

CHAPTER 31. RESIDENTIAL TREATMENT FACILITIES

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GENERAL

§ 31.1. Purpose.

The purpose of this chapter is to establish minimum licensing standards of facility operation, treatment and program services which include active medically necessary treatment utilizing family relationships and child strengths to enable children under 21 years of age to function within their home community, outside the residential treatment facility, with community supports, as needed upon discharge.

§ 31.2. Applicability

This chapter applies to residential treatment facilities that operate in the Commonwealth to serve children under 21 years of age.

§ 31.3. Inspections and certificates of compliance.

(a) Each facility to which this chapter applies shall be individually inspected at least once a year including at least one onsite unannounced inspection, unless otherwise specified by statute.

(b) A separate certificate of compliance shall be issued for each physical structure that qualifies for a certificate.

(c) The residential treatment facility shall post in a conspicuous and public place the current license, a list of organizations that can assist in lodging complaints and grievances, and a copy of this chapter.

§ 31.4. Definitions.

The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

Accredited RTF – A residential treatment facility accredited by a Department-recognized accrediting body, is licensed by the Department under this chapter, meets Federal requirements for participation as a psychiatric residential treatment facility and provides mental health treatment services to children.

Active treatment — The implementation of services outlined in a treatment plan developed by the treatment team in collaboration with the ISPT that is designed to meet the behavioral health needs of the child and is supervised by the psychiatrist who is responsible for the care of the child and designed to achieve the goal of the child's appropriate discharge from the residential treatment facility at the earliest possible time.

CAO – County Assistance Office.

CASSP (Child and Adolescent Service System Program) – A philosophy of collaborative service delivery in which services that are rendered to children, adolescents and their families are least restrictive and least intrusive, child centered, family focused, community based, multi-system and culturally competent.

CCYA – The County Children and Youth Agency.

Certified Day — A day of care approved by the Department under this chapter.

Change of Ownership—The sale or transfer of a facility and all of its assets to another person, corporation, organization or partnership, with the expectation that the facility will continue to operate for the same purpose for which it is currently being used.

CMS (Centers for Medicare and Medicaid Services) – An agency of the Federal Department of Health and Human Services which provides guidance to the states regarding Federal regulation of the Medicare and Medicaid programs.

Cost Settlement– A retroactive adjustment based on a cost report, following the end of a reporting period to bring the interim payments made to the provider during that reporting period into agreement with the reimbursable amount payable to the provider for the allowable services actually rendered to program beneficiaries during the period. Final adjustment is made after an audit is completed.

Covered Day — A medically necessary day of care approved by the Department for residential treatment facility services and provided by the residential treatment facility.

Department —The Department of Public Welfare of the Commonwealth of Pennsylvania.

Day of Care - Room, board, and professional behavioral health services furnished to an eligible recipient on a 24-hour day basis utilizing a midnight census hour. The term includes those items and services ordinarily furnished by the residential treatment facility for the care and treatment of the recipient. The day of admission is counted as a patient day of care but the day of discharge is not counted as a patient day of care. A day of care is counted on the day the recipient returns from temporary hospitalization but not on the day the recipient departs.

Delayed Coverage – When an admission or continued stay certification could not be accomplished because of a county assistance office (CAO) delay in determining recipient eligibility or a third party resource was responsible for payment of care.

Department's Cost Manual– The Department's non-accredited RTF Services and accredited RTF Services Manual for Cost Reporting Procedures.

Department's Utilization Review Manual- The manual used by the admission certification reviewers containing information required to

request admission certification, the review process , time lines for review and how medical necessity for admission to a residential treatment facility is determined.

Drug used as a restraint — Any drug that:

- (i) Is administered to manage a child's behavior in a way that reduces the safety risk to the child or others.
- (ii) Has the temporary effect of restricting the child's freedom of movement.
- (iii) Is not a standard treatment for the child's medical or psychiatric condition.

Eligible Recipient – An individual who has been determined eligible for MA Program benefits and is eligible on the date service is rendered and is one of the following:

- (i) Under 21 years of age.
- (ii) Age 21 and was receiving inpatient psychiatric services in an accredited residential treatment facility the day preceding the date the child reached age 21. This child continues to be recognized as an eligible recipient until the earlier of the date the child either:
 - (A) No longer requires inpatient services.
 - (B) Reaches age 22.

Emergency safety intervention —The use of an intervention such as a restraint as an immediate response to an emergency safety situation.

Emergency safety situation —Unanticipated child behavior that places the child or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention or restraint as defined in this section.

Facility - A residential treatment facility regulated under this chapter.

Family – Birth, adoptive or foster parents, grandparents, siblings and other relatives, legal custodians except child welfare agencies and others identified by the child.

Fire safety expert—A local fire department, fire protection engineer, Commonwealth certified fire protection instructor, college instructor in fire science, county or Commonwealth fire school, volunteer person trained and certified by a county or Commonwealth fire school or an insurance company loss control representative.

Fiscal Year - A period of time beginning July 1 and ending June 30 of the following year.

Hospital leave —An absence from the facility for more than 24 consecutive hours due to the child receiving inpatient treatment in a hospital, including treatment in a psychiatric unit of a hospital.

Hospital- Reserved Bed Day - A day when the recipient is approved for and admitted to an acute care general hospital, psychiatric or rehabilitation unit of an acute care general hospital, or a psychiatric or rehabilitation

hospital for which the Department agrees to make a reduced payment in order to hold the bed for the recipient's return to the facility upon discharge from the hospital or hospital unit.

Independent Team – In accredited RTFs, a team comprised of professionals in accordance with 42 CFR § 441.153(a) relating to team certifying need for services.

ISP—Individual Service Plan—A written document for each child describing the child's care and treatment needs.

ISPT (Interagency Service Planning Team) – An individualized team established to assist in the development and review of the treatment progress and ISP for every child who receives residential treatment facility services.

JPO - The Juvenile Probation Office.

Living Unit - A physically separate area in which an identifiable group of up to sixteen children reside. Living units are known as cottages, wings, dormitories, pods, or units.

Mechanical restraint —Any device attached or adjacent to the child's body that the child cannot easily remove that restricts freedom of movement or normal access to the child's body.

Mental Health-Only Admission - An admission of an eligible recipient who is not in the custody of the CCYA or under the supervision of the juvenile court and who is under 21 years of age with a mental health diagnosis, severe emotional or behavioral disorder or severe substance

abuse condition along with a a serious emotional or behavioral disorder which necessitates residential treatment facility care.

MH/MR – Mental Health/Mental Retardation

Non-Accredited RTF- A residential treatment facility that provides behavioral health treatment service to children but is not accredited by an entity recognized by the Department for enrollment as an accredited RTF and is eligible for Medicaid reimbursement for behavioral health services but not for room and board.

Non-Covered Day – Any day where the recipient is physically absent from the facility for administrative reasons, hospitalized beyond the hospital reserved bed day limit, AWOL in excess of the established policy limit or was on therapeutic leave in excess of the established therapeutic leave policy limits. This definition also includes any day of care which was determined not to be medically necessary, or was disapproved by the Department or managed care organization for failure to request admission or extension certification according to established time frames.

OCYF- The Office of Children Youth and Families.

OMAP- The Office of Medical Assistance Programs.

OMHSAS- The Office of Mental Health and Substance Abuse Services.

Patient Pay Amount - Income or assets that the CAO has determined to be available to a recipient to meet the cost of medical care. The recipient, not the Department, pays this amount toward the cost of care.

Plan of Care Summary - An overview of the child's diagnosis and individualized formal and informal services and supports provided to or requested for the child.

Personal restraint —The application of physical force without the use of any device, for the purposes of restraining the free movement of a child's body. The term personal restraint does not include briefly holding without undue force a child in order to calm or comfort him or her, or holding a child's hand to safely escort a child from one area to another.

Prospective Payment System - A payment system under which a provider's payment for future periods is determined in advance of the future periods.

Relative—A parent, child, child's guardian, individual with legal custody, stepparent, stepchild, grandparent, grandchild, sibling, half-sibling, aunt, uncle, niece, nephew or spouse.

Restraint —A personal restraint, mechanical restraint, or drug used as a restraint as defined in this section.

Seclusion —Restricting a child in a locked room, and isolating the person from any personal contact. The term locked room includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door closed, preventing the individual from leaving the room. Seclusion does not include the use of a time-out room as defined in this chapter. Locking an individual in a bedroom during sleeping hours is considered seclusion.

Secure care—Care provided in a 24-hour living setting to one or more children who are delinquent or alleged delinquent, from which voluntary egress is prohibited through one of the following mechanisms:

- (i) Egress from the building, or a portion of the building, is prohibited through internal locks within the building or exterior locks.
- (ii) Egress from the premises is prohibited through secure fencing around the perimeter of the building.

