutive hours, except in an emergency.

D. There shall be at least one trained child care worker on duty and actively supervising individuals at all times that one or more individuals are present.

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E. Whenever children are being supervised by staff there shall be at least one staff person present with a current basic certificate in standard first aid and a current certificate in cardiopulmonary resuscitation issued by the American Red Cross or other recognized authority.

F. Supervision policies.

1. The provider shall develop and implement written policies and procedures that address staff supervision of children including contingency plans for individual illnesses, emergencies, off-campus activities, and individual preferences. These policies and procedures shall be based on the:

- a. Needs of the population served;
- b. Types of services offered;
- c. Qualifications of staff on duty; and
- d. Number of individuals served.

2. At all times the following ratios of staff to children are required, during hours individuals are awake:

- a. For children from birth to the age of 16 months: one staff member for every three children;
- b. For children 16 months old to two years: one staff member for every four children;
- c. For two-year-old children to three years of age: one staff member for every six children;
- d. For children three years of age and older: one staff member for every eight children.

At all times the ratio of staff to children shall be one staff member for every eight children during hours individuals are asleep. The department may require a different ratio based on the needs of the population served. The provider may also apply for a supervision plan with a different ratio based on the needs of the population served.

3. Providers requesting a ratio that allows a higher number of individuals to be supervised by one staff person than was approved or required shall submit a justification to the department that shall include:

- a. Why individual care will not be adversely affected; and
- b. How individuals' needs will be met on an individual as well as group basis.

4. Written policies and procedures governing supervision of individuals and any justifications for a ratio deviation that allows a higher number of individuals to be supervised by one staff than was approved or required shall be reviewed and approved by the department prior to implementation.

5. The supervision policies or a summary of the policies shall be provided, upon request, to the placing agency or legal guardian prior to placement.

**12VAC35-107-540. Children's residential facilities – searches.**

Underlined = new language.

A. Strip searches and body cavity searches are prohibited except:

1. As permitted by other applicable state regulations; or
2. As ordered by a court of competent jurisdiction.

B. A provider shall have a written policies and procedures regarding pat downs. The policy or procedure shall include provisions which state:

1. Whether pat downs are prohibited by the provider;
2. If permitted, pat downs shall be limited to instances where they are necessary to prohibit contraband;
3. If permitted, pat downs shall be conducted by personnel of the same gender as the individual being searched;
4. If permitted, pat downs shall be conducted only by personnel who are specifically authorized to conduct searches by the written policies and procedures; and
5. If permitted, pat downs shall be conducted in such a way as to protect the individual's dignity and in the presence of one or more witnesses.

**12VAC35-107-550. Children's residential facilities – behavior support.**

A. Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the individual to self-manage his own behaviors. Each individualized behavior support plan shall be derived from functional behavior assessment procedures and at a minimum include:

1. Results of functional behavior assessment to include proposed hypothesized function(s) of problem behavior;
2. Definition(s) of problem behavior(s) and functionally equivalent replacement behavior(s);
3. Identification and consideration of the individual's preferences/reinforcers;
4. Identification of antecedent strategies;
5. Identification of consequence strategies;
6. Identification of strategies to promote acquisition of functionally equivalent replacement behaviors and/or alternative adaptive behaviors; and
7. Specification of how data will be collected for both problem and desired behavior(s).

B. Individualized behavior support plans shall be developed in consultation with the following, as applicable:

1. Individual;
2. Legal guardian;
3. Individual's parents, if appropriate;

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4. Program director;
5. Placing agency staff, if appropriate; and
6. Other appropriate individuals.

C. Prior to working alone with any individual each staff member shall demonstrate knowledge and understanding of that individual's behavior support plan.. Prior to working alone with any individual the provider shall test the staff member's knowledge, competency or both in the individual's behavior support plan, and retain documentation of the test of the staff member's knowledge, competency or both within the staff member's personnel file.

D. Each provider shall develop and implement written policies and procedures concerning behavior support plans and emergency crisis/safety interventions that are directed toward maximizing the growth and development of the individual. In addition to addressing the previous requirements of this regulation, these policies and procedures shall:

1. Comply with the Human Right Regulations, specifically 12VAC35-115-110 regarding behavior treatment plans;
2. Define and list techniques that are used and are available for use in the order of their relative degree of intrusiveness or restrictiveness;
3. Specify the staff members who may authorize the use of each technique;
4. Specify the processes for implementing such policies and procedures;
5. Specify the mechanism for monitoring the use of behavior support techniques; and
6. Specify the methods for documenting the use of behavior support and/or emergency crisis/safety techniques.

**12VAC35-107-560. Children's residential facilities – time-out.**

A. The provider shall develop and implement written policies and procedures governing the conditions under which an individual may be placed in timeout. The policies and procedures shall:

1. Comply with the requirements of the Human Rights Regulations, specifically 12VAC35-115-110;
2. Provide the maximum period of timeout. The conditions and maximum period of timeout shall be based on the individual's chronological age and developmental level and shall not exceed 30 minutes per episode;
3. Require that the area in which an individual is placed shall not be locked nor the door secured in a manner that prevents the individual from opening it, nor staff preventing egress in any other manner during the timeout; and
4. Require that an individual in timeout shall be able to communicate with staff.

D. The individual shall be in view at all times while time out procedures are being implemented;

E. Use of timeout shall be documented.

Underlined = new language.

**12VAC35-107-570. Children's residential facilities – case management services.**

A. The program of the facility shall be designed to provide case management services. At the time of the admission of any individual the provider shall identify in writing the staff member responsible for providing case management services. Case management services shall address:

1. Helping the individual and the parents or legal guardian to understand the effects on the individual of separation from the family and the effect of group living;

2. Assisting the individual and the family to maintain their relationships and prepare for the individual's future care;

3. Utilizing appropriate community resources to provide services and maintain contacts with such resources;

4. Helping the individual strengthen his capacity to function productively in interpersonal relationships;

5. Conferring with the staff in direct care positions to help them understand the individual's needs in order to promote adjustment to group living; and

6. Working with the individual and with the family or any placing agency that may be involved in planning for the individual's future and in preparing the individual for the return home or to another family for independent living or for other residential care. This shall include working with the individual on discharge, which shall meet all of the requirements of 12VAC35-106-450 and 12VAC35-107-650. The case manager shall ensure that the individual's discharge team consists at a minimum of:

\_\_\_\_\_ a. The individual served;

\_\_\_\_\_ b. The individual's legal guardian or authorized representative, if applicable;

\_\_\_\_\_ c. Any additional family members that will assist in the individual's return home;

\_\_\_\_\_ d. The individual's placing agency if appropriate;

\_\_\_\_\_ e. Appropriate treatment team members; and

\_\_\_\_\_ f. Appropriate medical team members, if appropriate.

B. The provision of case management services shall be documented in each individual's record.

**12VAC35-107-580. Children's residential facilities – education.**

A. Each individual of compulsory school attendance age shall be enrolled, as provided in the Code of Virginia, in an appropriate educational program within five school business days. Documentation of the enrollment shall be kept in the individual's record.

B. The provider shall ensure that educational guidance and counseling in selecting courses is provided for each individual.

Underlined = new language.

1. The provider shall provide such guidance and counseling at the time of enrollment.
  2. Additional counseling and guidance shall be provided any time the provider receives additional information about the individual's past education.
- C. The provider shall ensure that education is an integral part of the individual's total program, by ensuring that the individual's education is integrated into their ISP.
- D. Providers operating educational programs for children with disabilities shall operate those programs in compliance with applicable state and federal statutes and regulations, including §§ 22.1-319 through 22.1-333 of the Code of Virginia and the Regulations Governing Special Education Programs for Children with Disabilities in Virginia (8VAC20-81).
- E. When a child with a disability has been placed in a residential facility, the facility shall contact the division superintendent of the individual's home locality in writing. Documentation of the contact with the individual's home school shall be kept in the individual's record.
- F. A provider that has an academic or vocational program shall document that teachers meet the qualifications to teach the same subjects in the public schools.
- G. Each provider shall develop and implement written policies and procedures to ensure that each individual has adequate study time.

**12VAC35-107-590. Children's residential facilities – recreation.**

- A. The provider shall have a written description of its recreation program that describes activities that are consistent with the facility's total program and with the ages, developmental levels, interests, and needs of the individuals that includes:
1. Opportunities for individual and group activities;
  2. Free time for individuals to pursue personal interests that shall be in addition to a formal recreation program, except this subdivision does not apply to secure custody facilities;
  3. Use of available community recreational resources and facilities, except this subdivision does not apply to secure custody facilities;
  4. Scheduling of activities so that they do not conflict with meals, religious services, educational programs, or other regular events; and
  5. Regularly scheduled indoor and outdoor recreational activities that are structured to develop skills and attitudes.
- B. The provider shall develop and implement written policies and procedures to ensure the safety of individuals participating in recreational activities that include:
1. How activities will be directed and supervised by individuals knowledgeable in the safeguards required for the activities;
  2. How individuals are assessed for suitability for an activity and the supervision provided; and

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3. How safeguards for water-related activities will be provided, including ensuring that a certified lifeguard supervises all swimming activities.

C. For all overnight recreational trips away from the facility the provider shall document trip planning. The provider shall ensure that the trip planning documents that the same level of supervision and safety shall be provided to the individuals served as when the individuals are within the residential facility.

D. All overnight out-of-state or out-of-country recreational trips require written permission from each individual's legal guardian. Documentation of the written permission shall be kept in the individual's record.

**12VAC35-107-600. Children's residential facilities – clothing.**

A. Provision shall be made for each individual to have an adequate supply of clean, comfortable, and well-fitting clothes and shoes for indoor and outdoor wear.

B. Clothes and shoes shall be similar in style to those generally worn by children of the same age in the community who are engaged in similar activities, except this requirement does not apply to secure custody facilities.

C. Individuals shall have the opportunity to participate in the selection of their clothing, except this requirement does not apply to secure custody facilities.

D. Individuals shall be allowed to take personal clothing when leaving the facility.

**12VAC35-107-610. Children's residential facilities – allowances and spending money.**

A. The provider shall provide opportunities appropriate to the ages and developmental levels of the individuals for learning the value and use of money.

B. There shall be a written policy regarding allowances that shall be made available to legal guardians at the time of admission.

C. An individual's funds, including any allowance or earnings, shall be used for the individual's benefit.

**12VAC35-107-620. Children's residential facilities – work and employment.**

A. Assignment of chores, that are paid or unpaid work assignments, shall be in accordance with the age, health, ability, and service plan of the individual.

B. Chores shall not interfere with school programs, study periods, meals, or sleep.

C. Work assignments or employment outside the facility, including reasonable rates of pay, shall be approved by the program director with the knowledge and consent of the legal guardian.

D. In both work assignments and employment, the program director shall evaluate the appropriateness of the work and the fairness of the pay.

**12VAC35-107-630. Children's residential facilities – visitation at the facility, the individual's home and individual's visitation to the homes of staff.**

**Underlined = new language.**

A. The provider shall have and implement written visitation policies and procedures that allow reasonable visiting privileges and flexible visiting hours, except as permitted by other applicable state regulations.

B. Copies of the written visitation policies and procedures shall be made available to the parents, when appropriate, legal guardians, the individual, and other interested persons important to the individual no later than the time of admission, except that when parents or legal guardians do not participate in the admission process, visitation policies and procedures shall be mailed to them within 24 hours after admission.