Serious injury—Any significant impairment of the physical condition of the child as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff—Individuals employed by the facility with responsibility for managing a child's health or participating in a restraint.

Therapeutic Leave - A planned period of absence from an accredited RTF directly related to the treatment of the individual's illness to assist in the transition back to the home/community, promote adaptation post discharge, and identify areas of strengths and weakness that need to be addressed in the treatment plan before discharge. For payment purposes, a day of therapeutic leave is 12 to 24 hours of continuous

absence for therapeutic reasons without regard to the calendar day and may not be used as a reward or punishment.

Time out—The restriction of a child for a period of time to a designated area from which the child is not physically prevented from leaving and may not be used in a punitive fashion or for the purpose of excluding a child from general activities, for the purpose of providing the child an opportunity to regain self-control and can be at the request of a child.

Treatment plan—The written plan included in the ISP developed for each child to improve his condition to the extent that residential care is no longer indicated that includes a summary of the goals, objectives, discharge plan and behavioral interventions proposed to address the child's behavioral health issues in the environments in which the child exhibits a behavioral health treatment need, an explanation of the appropriate settings and time allocations, and a description of any changes or updates from previous treatment plans in sufficient detail that allows for full understanding of the planned goals, objectives and interventions and their clinical relationship to each other, as well as, the continued clinical need for the service.

Treatment Team —Interdisciplinary team comprised of those employed by, or those who provide services to children in the RTF, and is responsible for the review of the treatment needs of a child receiving behavioral health services. In accredited residential treatment facility the team is comprised of professionals who meet the requirements at 42 CFR

§ 441.153(a) and (b) (relating to the team certifying the need for services) and § 441.156 (relating to the team developing individual service plan including treatment plan).

GENERAL REQUIREMENTS

§ 31.11. Licensure or approval of facilities.

The requirements of Chapter 20 (relating to licensure or approval of facilities) shall be met.

§ 31.12. Appeals.

Appeals related to the Department's licensure or approval shall be made in accordance with 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure).

§ 31.13. Maximum capacity.

(a) The maximum capacity specified on the certificate of compliance shall be based on available bedroom square footage and the number of toilets and sinks and the capacity that is appropriate to the population of children residing in the facility.

(b) The maximum capacity specified on the certificate of compliance may not be exceeded.

§ 31.14. Fire safety approval.

(a) If a fire safety approval is required in accordance with State law or regulations, a valid fire safety approval from the appropriate authority, listing the type of occupancy, is required prior to receiving a certificate of compliance under this chapter.

(b) If the fire safety approval is withdrawn or restricted, the facility shall notify the Department orally within 24 hours and in writing within 48 hours of the withdrawal or restriction.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the facility shall submit the new fire safety approval, or written certification that a new fire safety approval is not required, from the appropriate fire safety authority.

§ 31.15. Child abuse.

(a) The facility shall immediately report suspected abuse of a child in accordance with 23 Pa.C.S. §§ 6301 - 6385 (relating to the Child Protective Services Law) and Chapter 3490 (relating to protective services).

(b) If there is an allegation of child abuse involving facility staff persons, the facility shall submit and implement a plan of supervision in accordance with 23 Pa.C.S. § 6368 (relating to investigation of reports) and § 3490.56 (relating to county agency investigation of suspected child abuse

perpetrated by persons employed or supervised by child care services and residential facilities).

§ 31.16. Reportable incidents.

(a) A reportable incident is the following:

- (1) A death of a child.
- (2) A physical act by a child to commit suicide.
- (3) An injury, trauma or illness of a child requiring inpatient treatment at a hospital.
- (4) A serious injury or trauma of a child requiring outpatient treatment at a hospital, not to include minor injuries such as sprains or cuts.
- (5) A violation of a child's rights.
- (6) Intimate sexual contact between children, consensual or otherwise.
- (7) Sexual assault of a child.
- (8) A child absence from the premises for 2 hours or more without the approval of staff persons, or for 30 minutes or more without the approval of staff persons if the child may be in immediate jeopardy.
- (9) Abuse or misuse of a child's funds.

(10) An outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions).

(11) An incident requiring the services of the fire, police, or emergency management departments, except for false alarms.

(12) Any condition which results in closure of the facility.

(13) Emergency relocation of residents, food poisoning of residents, bankruptcy filed by the legal entity, prescription medication error.

(14) Criminal conviction against the legal entity, administrator or staff that are subsequent to the reporting on the criminal history checks under §31.51.

(b) The facility shall develop written policies and procedures on the prevention, reporting, investigation and management of reportable incidents to remain compliant with current Department policy.

(c) The facility shall complete a written reportable incident report, in a format prescribed by the Department, and send it to the appropriate Departmental regional office, the contracting agency, the State Medicaid Agency, the Department of Health, and Pennsylvania Protection and Advocacy within 24 hours.

(d) The facility shall orally report to the appropriate Departmental regional office and the contracting agency within 12 hours, a fire requiring the relocation of children, an unexpected death of a child and a child who is missing from the facility if police have been notified.

(e) The facility shall initiate an investigation of a reportable incident immediately following the report of the incident and shall complete the investigation within a reasonable time.

(f) The facility shall submit a final reportable incident report to the agencies specified in subsection (c) immediately following the conclusion of the investigation.

(g) If the final report validates the occurrence of the alleged incident or condition, that the facility shall notify the affected resident and other residents who could be potentially harmed, or their family.

(h) A copy of reportable incident reports shall be kept.

(i) The facility shall notify the child's parent and, if applicable, a guardian or custodian, immediately, following a reportable incident relating to a specific child, unless restricted by applicable confidentiality statutes, regulations or an individual child's court order. The facility shall document actions taken subsequent to the event until the time of contact with the parent or guardian or both.

(j) In addition to the reporting requirements contained in (c), accredited facilities must report the death of any child to the CMS regional office by no later than close of business the next business day after the child's death. Staff must document in the child's record that the death was reported to the CMS regional office.

Cross References

This section cited in 55 Pa. Code § 31.17 (relating to recordable incidents); and 55 Pa. Code § 31.274 (relating to additional requirements).

§ 31.17. Recordable incidents.

The facility shall maintain a record of the following:

- (1) All seizures.
- (2) Suicidal gestures.
- (3) Any incidence of intentionally striking or physically injuring a child.
- (4) Property damage of more than \$500.
- (5) A child absence from the premises without the approval of staff persons, that does not meet the definition of reportable incident in § 31.16(a) (relating to reportable incidents).

(6) Injuries, traumas and illnesses of children that do not meet the definition of reportable incident in § 31.16(a), which occur at the facility or offsite.

§ 31.18. Child funds.

(a) Money earned or received by a child is the child's personal property.

(b) The facility may place reasonable limits on the amount of money to which a child has access.

(c) The facility shall maintain a separate accounting system for child funds, including the dates and amounts of deposits and withdrawals.

Commingling of child and facility funds is not permitted.

(d) Except for children expected to be in the facility for fewer than 30 days, the facility shall maintain an interest-bearing account for child funds, with interest earned tracked and applied for each child.

(e) Money in the child's account shall be returned to the child upon discharge or transfer.

(f) There shall be no borrowing of child funds by the facility or staff persons.

§ 31.19. Consent to treatment.

(a) The facility shall comply with the following statutes and regulations relating to consent to treatment, to the extent applicable:

- (1) 42 Pa.C.S. §§ 6301—6365 (relating to the Juvenile Act).
- (2) The Mental Health Procedures Act (50 P. S. §§ 7101—7503).
- (3) The act of February 13, 1970 (P. L. 19, No. 10) (35 P. S. §§ 10101—10105).
- (4) Chapter 5100 (relating to mental health procedures).
- (5) The Pennsylvania Drug and Alcohol Abuse Control Act (71 P. S. §§ 1690.101—1690.115).
- (6) Act 147 (relating to consent for treatment)
- (7) Other applicable statutes and regulations.

(b) The following consent requirements apply unless in conflict with the requirements of applicable statutes and regulations specified in subsection

(a):

- (1) The written consent shall be obtained upon admission, whenever possible, from the child's parent or legal guardian, for the provision of routine health care such as child health examinations, dental care, vision care, hearing care and treatment for injuries and illnesses.

(2) A separate written consent shall be obtained prior to treatment, from the child's parent or legal guardian, or, if the parent or guardian cannot be located, by court order, for each incidence of non-routine treatment such as elective surgery and experimental procedures.

(3) Consent for emergency care or treatment is not required.