C. If a provider permits staff to take residents to the staff's home, the facility must receive written permission of the individual's legal guardian or placing agency before the visit occurs. The written permission shall be kept in the individual's record.

**12VAC35-107-640. Children's residential facilities – prohibitions.**

The following actions are prohibited:

1. Deprivation of drinking water or food necessary to meet an individual's daily nutritional needs, except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record;

2. Limitation on contacts and visits with the individual's attorney, a probation officer, regulators, or placing agency representative;

3. Bans on contacts and visits with family or legal guardians, except as permitted by other applicable state regulations or by order of a court of competent jurisdiction;

4. Delay or withholding of incoming or outgoing mail, except as permitted by other applicable state and federal regulations or by order of a court of competent jurisdiction;

5. Any action that is humiliating, degrading, or abusive;

6. Corporal punishment;

7. Subjection to unsanitary living conditions;

8. Deprivation of opportunities for bathing or access to toilet facilities, except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record;

9. Deprivation of health care;

10. Deprivation of appropriate services and treatment;

11. Application of aversive stimuli, except as permitted pursuant to other applicable state regulations;

12. Administration of laxatives, enemas, or emetics, except as ordered by a licensed physician or poison control center for a legitimate medical purpose and documented in the individual's record;

13. Deprivation of opportunities for sleep or rest, except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record; and

Underlined = new language.

14. Limitation on contacts and visits with advocates employed by the department or the Virginia Office for Protection and Advocacy.

**12VAC35-107-650. Children's residential facilities – discharge.**

A. All providers shall comply with the provisions related to discharge within 12VAC35-106-450. In addition, children's residential providers shall have written criteria for discharge that shall include:

1. Criteria for an individual's completing the program that are consistent with the facility's programs and services;

2. Conditions under which an individual may be discharged before completing the program; and

3. Procedures for assisting placing agencies in placing the individuals should the facility cease operation.

B. The provider's criteria for discharge shall be accessible to individuals served, legal guardians, and placing agencies.

C. The individual record of each individual discharged upon receipt of the order of a court of competent jurisdiction shall contain a copy of the court order.

D. Individuals shall be discharged only to the legal guardian or legally authorized representative.

E. A facility approved to provide residential respite care shall discharge an individual when the legal guardian no longer intends to use the facility's services.

F. Information concerning current medications, need for continuing therapeutic interventions, educational status, and other items important to the individual's continuing care shall be provided to the legal guardian or legally authorized representative, as appropriate.

G. In lieu of a comprehensive discharge summary, as required by 12VAC35-106-450, the record of each individual discharged upon receipt of the order of a court of competent jurisdiction shall contain a copy of the court order.

**12VAC35-107-660. Children's residential facilities – placement of residents outside the facility.**

An individual shall not be placed outside the facility prior to the facility obtaining a child-placing agency license from the Department of Social Services, except as permitted by statute or by order of a court of competent jurisdiction.

**12VAC35-107-670. Children's residential facilities – additional physical environment requirements.**

A. Smoking shall be prohibited in living areas and in areas where individuals participate in programs.

B. Each living unit shall have a living room, or other area for informal use, relaxation, and entertainment. The furnishings shall provide a comfortable, homelike environment that is appropriate to the ages of the individuals.

Underlined = new language.

C. All facilities shall have indoor recreation space that contains indoor recreation materials appropriate to the ages and interests of the individuals.

D. Facilities licensed to care for 13 or more individuals shall have indoor recreation space distant from the living room. Recreation space is not required in every living unit.

E. Facilities serving a school-age population shall provide study space. Study space may be assigned in areas used interchangeably for other purposes.

F. Study space shall be well lighted, quiet, and equipped with tables or desk and chairs.

G. Meals shall be served in areas equipped with sturdy tables and benches or chairs that are size and age appropriate for the individuals.

H. Adequate kitchen facilities and equipment shall be provided for preparation and serving of meals.

I. Walk-in refrigerators, freezers, and other enclosures shall be equipped to permit emergency exits.

J. Space shall be provided for safe storage of items such as recreational equipment, luggage, out-of-season clothing, and other materials.

K. Space shall be provided for administrative activities including, as appropriate to the program, confidential conversations and provision for storage of records and materials.

L. Outdoor recreation space shall be available and appropriately equipped for the individuals' served use.

**Article 3. Correctional facilities.**

**12VAC35-107-680. Clinical and security coordination.**

A. The provider shall have formal and informal methods of resolving procedural and programmatic issues arising between the clinical and security employees or contractors. The methods shall ensure individual care.

B. The provider shall demonstrate ongoing communication between clinical and security employees to ensure individual care.

C. The provider shall provide cross-training for the clinical and security employees or contractors that includes:

1. Mental health, developmental disability, and substance abuse education;
2. Use of clinical and security restraints; and
3. Channels of communication.

D. Employees or contractors shall receive periodic in-service training, and have knowledge of and be able to demonstrate the appropriate use of clinical and security restraint.

Underlined = new language.

E. Security and behavioral assessments shall be completed at the time of admission to determine service eligibility and at least weekly for the safety of individuals, other persons, employees, and visitors.

F. Personal grooming and care services for individuals shall be a cooperative effort between the clinical and security employees or contractors.

G. Clinical needs and security level shall be considered when arrangements are made regarding privacy for individual contact with family and attorneys.

H. Living quarters shall be assigned on the basis of the individual's security level and clinical needs.

I. An assessment of the individual's clinical condition and needs shall be made when disciplinary action or restrictions are required for infractions of security measures.

J. Clinical services consistent with the individual's condition and plan of treatment shall be provided when security detention or isolation is imposed.

**12VAC35-107-690. Other requirements for correctional facilities.**

A. The use of audio equipment, such as televisions, radios, and record players, shall not interfere with therapeutic activities.