Cross References

This section cited in 55 Pa. Code § 31.31 (relating to notification of rights and grievance procedures); and 55 Pa. Code § 31.243 (relating to content of records).

§ 31.20. Confidentiality of records.

(a) The facility shall comply with the following statutes and regulations relating to confidentiality of records, to the extent applicable:

(1) 23 Pa.C.S. § § 6301—6385 (relating to the Child Protective Service Law).

(2) 23 Pa.C.S. § § 2101—2910 (relating to Adoption Act).

(3) The Mental Health Procedures Act (50 P. S. § § 7101—7503).

(4) Section 602(d) of the Mental Health and Mental Retardation Act (50 P. S. § 4602(d)).

- (5) The Confidentiality of HIV-Related Information Act (35 P. S. §§ 7601—7612).
 - (6) Sections 5100.31—5100.39 (relating to confidentiality of mental health records).
 - (7) Sections 3490.91—3490.95 (relating to confidentiality).
 - (8) Act 147 (relating to control of mental health treatment records).
 - (9) The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule (45 CFR Part 160, Subparts A and E of Part 164.)
 - (10) 42 C.F.R. (Code of Federal Regulations) PART II (relating to drug and alcohol issues)
 - (11) Other applicable statutes and regulations.
- (b) The following confidentiality requirements apply unless in conflict with the requirements of applicable statutes and regulations specified in subsection (a):
- (1) A child’s record, information concerning a child or family, and information that may identify a child or family by name or address, is confidential and may not be disclosed or used other than in the course of official facility duties.

(2) Information specified in paragraph (1) shall be released upon request only to the child's parent, the child's guardian or custodian, if applicable, the child's and parent's attorney, the court and court services, including probation staff, county government agencies, authorized agents of the Department and to the child if the child is 14 years of age or older. Information may be withheld from a child if the information may be harmful to the child. Documentation of the harm to be prevented by withholding of information shall be kept in the child's record.

(3) Information specified in paragraph (1) may be released to other providers of service to the child if the information is necessary for the provider to carry out its responsibilities. Documentation of the need for release of the information shall be kept in the child's record.

(4) Information specified in paragraph (1) may not be used for teaching or research purposes unless the information released does not contain information which would identify the child or family.

(5) Information specified in paragraph (1) may not be released to anyone not specified in paragraphs (2)—(4), without written authorization from the court, if applicable, and the child's parent and, if applicable, the child's guardian or custodian.

(6) Release of information specified in paragraph (1) may not violate the confidentiality of another child.

§ 31.21. Applicable health and safety laws.

The facility shall have a valid certificate or approval document from the appropriate State or Federal agency relating to health and safety protections for children required by another applicable law, not to include local zoning ordinances.

§ 31.22. Waivers.

(a) The facility may submit a written request for a waiver on a form prescribed by the Department, and the Department may grant a waiver of a specific section of this chapter if the following conditions exist:

(1) There is no jeopardy to the children.

(2) There is an alternative for providing an equivalent level of health, safety and well-being protection of the children.

(3) Children will benefit from the waiver of the requirement.

(b) The scope, definitions or applicability of this chapter may not be waived.

(c) The facility shall notify affected children and families of waiver decision and post both the waiver request and the Department's response in a conspicuous and public place in the facility.

(d) The Department will review waivers annually and may revoke if conditions of waiver are not met.

CHILD RIGHTS

§ 31.31. Notification of rights and grievance procedures.

(a) The RTF shall develop and implement written grievance procedures to assure the investigation and resolution of grievances.

(b) A copy of the child's rights, the grievance procedures and applicable consent to treatment protections shall be posted at the facility.

(c) The child, available parents and when applicable the child's guardian or custodian shall be informed of the child rights, and grievance procedures in an easily understood manner, and in the primary language or mode of communication of the child. The child must be informed of these rights and grievance procedures upon admission and the child's parent(s) and if applicable, the child's guardian or custodian shall be informed of the child rights and grievance procedures within seven days of the child's admission if not present when the child is admitted.

(1) The child, parent and guardian or custodian shall be given a copy of this information in writing and will sign a statement acknowledging receipt of this information to be retained in the child's file.

(2) If the RTF is unable to obtain an acknowledgement of receipt, the efforts made to obtain the signature shall be documented in the child's file

(d) A child and the child's family have the right to lodge a grievance with the facility for an alleged violation of the specific rights specified at §31.32 without fear of retaliation.

(e) The facility shall develop and implement written grievance procedures for the child, the child's family and staff persons to assure the investigation and resolution of grievances regarding an alleged violation of a child's rights.

Cross References

This section cited in 55 Pa. Code § 31.243 (relating to content of records).

§ 31.32. Specific rights.

(a) A child may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age or sex.

(b) A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

(c) A child has the right to be treated with fairness, dignity and respect.

(d) A child has the right to be informed of the rules of the facility.

(e) A child has the right to communicate with others by telephone subject to reasonable facility policy and written instructions from the contracting agency or court, if applicable, regarding circumstances, frequency, time, payment and privacy.

(f) A child shall have the right to visit with family at least once a week, at a time and location convenient for the family, the child and the facility, unless visits are restricted by court order. This right does not restrict more frequent family visits.

(g) A child has the right to receive and send mail.

(1) Outgoing mail may not be opened or read by staff persons.

(2) Incoming mail from Federal, State or county officials, or from the child's attorney, may not be opened or read by staff persons.

(3) Incoming mail from persons other than those specified in paragraph (2), may not be opened or read by staff persons. If there is reasonable suspicion that contraband, or other information that may jeopardize the child's health or safety may be enclosed, mail may be opened by the child in the presence of a staff person.

(h) A child has the right to communicate and visit privately with his attorney and clergy.

(i) A child has the right to be protected from unreasonable search and seizure. A facility may conduct search and seizure procedures, subject to reasonable facility policy approved by the Department.

(j) A child has the right to practice the religion or faith of choice, or not to practice any religion or faith.

(k) A child has the right to appropriate medical, behavioral health and dental treatment.

(l) A child has the right to appropriate rehabilitation.

(m) A child has the right to be free from excessive medication.

(n) A child may not be subjected to unusual or extreme methods of discipline which may cause psychological or physical harm to the child.

(o) A child has the right to clean, seasonal clothing that is age and gender appropriate.

§ 31.33. Prohibition against deprivation of rights.

(a) A child may not be deprived of specific or civil rights.

(b) A child's rights may not be used as a reward or sanction.

(c) A child's visits with family may not be used as a reward or sanction.

FAMILY PARTICIPATION

§ 31.41. Families involvement in the treatment process.

(a) The RTF shall ensure that the child's family is given the opportunity to participate fully, emphasizing mutual respect, in the planning for delivery of services to the child as evidenced by:

(1) Meetings being held at times convenient to the family and with adequate notice to maximize the possibility of family involvement.

(2) ISPT meetings and other formal meetings with the family as active members of the team.

(3) Frequent and regular family contact including telephone calls and visits with parents or legal guardians and other family members as well as community activities within and outside the facility.

(4) Family therapy as well as parent support and education groups involving parents or legal guardians or both, as appropriate shall be provided to all children as part of the overall treatment offered in the RTF.

(i) Consideration of providing treatment services in the child's home or community must be given during the time that the child is residing in the RTF.

(ii) The RTF shall document its efforts to link the child and family with community resources, both formal human service systems and informal community supports.

(iii) Community linkages outside the facility must be based on the planned expectation that the child will be returning to his/her own community and

will include supports to assist the child in making a smooth transition back home.

(5) Involvement of the family in making appropriate medical and medication decisions including arranging for family participation in the medical appointments when desired by the family.

(6) Involvement of the family in making appropriate decisions about activities of daily living.

(7) Formal process for families to resolve disagreements with the treatment plan or the delivery of service.

§ 31.42. Documentation of efforts for family contact.

(a) The facility shall document all efforts to involve the child's family in service planning and delivery.

(b) The facility shall ensure that the family is scheduled for an on-site visit as soon as possible and no later than 7 calendar days of the child's admission unless the family is present on the day of admission. The following information shall be discussed with the family at this time:

(1) Expectations of the family regarding their child's treatment.

(2) Expected length of stay and type of treatment that will be offered.

(3) Opportunities for family focused therapy with potential frequencies and possible locations when distance is an issue.

(4) Information about advocacy organizations and consumer satisfaction teams that are available to assist in the lodging of complaints and grievances.

§ 31.43. Space on campus for family visits.

The facility must have at least one designated area on-campus for family visits that offers privacy for the child and family.

§ 31.44. Assistance with coordination of transportation for family contacts.

The facility must assist with the coordination of available transportation for the family's on-site participation and visits when assistance with transportation is needed.