B. Aftercare planning for individuals nearing the end of incarceration shall include a provision for continuing medication and follow-up services with area community services to facilitate successful reintegration into the community including specific appointment provided to the inmate no later than the day of release.

**Article 4. Community gero-psychiatric residential services.**

**12VAC35-107-700. Community gero-psychiatric residential services admission criteria.**

An individual receiving community gero-psychiatric residential services shall have had a medical, psychiatric, and behavioral evaluation to determine that he cannot be appropriately cared for in a nursing home or other less intensive level of care but does not need inpatient care. These evaluations shall be a part of the individual's record. The individual's ISP shall include documentation that the individual's needs require community gero-psychiatric residential services.

**12VAC35-107-710. Physical environment requirements of community gero-psychiatric residential services.**

A. Providers shall be responsible for ensuring safe mobility and unimpeded access to programs or services by installing and maintaining ramps, handrails, grab bars, elevators, protective surfaces, and other assistive devices or accommodations as determined by periodic review of the needs of the individuals being served. Entries, doors, halls, and program areas, including bedrooms, must have adequate room to accommodate wheelchairs and allow for proper transfer of individuals. Single bedrooms shall have at least 100 square feet and multi-bed rooms shall have at least 80 square feet per individual.

Underlined = new language.

B. Floors must have resilient, nonabrasive, and slip-resistant floor surfaces and floor coverings that promote mobility in areas used by individuals and promote maintenance of sanitary conditions.

C. Temperatures shall be maintained between 70°F and 80°F throughout individual's served areas.

D. Bathrooms, showers, and program areas must be accessible to individuals. There must be at least one bathing unit available by lift, door, or swivel-type tub.

E. Areas must be provided for quiet and for recreation.

F. Areas must be provided for charting, storing of administrative supplies, a utility room, employee hand washing, dirty linen, clean linen storage, clothes washing, and equipment storage.

**12VAC35-107-720. Service requirements for providers of gero-psychiatric residential services.**

A. Providers shall provide mental health, nursing and rehabilitative services; medical and psychiatric services; and pharmaceutical services for each individual as specified in the ISP.

B. Providers shall provide crisis stabilization services.

C. Providers shall implement written policies and procedures that support an active program of mental health and behavioral management services directed toward assisting each individual to achieve outcomes consistent with the highest level of self-care, independence, and quality of life. Programming may be on-site or at another location in the community.

D. Providers shall implement written policies and procedures that respond to the nursing needs of each individual to achieve outcomes consistent with the highest level of self-care, independence, and quality of life. Providers shall be responsible for:

1. Providing each individual services to prevent clinically avoidable complications, including: skin care, dexterity and mobility, continence, hydration, and nutrition;
2. Giving each individual proper daily personal attention and care, including skin, nail, hair, and oral hygiene, in addition to any specific care ordered by the attending physician;
3. Dressing each individual in clean clothing and encouraging each individual to wear day clothing when out of bed;
4. Providing each individual tub or shower baths as often as needed, but not less than twice weekly or a sponge bath daily if the medical condition prohibits tub or shower baths;
5. Providing each individual appropriate pain management; and
6. Ensuring that each individual has his own personal utensils, grooming items, adaptive devices, and other personal belongings including those with sentimental value.

E. Providers shall integrate behavioral and mental health care and medical and nursing care in the ISP.

Underlined = new language.

F. Providers shall have available nourishment between scheduled meals.

G. Providers shall have employees or contractors regularly monitor individuals in all areas of the residence to ensure safety.

**12VAC35-107-730. Staffing requirements for community gero-psychiatric residential services.**

A. Community gero-psychiatric residential services shall be under the direction of a:

1. Program director with experience in gero-psychiatric services;
2. Medical director; and
3. Director of clinical services who is a registered nurse with experience with a geriatric population and with psychiatric services.

B. Providers shall provide qualified nursing supervisors, nurses, and certified nurse aides on all shifts, seven days per week, in sufficient number to meet the assessed nursing care and behavioral management needs determined by the ISPs of the individual's served.

C. Providers shall provide qualified staff for behavioral, psychosocial rehabilitation, rehabilitative, mental health, or recreational programming to meet the needs determined by the ISPs of the individual's served. These services shall be under the direction of a registered nurse, licensed psychologist, licensed clinical social worker, or licensed therapist.

**12VAC35-107-740. Interdisciplinary services planning team required for gero-psychiatric residential services.**

A. At a minimum, a registered nurse, a licensed psychologist, a licensed social worker, a therapist (recreational, occupational or physical therapist), a pharmacist, and a psychiatrist shall participate in the development and review of the ISP. Other employees or contractors as appropriate shall be included.

B. The interdisciplinary services planning team shall meet to develop the ISP and review it quarterly. Members of the team shall be available for consultation on an as needed basis.

C. The interdisciplinary services planning team shall review the medications prescribed at least quarterly and consult with the primary care physician as needed.

D. The interdisciplinary services planning team shall integrate medical care plans prescribed by the primary care physician into the ISP and consult with the primary care physician as needed.

**12VAC35-107-750. Employee or contractor qualifications and training for gero-psychiatric residential services.**

A. A nurse aide may be employed only if he is certified by the Board of Nursing. During the initial 120 days of employment, a nurse aide may be employed if he is enrolled full-time in a nurse aide education program approved by the Virginia Board of Nursing or has completed a nurse aide education program or competency testing.

Underlined = new language.

B. All nursing employees or contractors, including certified nursing assistants, must have additional competency-based training in providing mental health services to geriatric individuals, including behavior management.

**12VAC35-107-760. Medical director for gero-psychiatric residential services.**

Providers of community gero-psychiatric residential services shall employ or have a written agreement with one or more psychiatrists with training and experience with a geriatric population and with psychiatric services to serve as medical director. The duties of the medical director shall include:

1. Responsibility for overall medical and psychiatric care;
2. Advising the program director and the director of clinical services on medical and psychiatric issues, including the criteria for individuals to be admitted, transferred, or discharged;
3. Advising on the development, execution, and coordination of policies and procedures that have a direct effect upon the quality of medical, nursing, and psychiatric care delivered to individuals; and
4. Acting as liaison and consulting with the administrator and the primary care physician on matters regarding medical, nursing, and psychiatric care policies and procedures.

**12VAC35-107-770. Physician services and medical care required for gero-psychiatric residential services.**

A. Each individual in a community gero-psychiatric residential service shall be under the care of a primary care physician. Nurse practitioners and physician assistants licensed to practice in Virginia may provide care in accordance with their practice agreements. Prior to, or at the time of admission, each individual, his authorized representative, or the entity responsible for his care shall designate a primary care physician.

B. The primary care physician shall conduct a physical examination at the time of admission or within 72 hours of admission into a community gero-psychiatric residential service. The primary care physician shall develop, in coordination with the interdisciplinary services planning team, a medical care plan of treatment for an individual.

C. All physicians or other prescribers shall review all medication orders at least every 60 days or whenever there is a change in medication.

D. The provider shall have an emergency medical care plan.

**12VAC35-107-780. Pharmacy services for providers of community gero-psychiatric residential services.**

A. The provider shall make provision for 24-hour emergency pharmacy services.

B. The provider shall have a written agreement with a qualified pharmacist to provide consultation on all aspects of the provision of pharmacy services and for regular visits, at least monthly.

Underlined = new language.

C. A pharmacist licensed by the Virginia Board of Pharmacy shall review each individual's medication regimen. Any irregularities identified by the pharmacist shall be reported to the physician and the director of clinical services, and their response documented.

**Article 5. Sponsored residential homes.**

**12VAC35-107-790. Sponsored residential home information.**

Providers of sponsored residential home services shall maintain the following information:

1. Names and ages of residential sponsors;
2. Date of sponsored residential home agreement;
3. The maximum number of individuals that can be placed in the home at a given time;
4. Names and ages of all other individuals who are not receiving services but are residing in a sponsored residential home;
5. Address and telephone number of the sponsored residential home; and
6. Names of all staff employed in the home, including on-call and substitute staff.

**12VAC35-107-800. Sponsored residential home agreements.**

A. The provider shall maintain a written agreement with residential home sponsors. Sponsors are persons who provide the home where the service is located and are directly responsible for the provision of services. The agreement shall include the:

1. Provider's responsibilities;
2. Sponsor's responsibilities;
3. Scope of services;
4. Supervision;
5. Compensation;
6. Training; and
7. Reporting requirements and procedures.

B. The agreement shall be available for inspection by the licensing specialist and shall include a provision for granting the right of entry to state licensing specialists or human rights advocates to conduct inspections.

**12VAC35-107-810. Sponsor qualification and approval process.**

A. The provider shall evaluate and certify each sponsored residential home other than his own through face-to-face interviews, home inspections, and other information documenting compliance with this section. The provider shall submit the certification form to the department before individuals are placed in the home and ensure that the following requirements are met annually.

Underlined = new language.

B. The provider shall certify and document that each sponsored residential home meets the criteria for physical environment and residential services in these regulations.

C. The provider shall document the ability of the sponsored residential home staff to meet the needs of the individuals placed in the home by assessing and documenting:

1. The ability of the sponsor or any staff to communicate and understand individuals receiving services;
2. The ability of the sponsor or any staff to provide the care, treatment, training, or habilitation for individuals receiving services in the home;
3. The abilities of all members of the sponsored household to accept individuals with disabilities and their disability-related characteristics, especially the ability of children in the household to adjust to nonfamily members living with them;
4. The financial capacity of the sponsor to meet the sponsor's own expenses for up to 90 days, independent of payments received for individuals living in the home; and
5. The education, qualifications, and experience of the sponsor or staff with the individuals served including Virginia Department of Motor Vehicles driving record, tuberculosis screening, first-aid and CPR certification, and completion of medication administration and behavior interventions training.

D. The provider shall comply with all elements of 12VAC35-106-250 for the sponsor and all staff.

E. The provider shall implement written policies for obtaining references, criminal background checks, and registry checks for all adults in the home who are neither staff nor individuals being served. The policy shall indicate what action the provider will take if the results indicate that a member of the sponsor family has been convicted of a barrier crime or fails to meet the requirements of this regulation should an ineligible result be received.

F. The sponsored residential home shall submit to the provider the results of a physical and mental health examination of family members when requested by the provider based on indications of a physical or mental health issue.

G. Sponsored residential homes shall not also operate as group homes or Department of Social Services approved homes or foster homes.

H. The provider shall submit a service modification application as required by 12VAC35-106-80 prior to adding a sponsored residential home. The provider shall submit the name and address of the sponsored residential home to the department prior to closing a home.

### **12VAC35-107-820. Supervision.**

A. The provider shall have a supervisor for every 15 sponsored residential homes where individuals are residing.

B. A responsible adult shall be available to provide supervision to the individual as specified in the ISP.

Underlined = new language.

C. Any member of the sponsor family household who transports individuals receiving services must have a valid driver's license and automobile liability insurance. The vehicle used to transport individuals receiving services shall have a valid registration and inspection sticker.

D. The sponsor shall inform the provider in advance of any anticipated additions or changes in the sponsored residential home or as soon as possible after an unexpected change occurs.

E. In addition to the current reporting requirements the sponsor shall report all hospitalizations of individuals being served to the provider and the individual's case manager within 24 hours.