STAFFING

§ 31.51. Child abuse and criminal history checks.

Child abuse and criminal history checks shall be completed in accordance with 23 Pa.C.S. § § 6301—6385 (relating to the Child Protective Services Law) and Chapter 3490 (relating to protective services).

§ 31.52. Staff hiring, retention and utilization.

(a) Staff hiring retention and utilization shall be in accordance with 23 Pa.C.S. § § 6301—6385 (relating to the Child Protective Services Law) and Chapter 3490 (relating to protective services).

(b) Each prospective employee responsible for providing direct care to children must have a pre-employment physical, and a drug screening.

§ 31.53. Director.

(a) There shall be one director responsible for the facility. A director may be responsible for more than one facility.

(b) The director shall be responsible for administration and management of the facility, including the safety and protection of the children, implementation of policies and procedures and compliance with this chapter.

(c) A director of a facility shall have one of the following:

(1) A master's degree from an accredited college or university and 2 years work experience in administration or human services.

(2) A bachelor's degree from an accredited college or university and 4 years work experience in administration or human services.

§ 31.54. Medical director.

(a) There shall be one medical director who oversees the delivery of the treatment interventions to children.

(b) The medical director must be a board certified or board eligible psychiatrist experienced in the delivery of child and adolescent behavioral health services who is responsible for the following duties:

(1) Regular and ongoing contact with all children and more frequent contact for those children on medication, ensuring at least 2 hours per week of psychiatric time for every 5 children.

(2) Ensuring a psychiatric face to face visit with each child as deemed clinically appropriate, but not less frequently than every 30 day review period.

(3) Regular and ongoing contact with treatment staff to formulate and monitor the implementation of the child's treatment plan.

(4) Regular and ongoing face-to-face or phone contact with the child's family.

(5) Regular and ongoing contact as appropriate with external, community agencies and natural supports important to the child's life including informal networking and face-to-face participation in ISPT and treatment team meetings.

(6) Preparation of formal, written psychiatric evaluations as required.

(7) Coordination and supervision of facility staff on clinical and medical matters including the prescription and monitoring of psychotropic and other medication.

§ 31.55. Clinical director.

(a) There shall be one clinical director who ensures that all staff receives training and clinical supervision.

(b) The clinical director shall meet the minimum requirements of a mental health professional.

(c) The medical director may serve as the clinical director.

§ 31.56. Mental health professional.

(a) There shall be one mental health professional available either onsite or by telephone at all times children are at the facility.

(b) For facilities serving 16 or more children, whenever 16 or more children are present at the facility, there shall be at least one mental health professional present at the facility during awake hours.

(c) The mental health professional shall be responsible for developing and implementing the program and schedule for the children and for supervision of mental health workers.

(d) The mental health professional shall have the following:

(1) A graduate degree in a generally recognized clinical, mental health discipline including, but not limited to, psychiatry, social work, psychology, counseling, nursing, rehabilitation or activities therapies.

(2) At least 1 year of clinical experience working with children or adolescents in a behavioral health program whose operating principles were in accordance with CASSP principles.

Cross References

This section cited in 55 Pa. Code § 31.106 (relating to swimming).

§ 31.57. Mental health worker and mental health aide.

(a) The staffing ratio during awake hours must reflect the needs of the population being served. The minimum staffing ratios in this chapter shall

apply unless the Department's clinical consultants determine these minimum staffing ratios are inadequate to meet the needs of the population being served as described in the facility's program description.

(b) Staff to child ratios when the children are 6 years of age and older.

(1) During hours children are awake, there shall be 1 mental health worker present with the children for every 5 children.

(2) During sleep hours, there shall be 1 mental health worker or mental health aide present with every 10 children.

(c) Staff to child ratios when the children are under 6 years of age.

(1) During hours children are awake, there shall be one mental health worker present with the children for every 4 children.

(2) During sleep hours, there shall be one mental health worker or mental health aide present for every 8 children who are under 6 years of age.

(d) Staff to child ratios when the ages of children include under and over 6 years of age.

(1) During hours children are awake, there shall be one mental health worker present for every 4 children.

(2) During sleep hours, there shall be 1 mental health worker or mental health aide present for every 8 children.

(e) The mental health worker shall be responsible for implementing daily activities and for supervision of the children.

(f) The mental health worker shall meet one of the following requirements:

(1) A bachelor's degree; at least 12 credit hours of education in psychology, sociology, social work, counseling, nursing, education, rehabilitation counseling, or theology; and one year of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles.

(2) A licensed registered nurse and one year of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles.

(3) A high school diploma or equivalent and four years of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles.

(g) The mental health aide shall have a high school diploma or general education development certificate.

(h) A mental health worker or mental health aide who is counted in the worker to child ratio shall be 21 years of age or older.

Cross References

This section cited in 55 Pa. Code § 31.106 (relating to swimming); 55 Pa. Code § 31.171 (relating to safe transportation); and 55 Pa. Code § 31.273 (relating to exceptions for secure care).

§ 31.58. Primary contact.

(a) At the time of the child's admission, the RTF must designate an individual to be the child's primary contact during the stay at the RTF and have primary responsibility for case management. The assignment of a primary contact person for the family will, at no time, preclude parents from communicating directly with the treating physician or direct clinical care staff about their child.

(b) The primary contact's responsibilities include liaison activities with the county representative, the appropriate Behavioral Health MCO, if applicable, and with other systems involved with the child, including the child's family, behavioral health care manager, intensive case manager, and the education system.

(c) An onsite meeting with the parents or legal guardians shall occur within the first seven days of the child's admission including day of admission.

(d) The primary contact is responsible for coordinating the child's aftercare plan with the involved community agencies, education system, natural supports, and the family when the child will be returning home.

(e) The primary contact shall provide all aftercare agencies with a comprehensive written discharge summary that includes the clinical

rationale for each medication, information on treatment rendered during the RTF stay and the treatment plans developed by the treatment team.

(f) The primary contact shall ensure that all medications that the child will need before the scheduled appointment time with the community based psychiatrist are prepared for discharge.

(g) The primary contact shall assist the child's family in determining whether the medications prescribed are covered by the child's insurance so that an appropriate substitute which is covered can be prescribed.

§ 31.59. Supervision.

(a) While children are at the facility, children shall be supervised during awake and sleeping hours by conducting observational checks of each child at least every 15 minutes.

(b) Observational checks of children specified in subsection (a) shall include actual viewing of each child.

(c) Staff persons may not sleep while being counted in the staff to child ratios.

§ 31.60. Training for staff and other persons with regular and significant direct contact with children.

(a) Prior to working with children, full time, part-time and temporary staff, and volunteers, shall have an orientation to their specific duties and responsibilities; policies and procedures of the facility, including

reportable incident reporting; discipline, care and management of children; and use of restrictive procedures.

(b) Prior to working alone with children and within 120 calendar days after the date of hire, the director and each full-time, part-time and temporary staff person shall have at least 30 hours of training. If a staff person has completed comparable training within 12 months prior to the staff person's date of hire, the requirement for training under this paragraph does not apply. Training shall include at least the following areas:

(1) The requirements of this chapter.

(2) 23 Pa.C.S. §§ 6301—6385 (relating to child protective services law) and Chapter 3490 (relating to protective services).

(3) Fire safety.

(4) First aid, Heimlich techniques, cardiopulmonary resuscitation and blood borne pathogen training.

(5) Crisis intervention, behavior management and suicide prevention.

(6) Health and other special issues affecting the population.

(c) Ongoing annual training.

(1) After initial training each full-time, part-time and temporary staff person, shall have at least 40 hours of training relating to the care and management of children. This requirement for annual training does not apply for the initial year of employment unless the person to be trained is exempt from paragraph (b) above.

(2) Staff shall complete training in first aid, Heimlich techniques and cardiopulmonary resuscitation taught by an individual certified as a trainer by a hospital or other recognized health care organization. Annual training is required even if the certification is for longer than one year.

(3) Staff shall complete training in fire safety taught by a fire safety expert in facilities serving more than 20 children or in facilities serving 20 or fewer children, by a staff person trained by a fire safety expert. Video tapes prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

(4) Twenty hours of training in the following:

(A) Professional ethics and conduct and legal issues including professional boundaries with children and their families, child and general protective services, mandated reporting and confidentiality.

(B) Understanding CASSP principles and implementing and supporting those principles in clinical practice.

(C) Understanding cultural competency as described in the Cultural Competence Clinical/Rehabilitation Standards of Practice.

(D) Understanding and supporting the Department's Special Transmittal on Strategies and Practices to Eliminate the Unnecessary Use of Restraint issued on January 30, 2006 or subsequent updates.