#### **12VAC35-107-830. Sponsored residential home service records.**

Providers of sponsored residential home services shall maintain the following records on each sponsored residential home:

1. Documentation of all elements required within the Sponsor qualification and approval process as laid out in 12VAC35-107-810;

2. Orientation and training provided by the provider to the sponsor and employees;

3. The log of provider inspections of the sponsored residential home including the date, the employee conducting the inspection, the purpose of the inspection, and a description of any significant events or findings; and

4. The daily log maintained by the sponsor of significant events related to individuals receiving services.

#### **12VAC35-107-840. Sponsored residential home staff.**

Providers shall certify and document compliance of sponsors with all regulatory provisions pertaining to staff within the General Chapter 12VAC35-106 and this chapter.

#### **12VAC35-107-850. Sponsored residential home service policies.**

A. The provider shall implement written policies to provide orientation and supportive services to the sponsored residential home staff specific to the needs of the individuals receiving services.

B. The provider shall implement a training plan for the sponsor staff consistent with the needs of the individuals receiving services.

C. The provider shall specify and provide staffing arrangements in all sponsored residential homes, including on-call and substitute care arrangements.

D. The provider shall implement a written policy on managing, monitoring, and supervising sponsored residential homes. This policy shall address changes in supervision arrangements as the number of homes increase.

E. The provider shall conduct inspections of each sponsored residential home other than his own. Inspections shall be performed at least on a quarterly basis during the year with at least two being unannounced inspections.

Underlined = new language.

F. On an on-going basis and at least annually, the provider shall review and document compliance by each sponsored residential home and sponsor with regulations related to sponsored residential homes.

G. The provider shall develop written policies for terminating a sponsored residential home.

H. The individual's support coordinator or case manager shall provide and document that the individual or their authorized representative is provided informed choice to choose a new placement when the current placement ends. Prior to moving an individual to another placement the support coordinator or case manager shall conduct and document a meeting to include the individual and his authorized representative, if applicable, the current sponsor, and a receiving placement staff, if possible.

**12VAC35-107-860. Maximum number of beds or occupants in sponsored residential homes.**

The maximum number of individuals served in a sponsored residential home is two. The maximum number of occupants in a sponsored residential home is seven.

**12VAC35-107-870. Sponsored residential home services for children.**

In addition, the following requirements shall be met for homes serving children:

1. The provider shall develop a service description based upon evidence-based practices or an accepted therapeutic model of mental health, developmental or substance abuse services, or brain injury care for children.
2. The provider shall use a treatment team model consisting of staff who provide intensive support and consultation to the sponsor.
3. Weekly team meetings and supervision shall be held with the sponsor and the individual's authorized representative to review progress on each case, review the daily behavioral information collected, and adjust the child's ISP.
4. The sponsor shall keep a daily log of behavioral and other child specific information and be available for daily Monday through Friday contact from the provider.
5. The sponsor shall receive 25 hours per year of in-service training pertaining to providing services for the child they serve in addition to the training otherwise required in these regulations. The sponsor shall also participate in ongoing training at least once a quarter.
6. The provider is not considered a child placing agency. Children are placed with the provider by licensed child placing agencies, local departments of social services, or parents.
7. The sponsor shall be at least 25 years old.
8. The sponsor shall be able to provide care and supervision during nonschool hours. If the child is not attending school, i.e. due to sickness, the sponsor shall be able to provide care and supervision during school hours.

Underlined = new language.

9. The provider shall have access through directly providing it or developing agreements for 24-hour emergency mental health care for children served with serious emotional disturbances.

**Article 6. ASAM.**

**12VAC35-107-880. Medically managed intensive inpatient (ASAM LOC 4.0) staff criteria.**

A medically managed intensive inpatient program shall meet the following staff requirements:

1. Have a team of appropriately trained and credentialed professionals who provide medical management by physicians 24 hours a day, primary nursing care and observation 24 hours a day, and professional counseling services 16 hours a day;
2. Have an interdisciplinary team of appropriately credentialed clinical staff, including addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers, who assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or behavioral disorders;
3. Have staff who are knowledgeable about the biopsychosocial dimensions of addiction as well as biomedical, emotional, behavioral, and cognitive disorders;
4. Have facility-approved addiction counselors or licensed, certified, or registered addiction clinicians who administer planned interventions according to the assessed needs of the individual; and
5. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-107-890. Medically managed intensive inpatient (ASAM LOC 4.0) program criteria.**

A medically managed intensive inpatient program shall meet the following programmatic requirements. The program shall:

1. Deliver services in a 24-hour medically managed, acute care setting and shall be available to all individuals within that setting;
2. Provide cognitive, behavioral, motivational, pharmacologic, and other therapies provided on an individual or group basis, depending on the individual's needs;
3. Provide, for the individual who has a severe biomedical disorder, physical health interventions to supplement addiction treatment;
4. Provide, for the individual who has stable psychiatric symptoms, individualized treatment activities designed to monitor the individual's mental health;
5. Provide planned clinical interventions that are designed to enhance the individual's understanding and acceptance of his addiction illness;
6. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

Underlined = new language.

7. Provide health education services;
8. Make medication assisted treatment (MAT) available for all individuals admitted to the service. MAT may be provided by facility staff or coordinated through alternative resources; and
9. Comply with 12VAC35-xxx-xxxx through 12VAC35-xxx-xxxx of the Center Based Chapter.

**12VAC35-107-900. Medically managed intensive inpatient (ASAM LOC 4.0) admission criteria.**

Before a medically managed intensive inpatient program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
2. Meet the admission criteria of Level 4.0 of ASAM, including the specific criteria for adult and adolescent populations.