(E) Staff must be trained on agency policy and must demonstrate the ability to effectively transfer the application of policy and procedure to their direct care work with children and their families.

(F) Characteristics of trauma informed care and attachment issues.

(G) Signs and symptoms of abuse and neglect.

(H) Serious emotional or behavioral disorders and other behavioral health needs in children as they relate to the bio-psychosocial needs of the children being served.

(I) Understanding applicable state laws related to the scope of practice for medication administration.

(J) Understanding psychotropic medications, including types, appropriate uses and possible side effects.

(K) Training appropriate to the age, characteristics, diagnosis, and development needs of the children served.

(L) Training on the discharge process.

(M) Cross–system training appropriate to the population the facility serves.

(N) Current clinical practice and methodologies to address the unique characteristics of the children served.

(O) Documentation skills and requirements.

(P) Understanding the recovery and resiliency model..

(Q) Using de-escalation techniques and alternative nonrestrictive strategies.

(R) Child development principles appropriate for the age of the children served, to understand normal behavior reactions to stress at various ages.

(d) Restrictive procedure training.

(1) In addition to the ongoing annual training listed in (c), each staff person who administers a restrictive procedure shall have completed training on a semi-annual basis in the use of interventions they may use and when they may be used.

(2) Only staff trained in the application of the type of restraint to be used may restrain a child during an emergency safety situation.

(3) Training in restraint techniques shall include:

Training in restraint techniques shall include:

- (A) Techniques to identify staff and child behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
- (B) Using de-escalation techniques and alternative nonrestrictive strategies.
- (C) Child development principles appropriate for the age of the children served, to understand normal behavior reactions to stress at various ages.
- (D) The use of nonphysical intervention skills.
- (E) Choosing the least restrictive intervention based on an individualized assessment of the child's medical, or behavioral status or condition.
- (F) Techniques and procedures appropriate for the age and weight of the children served.
- (G) The safe application and use of all types of restraints used including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);
- (H) Health risks for the child associated with use of specific procedures.

(I) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(J) Monitoring the physical and psychological well-being of the child who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by policy associated with the 1-hour face-to-face evaluation.

(K) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required annual recertification.

(L) Addressing the child's feelings after use of a restrictive procedure.

(M) Experience the specific techniques taught first-hand on themselves after demonstration by a qualified trainer.

(N) A testing process to demonstrate understanding of and ability to apply specific procedures. The staff member may only apply procedures in which they have been trained and shown mastery.

(e) A record of training including the name of the trained individual, along with the date, source, content, length of each course and copies of any certificates received, shall be kept in each staff training file.

Cross References

This section cited in 55 Pa. Code § 31.171 (relating to safe transportation).

PHYSICAL SITE

§ 31.81. Physical accommodations and equipment.

The facility shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a child with a disability.

§ 31.82. Poisons.

(a) Poisonous materials shall be kept locked and inaccessible to children.

(b) Poisonous materials shall be stored in their original, labeled containers.

(c) Poisonous materials shall be kept separate from food, food preparation surfaces and dining surfaces.

§ 31.83. Heat sources.

Heat sources, such as hot water pipes, fixed space heaters, hot water heaters and radiators, exceeding 120°F that are accessible to children, shall be equipped with protective guards or insulation to prevent children from coming in contact with the heat source.

§ 31.84. Sanitation.

(a) Sanitary conditions shall be maintained.

(b) There may be no evidence of infestation of insects or rodents in the facility.

(c) Trash shall be removed from the premises at least once a week.

(d) Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

(e) Trash outside the facility shall be kept in closed receptacles that prevent the penetration of insects and rodents.

§ 31.85. Ventilation.

Living areas, recreation areas, dining areas, bathrooms, bedrooms and kitchens shall be ventilated by at least one operable window or mechanical ventilation.

§ 31.86. Lighting.

Rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps and fire escapes shall be lighted to avoid accidents.

§ 31.87. Surfaces.

(a) Floors, walls, ceilings, windows, doors and other surfaces shall be free of hazards.

(b) If the facility was constructed before 1978 and serves one or more children who are 2 years of age or younger or who are likely to ingest inedible substances, the facility shall test all layers of interior paint in the facility and exterior paint and soil accessible in the play and recreation areas, for lead content. If lead content exceeds .06% in wet paint, .5% in a paint chip sample or 400 ppm in the soil, lead remediation activity is required based on recommendations of the Department of Health. Documentation of lead testing, results and corrections made shall be kept.

(c) The facility may not use asbestos products for any renovations or new construction.

§ 31.88. Water.

(a) The facility shall have hot and cold water under pressure.

(b) Hot water temperature in areas accessible to children may not exceed 120°F.

(c) A facility that is not connected to a public water system shall have a coliform water test at least every 3 months, by a Department of Environmental Protection-certified laboratory, stating that the water is safe for drinking. Documentation of the certification shall be kept.

§ 31.89. Temperature.

(a) Indoor temperature shall be at least 65°F during awake hours when children are present in the facility.

(b) Indoor temperature may not be less than 62°F during sleeping hours.

(c) When indoor temperature exceeds 90°F, mechanical ventilation such as fans or air conditioning shall be used.

§ 31.90. Communication system.

(a) The facility shall have a working, noncoin-operated, telephone with an outside line that is accessible to staff persons in emergencies.

(b) The facility shall have a communication system to allow staff persons to contact other staff persons in the facility for assistance in an emergency.

§ 31.91. Emergency telephone numbers.

Telephone numbers for the nearest hospital, police department, fire department, ambulance and poison control center shall be posted on or by each telephone with an outside line.

§ 31.92. Screens.

Windows, including windows in doors, shall be securely screened when doors or windows are open.

§ 31.93. Handrails and railings.

(a) Each ramp, interior stairway and outside steps exceeding two steps shall have a well secured handrail.

(b) Each porch that has over an 18-inch drop shall have a well-secured railing.

§ 31.94. Landings and stairs.

(a) There shall be a landing which is at least as wide as the doorway, beyond each interior and exterior door which opens directly into a stairway.

(b) Interior stairs shall have nonskid surfaces.

§ 31.95. Furniture and equipment.

(a) Furniture and equipment shall be free of hazards.

(b) There shall be enough furniture to accommodate the largest group of children that may routinely congregate in a room at any given time.

(c) Power equipment shall be kept in safe condition.

(d) Power equipment, excluding normal household appliances, shall be stored in a place that is inaccessible to children.

(e) Power equipment excluding normal household appliances, may not be used by children except under supervision of a staff person.

§ 31.96. First aid supplies.

The facility shall have a first aid manual, nonporous disposable gloves, antiseptic, assorted band-aids, adhesive bandages, gauze pads, thermometer, tape, tweezers and scissors that are stored together.

§ 31.97. Elevators.

Each elevator shall have a valid certificate of operation from the Department of Labor and Industry.

§ 31.98. Indoor activity space.

The facility shall have separate indoor activity space for activities such as studying, recreation and group activities.

§ 31.99. Recreation space.

The facility shall have regular access to outdoor, or large indoor, recreation space and equipment.

§ 31.100. Exterior conditions.

(a) The exterior of the building and the building grounds or yard shall be free of hazards.

(b) Outside walkways shall be free of ice, snow and obstruction.

§ 31.101. Firearms and weapons.

Firearms, weapons and ammunition are not permitted in the facility or on the facility grounds, except for those carried by law enforcement personnel.

§ 31.102. Child bedrooms.

(a) Each single bedroom shall have at least 70 square feet of floor space per child measured wall to wall, including space occupied by furniture.

(b) Each shared bedroom shall have at least 60 square feet of floor space per child measured wall to wall, including space occupied by furniture.

(c) No more than four children may share a bedroom.

(d) Ceiling height in each bedroom shall be at least an average of 7 1/2 feet.

(e) Each bedroom shall have a window with a source of natural light.

(f) Each child shall have the following in the bedroom:

- (1) A bed with solid foundation and fire retardant mattress in good repair.
- (2) A pillow and bedding appropriate for the temperature in the facility.
- (3) A storage area for clothing.

- (g) Cots or portable beds are not permitted.

- (h) Bunk beds shall allow enough space in between each bed and the ceiling to allow the child to sit up in bed.

- (i) Bunk beds shall be equipped with securely attached ladders capable of supporting a staff person.

- (j) The top bunk of bunk beds shall be equipped with a secure safety rail on each open side and open end of the bunk.

- (k) A bedroom may not be used as a means of egress from or access to another part of the facility.

Cross References

This section cited in 55 Pa. Code § 31.273 (relating to exceptions for secure care).

§ 31.103. Bathrooms.

- (a) There shall be at least one flush toilet for every six children.

- (b) There shall be at least one sink for every six children.
- (c) There shall be at least one bathtub or shower for every six children.
- (d) There shall be slip-resistant surfaces in all bathtubs and showers.
- (e) Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.
- (f) There shall be at least one wall mirror for every six children.
- (g) An individual towel, washcloth, comb, hairbrush and toothbrush shall be provided for each child.
- (h) Toiletry items including toothpaste, shampoo, deodorant and soap shall be provided.
- (i) Bar soap is not permitted unless there is a separate bar clearly labeled for each child.

Cross References

This section cited in 55 Pa. Code § 31.273 (relating to exceptions for secure care).

§ 31.104. Kitchen areas.

- (a) A facility shall have a kitchen area with a refrigerator, sink, cooking equipment and cabinets for storage.

(b) Utensils for eating, drinking and food serving and preparation shall be washed and rinsed after each use.

(c) Food shall be protected from contamination while being stored, prepared, transported and served.

(d) Uneaten food from a person's dish may not be served again or used in the preparation of other dishes.

(e) Cold food shall be kept at or below 40°F. Hot food shall be kept at or above 140°F. Frozen food shall be kept at or below 0°F.

§ 31.105. Laundry.

Bed linens, towels, washcloths and clothing shall be laundered at least weekly.

§ 31.106. Swimming.

(a) Above-ground and in-ground outdoor pools shall be fenced with a gate that is locked when the pool is not in use.

(b) Indoor pools shall be made inaccessible to children when not in use.

(c) A certified lifeguard shall be present with the children at all times while children are swimming.

(d) The certified lifeguard specified in subsection (c) may not be counted in the staff to child ratios specified in §§ 31.54 and 31.55 (relating to mental health professional; and mental health worker).

FIRE SAFETY

§ 31.121. Unobstructed egress.

(a) Stairways, hallways, doorways, passageways and egress routes from rooms and from the building shall be unlocked and unobstructed, unless the fire safety approval specified in § 31.14 (relating to fire safety approval) permits locking of certain means of egress. If a fire safety approval is not required in accordance with § 31.14, means of egress may not be locked.

(b) Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of children from the building.

§ 31.122. Exits.

If more than four children sleep above the ground floor, there shall be a minimum of two interior or exterior exits from each floor. If a fire escape is used as a means of egress, it shall be permanently installed.

§ 31.123. Evacuation procedures.

There shall be written emergency evacuation procedures that include staff responsibilities, means of transportation and emergency location.

§ 31.124. Notification of local fire officials.

The facility shall notify local fire officials in writing of the address of the facility, location of bedrooms and assistance needed to evacuate in an emergency. The notification shall be kept current.

§ 31.125. Flammable and combustible materials.

(a) Combustible materials may not be located near heat sources.

(b) Flammable materials shall be used safely, stored away from heat sources and inaccessible to children.

§ 31.126. Furnaces.

Furnaces shall be inspected and cleaned at least annually by a professional furnace cleaning company or trained maintenance staff persons. Documentation of the inspection and cleaning shall be kept.

§ 31.127. Portable space heaters.

Portable space heaters, defined as heaters that are not permanently mounted or installed, are not permitted in the facility.

§ 31.128. Wood and coal burning stoves.

The use of wood and coal burning stoves is not permitted.

§ 31.129. Fireplaces.

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

(b) A staff person shall be present with the children while a fireplace is in use.

(c) A fireplace chimney and flue shall be cleaned when there is an accumulation of creosote. Written documentation of the cleaning shall be kept.

§ 31.130. Smoke detectors and fire alarms.

(a) A facility shall have a minimum of one operable automatic smoke detector on each floor, including the basement and attic.

(b) There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

(c) The smoke detectors specified in subsections (a) and (b) shall be located in common areas or hallways.

(d) Smoke detectors and fire alarms shall be of a type approved by the Department of Labor and Industry or listed by Underwriters Laboratories.

(e) If the facility serves four or more children or if the facility has three or more stories including the basement and attic, there shall be at least one smoke detector on each floor interconnected and audible throughout the facility or an automatic fire alarm system that is audible throughout the facility.

(f) If one or more children or staff persons are not able to hear the smoke detector or fire alarm system, all smoke detectors and fire alarms shall be equipped so that each person with a hearing impairment will be alerted in the event of a fire.

(g) If a smoke detector or fire alarm becomes inoperative, repair or replacement shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

(h) There shall be a written procedure for fire safety

§ 31.131. Fire extinguishers.

(a) There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

(b) If the indoor floor area on a floor including the basement or attic is more than 3,000 square feet, there shall be an additional fire extinguisher with a minimum 2-A rating for each additional 3,000 square feet of indoor floor space.

(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher meets the requirements for one floor as required in subsection (a).

(d) Fire extinguishers shall be listed by Underwriters Laboratories or approved by Factory Mutual Systems.

(e) Fire extinguishers shall be accessible to staff persons. Fire extinguishers may be kept locked if access to the extinguisher by a child may cause a safety risk to the child. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

(f) Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

§ 31.132. Fire drills.

(a) An unannounced fire drill shall be held at least once a month.

(b) Fire drills shall be held during normal staffing conditions and not when additional staff persons are present.

(c) A written fire drill record shall be kept of the date, time, the amount of time it took for evacuation, the exit route used, the number of children in the facility at the time of the drill, problems encountered and whether the fire alarm or smoke detector was operative.

(d) Children shall be able to evacuate the entire building into a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within 2 1/2 minutes or within the period of time specified in writing within the past year by a fire safety expert. The fire safety expert may not be an employee of the facility.

(e) A fire drill shall be held during sleeping hours at least every 6 months.

(f) Alternate exit routes shall be used during fire drills at least every 3 months.

(g) Fire drills shall be held on different days of the week, at different times of the day and night and on different staffing shifts.

(h) Children shall evacuate to a designated meeting place outside the building or within the fire-safe area during each fire drill.

(i) A fire alarm or smoke detector shall be set off during each fire drill.

(j) Elevators may not be used during a fire drill or a fire.

CHILD HEALTH

§ 31.141. Child health and safety assessment.

(a) A child shall have a written health and safety assessment within 24 hours of admission.

(b) The assessment shall be completed or coordinated, signed and dated by medical personnel or staff persons trained by medical personnel.

(c) The assessment shall include the following:

(1) Medical information and health concerns such as allergies; medications; immunization history; hospitalizations; medical diagnoses; medical problems that run in the family; issues experienced by the child's mother during pregnancy; special dietary needs; illnesses; injuries; dental, mental or emotional problems; body positioning and movement stimulation for children with disabilities, if applicable; and ongoing medical care needs.

(2) Known or suspected suicide or self-injury attempts or gestures and emotional history which may indicate a predisposition for self-injury or suicide.

(3) Known incidents of aggressive or violent behavior.

(4) Substance abuse history.

(5) Sexual history or behavior patterns that may place the child or other children at a health or safety risk.

(d) A copy of the assessment shall be kept in the child's record.

(e) The child's health assessment shall be revised and updated as necessary and appropriate.

Cross References

This section cited in 55 Pa. Code § 31.142 (relating to health and safety plan); 55 Pa. Code § 31.274 (relating to additional requirements); and 55 Pa. Code § 31.283 (relating to additional requirements).

§ 31.142. Health and safety plan.

If the health and safety assessment in § 31.141 (relating to health and safety assessment) identifies a health or safety risk, a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed.

§ 31.143. Child health examination.

(a) A child shall have a health examination within 15 days after admission and annually thereafter, or more frequently as specified at specific ages in the periodicity schedule recommended by the American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care (RE9939)" available on the worldwide web at <http://www.aap.org/policy/periodicity.pdf> .

(b) If the child had a health examination prior to admission that meets the requirements of subsection (e) within the periodicity schedule specified in

subsection (a), and there is written documentation of the examination, an initial examination within 15 days after admission is not required. The next examination shall be required within the periodicity schedule specified in subsection (a).

(c) If the child will participate in a program that requires significant physical exertion, a health examination shall be completed before the child participates in the physical exertion portion of the program.

(d) The health examination shall be completed, signed and dated by a licensed physician, certified registered nurse practitioner or licensed physician's assistant. Written verification of completion of each health examination, date and results of the examination, the name and address of the examining practitioner and follow-up recommendations made, including each component, shall be kept in the child's record.

(e) The health examination shall include:

(1) A comprehensive health and developmental history, including both physical and behavioral health development.

(2) A comprehensive, unclothed physical examination.

(3) Immunizations, screening tests and laboratory tests as recommended by the American Academy of Pediatrics document entitled Recommendations for Preventive Pediatric Health Care (RE9939)

available on the worldwide web at

<http://www.aap.org/policy/periodicity.pdf>.