**12VAC35-107-910. Medically managed intensive inpatient (ASAM LOC 4.0) discharge criteria.**

Before a medically managed intensive inpatient program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 4.0 level of care;
2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or
3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

**12VAC35-107-920. Medically managed intensive inpatient (ASAM LOC 4.0) co-occurring enhanced programs.**

A. Medically managed intensive inpatient co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals who assess and treat the individual's co-occurring mental disorders. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

B. Medically managed intensive inpatient co-occurring enhanced programs shall offer individualized treatment activities designed to stabilize the individual's active psychiatric symptoms, including medication evaluation and management.

**12VAC35-107-930. Medically monitored intensive inpatient services (ASAM LOC 3.7) staff criteria.**

Underlined = new language.

A medically monitored intensive inpatient treatment program shall meet the following staff requirements. The program shall:

1. Have a licensed physician to oversee the treatment process and ensure quality of care. A physician, a licensed nurse practitioner, or a licensed physician assistant shall be available 24 hours a day in person or by telephone. A physician shall assess the individual in person within 24 hours of admission;
2. Offer 24-hour nursing care and conduct a nursing assessment on admission. The level of nursing care must be appropriate to the severity of needs of individuals admitted to the service;
3. Have interdisciplinary staff, including physicians, nurses, addiction counselors, and behavioral health specialists, who are able to assess and treat the individual and obtain and interpret information regarding the individual's psychiatric and substance use or addictive disorders;
4. Offer daily onsite counseling and clinical services. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders with specialized training in behavior management techniques and evidence-based practices;
5. Have staff able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services;
6. Make MAT available for all individuals. MAT may be provided by facility staff or coordinated through alternative resources; and
7. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-107-940. Medically monitored intensive inpatient services (ASAM LOC 3.7) program criteria.**

A medically monitored intensive inpatient treatment program shall meet the following programmatic requirements. The program shall:

1. Be made available to all individuals within the inpatient setting;
2. Provide a combination of individual and group therapy as deemed appropriate by a licensed mental health professional and included in an assessment and treatment plan. Such therapy shall be adapted to the individual's level of comprehension;
3. Make available medical and nursing services onsite to provide ongoing assessment and care of addiction needs;
4. Provide direct affiliations with other easily accessible levels of care or close coordination through referral to more or less intensive levels of care and other services;
5. Provide family and caregiver treatment services as deemed appropriate by a licensed mental health professional and included in an assessment and treatment plan;
6. Provide educational and informational programming adapted to individual needs. The educational and informational programming shall include materials designed to enhance the

Underlined = new language.

individual's understanding of addiction and may include peer recovery support services as appropriate;

7. Utilize random drug screening to monitor drug use and reinforce treatment gains;
8. Regularly monitor the individual's adherence in taking any prescribed medications; and
9. Comply with 12VAC35-xxx-xxxx through 12VAC35-xxx-xxxx of the Center Based chapter.

**12VAC35-107-950. Medically monitored intensive inpatient (ASAM LOC 3.7) admission criteria.**

Before a medically monitored intensive inpatient program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder of the DSM or addictive disorder of moderate to high severity; and
2. Meet the admission criteria of Level 3.7 of ASAM, including the specific criteria for adult and adolescent populations.

**12VAC35-107-960. Medically monitored intensive inpatient (ASAM LOC 3.7) discharge criteria.**

A. Before a medically monitored intensive inpatient program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.7 level of care;
2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or
3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

B. Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.

**12VAC35-107-970. Medically monitored intensive inpatient (ASAM LOC 3.7) co-occurring enhanced programs.**

A. Medically monitored intensive inpatient co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services as indicated by the needs of individuals admitted to the service. A psychiatrist shall assess the individual by telephone within four hours of admission and in person with 24 hours following admission. An LMHP shall conduct a behavioral health-focused assessment at the time of admission. A registered nurse shall monitor the individual's progress and administer or monitor the individual's self-administration of psychotropic medications.

Underlined = new language.

B. Medically monitored intensive inpatient co-occurring enhanced programs shall be staffed by addiction psychiatrists and appropriately credentialed behavioral health professionals who are able to assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management techniques and evidence based practices. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Medically monitored intensive inpatient co-occurring enhanced programs shall offer planned clinical activities designed to promote stabilization of the individual's behavioral health needs and psychiatric symptoms and to promote such stabilization, including medication education and management and motivational and engagement strategies.

**12VAC35-107-980. Clinically managed high-intensity residential services (ASAM LOC 3.5) staff criteria.**

A clinically managed high-intensity residential care program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician, a licensed nurse practitioner, or a licensed physician assistant in case of emergency related to an individual's substance use disorder 24 hours a day seven days a week;
2. Offer onsite 24-hour-a-day clinical staffing by credentialed addiction treatment professionals and other allied health professionals, such as peer recovery specialists, who work in an interdisciplinary team;
3. Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Staff shall be able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and
4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-107-990. Clinically managed high-intensity residential services (ASAM LOC 3.5) program criteria.**

A clinically managed high-intensity residential care program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services, including a range of cognitive, behavioral, and other therapies in individual or group therapy; programming; and psychoeducation as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
2. Provide counseling and clinical interventions to teach an individual the skills needed for daily productive activity, prosocial behavior, and reintegration into family and community;
3. Provide motivational enhancement and engagement strategies appropriate to an individual's stage of readiness to change and level of comprehension;

Underlined = new language.

4. Have direct affiliations with other easily accessible levels of care or provide coordination through referral to more or less intensive levels of care and other services;
5. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
6. Provide educational, vocational, and informational programming adaptive to individual needs;
7. Utilize random drug screening to monitor progress and reinforce treatment gains as appropriate to an individual treatment plan;
8. Ensure and document that the length of an individual's stay shall be determined by the individual's condition and functioning;
9. Make a substance use treatment program available for all individuals; and
10. Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff, or coordinated through alternative resources.