(4) Blood lead level assessments for children 5 years of age or younger, unless the examining practitioner determines that the testing is unnecessary, after reviewing the results of previously conducted blood lead testing, which review and conclusion is documented in the child's medical record.

(5) Sickle cell screening for children who are African-American unless the examining practitioner determines that the testing is unnecessary, after reviewing the results of previously conducted sickle cell testing, which review and conclusion is documented in the child's medical record.

(6) A gynecological examination including a breast examination and a Pap test if recommended by medical personnel.

(7) Communicable disease detection if recommended by medical personnel based on the child's health status and with required written consent in accordance with applicable laws.

(8) Specific precautions to be taken if the child has a communicable disease, to prevent spread of the disease to other children.

(9) An assessment of the child's health maintenance needs, medication regimen and the need for blood work at recommended intervals.

- (10) Special health or dietary needs of the child.
 - (11) Allergies or contraindicated medications.
 - (12) Medical information pertinent to diagnosis and treatment in case of an emergency.
 - (13) Physical or mental disabilities of the child, if any.
 - (14) Health education, including anticipatory guidance.
 - (15) Recommendations for follow-up physical and behavioral health services, examinations and treatment.
- (f) Immunization records, screening tests and laboratory tests may be completed, signed and dated by a registered nurse or licensed practical nurse instead of a licensed physician, certified registered nurse practitioner or licensed physician's assistant.

Cross References

This section cited in 55 Pa. Code § 31.283 (relating to additional requirements).

§ 31.144. Dental care.

(a) Each child shall receive dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

(b) A child who is 3 years of age or older shall have a dental examination performed by a licensed dentist and teeth cleaning performed by a licensed dentist or dental technician at least semiannually. If a child has not had a dental examination and teeth cleaning within 6 months prior to admission, a dental examination and teeth cleaning shall be performed within 30 days after admission.

(c) A written record of completion of each dental examination, including the preadmission examination permitted in subsection (b), specifying the date of the examination, the dentist's name and address, procedures completed and follow-up treatment recommended and dates provided, shall be kept in the child's record.

(d) Follow-up dental work indicated by the examination, such as treatment of cavities and the application of protective sealants, shall be provided in accordance with recommendations by the licensed dentist.

§ 31.145. Vision care.

(a) Each child shall receive vision screening and services to include diagnosis and treatment including eyeglasses, for defects in vision.

(b) Each child who is 3 years of age or older shall receive vision screening within 30 days after admission in accordance with the periodicity schedule recommended by the American Academy of Pediatrics, “Guidelines for Health Supervision,” and “Eye Examination and Vision Screening in Infants, Children and Young Adults (RE9625).”

(c) If the child had a vision screening prior to admission that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b), an initial examination within 30 days after admission is not required. The next screening shall be required within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment and services, such as provision of eyeglasses, shall be provided as recommended by the treating practitioner.

(e) A written record of completion of each vision screening, including the preadmission screening permitted in subsection (c), specifying the date of the screening, the treating practitioner’s name and address, results of the screening, follow-up recommendations made, and the dates and provision of follow-up services and treatment, shall be kept in the child’s record.

§ 31.146. Hearing care.

(a) Each child shall receive a hearing screening and services to include diagnosis and treatment including hearing aids, for defects in hearing.

(b) Each child who is 3 years of age or older shall receive a hearing screening within 30 days after admission in accordance with the periodicity schedule recommended by the American Academy of Pediatrics, "Guidelines for Health Supervision."

(c) If the child had a hearing screening prior to admission that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b), an initial examination within 30 days after admission is not required. The next screening shall be required within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment and services, such as provision of hearing aids, shall be provided as recommended by the treating practitioner.

(e) A written record of completion of each hearing screening, including the preadmission screening permitted in subsection (c), specifying the date of the screening, the treating practitioner's name and address, the results of the screening, follow-up recommendations made, and the dates and provision of follow-up services and treatment, shall be kept in the child's record.

§ 31.147. Use of tobacco.

(a) Use or possession of tobacco products by children is prohibited.

(b) Use or possession of tobacco products by staff persons is prohibited in the facility and during transportation provided by the facility.

(c) If staff persons use tobacco products outside but on the premises of the facility, the following apply:

(1) The facility shall have written fire safety procedures. Procedures shall include extinguishing procedures and requirements that smoking shall occur only a safe distance from the facility and from flammable or combustible materials or structures.

(2) Written safety procedures shall be followed.

(3) Use of tobacco products shall be out of the sight of the children.

§ 31.148. Health and behavioral health services.

(a) The facility shall identify acute and chronic conditions of a child and shall arrange for or provide appropriate medical treatment.

(b) Medically necessary physical and behavioral health services, diagnostic services, follow-up examinations and treatment, such as medical, nursing, pharmaceutical, dental, dietary, hearing, vision, blood lead level, psychiatric and psychological services that are planned or prescribed for the child, shall be arranged for or provided.

§ 31.149. Emergency medical plan.

(a) The facility shall have a written emergency medical plan listing the following:

(1) The hospital or source of health care that will be used in an emergency.

(2) The method of transportation to be used.

(3) An emergency staffing plan.

(4) Medical and behavior health conditions or situations under which emergency medical care and treatment are warranted.

(b) The child's parent and, if applicable, the child's guardian or custodian, shall be given a copy of the emergency medical plan upon admission.

(c) The child's parent and, if applicable, the child's guardian or custodian, shall be notified immediately if the emergency plan is implemented for the child.

STAFF HEALTH

§ 31.151. Staff health statement.

A staff person or volunteer who comes into direct contact with the children or who prepares or serves food, shall have a statement signed and dated by a licensed physician, certified registered nurse practitioner or licensed physician's assistant, within 12 months prior to working with children or

food service and every 2 years thereafter, stating that the person is free of serious communicable disease that may be spread through casual contact or that the staff person has a serious communicable disease that may be spread through casual contact but is able to work in the facility if specific precautions are taken that will prevent the spread of the disease to children.

§ 31.152. Serious communicable diseases.

(a) If a staff person or volunteer has a serious communicable disease that may be spread through casual contact, written authorization from a licensed physician, certified nurse practitioner or licensed physician's assistant is required for the person to be present at the facility.

(b) Written authorization from a licensed physician, certified nurse practitioner or licensed physician's assistant shall include a statement that the person will not pose a serious threat to the health of the children and specific instructions and precautions to be taken for the protection of the children.

(c) The written instructions and precautions specified in subsection (b) shall be followed.

NUTRITION

§ 31.161. Three meals a day.

At least three meals and one snack a day shall be provided to the children.

§ 31.162. Quantity of food.

(a) The quantity of food served shall meet minimum daily requirements as recommended by the United States Department of Agriculture, unless otherwise recommended in writing by a licensed physician, certified nurse practitioner or licensed physician's assistant for a specific child.

(b) Additional portions of meals shall be available for the children.

§ 31.163. Food groups and alternative diets.

(a) Each meal shall contain at least one item from the dairy, protein, fruits and vegetables and grain food groups, unless otherwise recommended in writing by a licensed physician, certified nurse practitioner or licensed physician's assistant for a specific child.

(b) Dietary alternatives shall be available for a child who has special health needs, religious beliefs regarding dietary restrictions or vegetarian preferences.

§ 31.164. Withholding or forcing of food prohibited.

(a) A facility may not withhold meals or drink as punishment.

(b) A child may not be forced to eat food.

TRANSPORTATION

§ 31.171. Safe transportation.

The following requirements apply whenever the facility, facility staff persons or facility volunteers provide transportation for the children. These requirements do not apply if transportation is provided by a source other than the facility.

(1) The mental health worker to child ratios specified in § 31.55 (relating to mental health worker) apply.

(2) Each child shall be in an individual, age and size appropriate, safety device at all times the vehicle is in motion.

(3) Restraint shall not be used routinely for transport and may only be used in the event of an emergency safety situation as specified in §§ 31.201—31.213 (relating to Restrictive procedures) .

(4) The driver of a vehicle shall be 21 years of age or older.

(5) Vehicles utilized for transportation of children shall comply with local, state and federal laws.

Cross References

This section cited in 55 Pa. Code § 31.273 (relating to exceptions for secure care).

MEDICATIONS

§ 31.181. Storage of medications.

(a) Prescription and over-the-counter medications shall be kept in their original containers.

(b) Prescription and potentially poisonous over-the-counter medications shall be kept in an area or container that is locked.

(c) Prescription and potentially poisonous over-the-counter medications stored in a refrigerator shall be kept in a separate locked container.

(d) Prescription and over-the-counter medications shall be stored separately.