**12VAC35-107-1000. Clinically managed high-intensity residential services (ASAM LOC 3.5) admission criteria.**

A. The individuals served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.

B. Before a clinically managed high-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
2. Meet the admission criteria of Level 3.5 of ASAM.

**12VAC35-107-1010. Clinically managed high-intensity residential services (ASAM LOC 3.5) discharge criteria.**

Before a clinically managed high-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.5 level of care;
2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or
3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

**12VAC35-107-1020. Clinically managed high-intensity residential services (ASAM LOC 3.5) co-occurring enhanced programs.**

Underlined = new language.

A. Clinically managed high-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within eight hours and onsite or closely coordinated offsite within 24 hours.

B. Clinically managed high-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Clinically managed high-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the individual's substance use disorder and any co-occurring mental disorder.

**12VAC35-107-1030. Clinically managed population - specific high-intensity residential services (ASAM LOC 3.3) staff criteria.**

A high-intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician, a licensed nurse practitioner, or a physician assistant in case of emergency related to an individual's substance use disorder 24 hours a day, seven days a week;
2. Have allied health professional staff onsite 24 hours a day. At least one clinician with competence in the treatment of substance use disorder shall be available onsite or by telephone 24 hours a day;
3. Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment and able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and
4. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-107-1040 Clinically managed population- specific high-intensity residential services (ASAM LOC 3.3) program criteria.**

A high-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services that shall include a range of cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreation activities as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

Underlined = new language.

2. Provide daily professional addiction and mental health treatment services that may include relapse prevention, exploring interpersonal choices, peer recovery support, and development of a social network;
3. Provide services to improve the individual's ability to structure and organize the tasks of daily living and recovery. Such services shall accommodate the cognitive limitations within this population;
4. Make available medical, psychiatric, psychological, and laboratory and toxicology services through consultation or referral as indicated by the individual's condition;
5. Provide case management, including ongoing transition and continuing care planning;
6. Provide motivational interventions appropriate to the individual's stage of readiness to change and designed to address the individual's functional limitations;
7. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;
8. Provide family and caregiver treatment services as deemed appropriate by an assessment and treatment plan;
9. Utilize random drug screening to monitor progress and reinforce treatment gains;
10. Regularly monitor the individual's adherence to taking prescribed medications;
11. Make the substance use treatment program available to all individuals served by the residential care service; and
12. Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff or coordinated through alternative resources.

**12VAC35-107-1050. Clinically managed population-specific high-intensity residential services (ASAM LOC 3.3) admission criteria.**

Before a clinically managed, population-specific, high-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
2. Meet the admission criteria of Level 3.3 of ASAM.

**12VAC35-107-1060. Clinically managed population-specific high intensity residential services (ASAM LOC 3.3) discharge criteria.**

A. Before a clinically managed, population-specific, high-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

Underlined = new language.

1. Achieved the goals of the treatment services and no longer require ASAM 3.3 level of care;
  2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or
  3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.
- B. Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.

**12VAC35-107-1070. Clinically managed population-specific high-intensity residential services (ASAM LOC 3.3) co-occurring enhanced programs.**

- A. Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within eight hours and onsite or closely coordinated offsite within 24 hours, as appropriate to the severity and urgency of the individual's mental condition.
- B. Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed psychiatrists and licensed mental health professionals who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.
- C. Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental health disorder.

**12VAC35-107-1080. Clinically managed low - intensity residential services (ASAM LOC 3.1) staff criteria.**

A clinically managed low-intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician in case of emergency related to an individual's substance use disorder, available 24 hours a day, seven days a week. The program shall also provide allied health professional staff onsite 24 hours a day;
2. Have clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorder and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions;
3. Have a team comprised of appropriately trained and credentialed medical, addiction, and mental health professionals; and

Underlined = new language.

4. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-107-1090. Clinically managed low-intensity residential services (ASAM LOC 3.1) program criteria.**

A clinically managed low-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Offer a minimum of five hours a week of professionally directed treatment in addition to other treatment services offered to individuals, such as partial hospitalization or intensive outpatient treatment the focus of which is stabilizing the individual's substance use disorder. Services shall be designed to improve the individual's ability to structure and organize the tasks of daily living and recovery;
2. Ensure collaboration with care providers to develop an individual treatment plan for each individual with time-specific goals and objectives;
3. Provide counseling and clinical monitoring to support successful initial involvement in regular, productive daily activity;
4. Provide case management services;
5. Provide motivational interventions appropriate to the individual's stage of readiness to change and level of comprehension;
6. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;
7. Include the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition;
8. Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
9. Provide addiction pharmacotherapy and the ability to arrange for pharmacotherapy for psychiatric medications;
10. Utilize random drug screening to monitor progress and reinforce treatment gains;
11. Make a substance abuse treatment program available to all individuals; and
12. Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff or coordinated through alternative resources.

**12VAC35-107-1100. Clinically managed low-intensity residential services (ASAM LOC 3.1) admission criteria.**

Before a clinically managed low-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

Underlined = new language.

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
2. Meet the admission criteria of Level 3.1 of ASAM.

**12VAC35-107-1110. Clinically managed low-intensity residential services (ASAM LOC 3.1) discharge criteria.**

Before a clinically managed low-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.1 level of care;
2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or
3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

**12VAC35-107-1120. Clinically managed low-intensity residential services (ASAM 3.1) co-occurring enhanced programs.**

A. Clinically managed low-intensity residential services co-occurring enhanced programs shall offer psychiatric services, including medication evaluation and laboratory services. Such services shall be provided onsite or closely coordinated offsite, as appropriate to the severity and urgency of the individual's mental condition.

B. Clinically managed low-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed licensed mental health professionals who are able to assess and treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Clinically managed low-intensity residential services co-occurring enhanced programs shall offer planned clinical activities that are designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.