(e) Prescription and over-the-counter medications shall be stored under proper conditions of sanitation, temperature, moisture and light.

(f) Discontinued and expired medications, and prescription medications for children who are no longer served at the facility, shall be disposed of in a safe manner.

§ 31.182. Labeling of medications.

(a) The original container for prescription medications shall be labeled with a pharmacy label that includes the child's name, the name of the

medication, the date the prescription was issued, the prescribed dosage and the name of the prescribing physician.

(b) Over-the-counter medications shall be labeled with the original label.

§ 31.183. Use of prescription medications.

(a) A physician must write all psychotropic medication orders.

(b) The rationale for each medication must be clearly documented in the child's medical record.

(c) All changes in medication must be documented in the medical record.

(d) The psychiatrist must see each child on psychotropic medications at least every thirty days, and more frequently until the child's condition is stable, with progress and clinical status documented in writing.

(e) The prescribing physician must obtain and document consent from the responsible party for each medication prescribed, explaining the medication's expected effects, expected side effects, and the expected effects of withholding the medication.

(f) Dosage changes do not require additional consent; however, recognizing the importance of family participation and the value of fostering a collaborative relationship between the child and the family, the prescriber should attempt to notify, by phone or in writing, the parents or legal guardian whenever dosage changes are made.

(g) The clinical rationale for each medication must be clearly documented on the child's discharge summary or final evaluation.

(h) Prescription medications shall be used only by the child for whom the medication was prescribed.

(i) Children and their families may not be threatened or incur negative consequences when they disagree with or refuse a clinical recommendation for medication.

(j) Children shall not be discharged as a consequence of refusing medication.

(k) Facilities shall put in place strategies that promote choice in medication decisions including:

(1) Full access to information for child and family about medications including side effects.

(2) Staff who are willing and able to help the child and family explore and understand the positive and negative possible consequences of taking a medication.

(3) Processes which are immediately responsive to any concerns or side effects which the family or child suspect are related to the medication, including a consult with the prescribing physician within 24 hours, or sooner if necessary.

(4) Staff who are able to identify alternative and complementary strategies which address the areas of concern that the medication seeks to address, including relaxation and coping processes which match the child's interests, temperament, culture, and developmental levels.

§ 31.184. Medication log.

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

- (1) A list of prescription medications.
- (2) The prescribed dosage.
- (3) Possible side effects.
- (4) Contraindicated medications.
- (5) Specific administration instructions, if applicable.
- (6) The name of the prescribing physician.

(b) For each prescription and over-the-counter medication including insulin administered or self-administered, documentation in the log shall include the medication that was administered, dosage, date, time and the name of the person who administered or self-administered the medication.

(c) The information in subsection (b) shall be logged at the same time each dosage of medication is administered or self-administered.

Cross References

This section cited in 55 Pa. Code § 31.188 (relating to self-administration of medications).

§ 31.185. Medication errors.

(a) Documentation of medication errors shall be kept in the medication log. Medication errors include the failure to administer medication, administering the incorrect medication, administering the correct medication in an incorrect dosage or administering the correct medication at the incorrect time.

(b) After each medication error, follow-up action to prevent future medication errors shall be taken and documented.

§ 31.186. Adverse reaction.

If a child has a suspected adverse reaction to a medication, the facility shall notify the prescribing physician, the child's parent and, if applicable, the child's guardian or custodian, immediately. Documentation of adverse reactions and the physician's response shall be kept in the child's record.

§ 31.187. Administration.

(a) Prescription medications and injections of any substance shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the facility.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the facility.

(4) A child who meets the requirements in § 31.188 (relating to self-administration of medications).

(b) Prescription medications and injections shall be administered according to the directions specified by a licensed physician, certified registered nurse practitioner or licensed physician's assistant.

Cross References

This section cited in 55 Pa. Code § 31.188 (relating to self-administration of medications).

§ 31.188. Self-administration of medications.

A child is permitted to self-administer medications, insulin injections, and epinephrine injections for insect bites, food and latex allergies, if the following requirements are met:

(1) A person who meets the qualifications of § 31.187(a) (1)—(3) (relating to administration) is physically present observing the

administration and immediately records the administration in accordance with § 31.184 (relating to medication log).

(2) The child recognizes and distinguishes the medication and knows the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken.

Cross References

This section cited in 55 Pa. Code § 31.187 (relating to administration).

RESTRICTIVE PROCEDURES

§ 31.201. General Information.

(a) If a restrictive procedure is used, the staff person who administers the procedure shall have completed training specified at § 31.60. (d) relating to Training for staff and other persons with regular and significant direct contact with children within the past year and shown expertise in the use of the particular restrictive procedures to be used.

(b) Restrictive procedure includes exclusion, time-out, drug used as a restraint, personal or manual restraint, mechanical restraint, and seclusion.

(c) Restraint includes drug used as a restraint, personal or manual restraint, mechanical restraint and seclusion.

(d) Only drug used as a restraint and personal or manual restraint are permitted in RTFs in an emergency safety situation in accordance with the provisions of this chapter.

(e) A restrictive procedure may not be used in a punitive manner, as a means of coercion, discipline, retaliation and retribution or for the convenience of staff persons, or as compensation for the lack of staff presence or competency or as a program substitution.

(f) A restrictive procedure shall be discontinued when the child demonstrates he has regained self-control.

(g) The restrictive procedure used may not be expected to result in the harm or injury to the child.

Cross References

This section cited in 55 Pa. Code § 31.171 (relating to safe transportation).

§ 31.202. Restrictive procedure policy

(a) Each facility shall establish a policy for the use of any restrictive procedure and individually address the use of restraint as an emergency safety intervention.

(b) The policy shall address all requirements set forth in this Chapter and appropriate Federal requirements if applicable.

§ 31.203. Written plan to eliminate the use of restraint.

(a) All enrolled RTF providers shall develop a written plan with goals and objectives and time-frames to establish a trauma informed approach which establishes a restraint free environment within the facility.

(b) The written plan to address the elimination of the use of restraint shall include:

(1) Alternative approaches to the use of coercive techniques consistent with the Department's January 30, 2006, and updates to the Special Transmittal on "Strategies and Practices to Eliminate the Unnecessary Use of Restraint".

(2) The content and process for the collection of data based on the requirements of the Department.

(3) The plan to eliminate the use of restraint in the facility shall be reviewed and approved by the Department.

§ 31.204. Time Out

(a) Time out is used as clinical intervention to provide the child with a period of time in a designated quiet area such as their room or in a place

away from the area of activity or other children for the purpose of providing the child an opportunity to learn when they need to gain self-control. The child may request time out, or a staff who notices changes in the child's behavior which have not been self identified but appears to be escalating or has escalated to loss of self control may ask the child to take time out to retain or regain self control and function in a more positive fashion.

(b) Staff must monitor the child while he or she is in time out and record in the child's record the date and times of the time out, circumstances relating to the time out including whether it was requested by the child, the name of the person who monitored the time out, the level of success or resolution of the time out, and the signature of the monitoring individual.

(c) A child in time out must never be physically prevented from leaving the time out area.

(d) If the child is not permitted to leave the time-out area, the intervention ceases to be a time out and is considered seclusion.

§ 31.205. Emergency Safety Intervention

(a) A restraint may only be used:

(1) In an emergency safety situation that is the result of unanticipated child behavior that places the child or others at immediate and serious threat of violence or injury if no intervention occurs.

(2) Only after every attempt has been made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restraint, but these interventions have failed.

(b) Prohibited Interventions:

(1) Standing orders for restraint- A Pro Re Nata (PRN) order for controlling acute, episodic behavior.

(2) Restraints that apply pressure or weight on the child's respiratory system.

(3) Prone position restraints.

(4) Drug used as a restraint - used to control acute, episodic behavior that restricts the movement or function of a child unless the drug is ordered by a licensed physician present at the facility after examining the child. A drug ordered by a licensed physician as part of ongoing medical treatment, or as pretreatment prior to a medical or dental examination or treatment, is not a drug used as a restraint.

(5) Mechanical restraint –

(A) Examples of mechanical restraints that are prohibited include handcuffs, anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist

straps, head straps, papoose boards, restraining sheets and similar devices.

(B) Devices used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet used for prevention of injury during seizure activity, or the routine use of a seat belt during transportation are not considered mechanical restraints.

(6) Seclusion

(7) Aversive conditioning- The application of startling, painful or noxious stimuli.

(8) Pressure point techniques- application of pain for the purpose of achieving compliance except pressure at the child's jaw point for the purpose of bite release.

(c) Orders for the use of restraint as an emergency safety intervention.

(1) Restraint shall only be ordered by one of the following:

(A) If the child's treatment team physician is available only this physician may order restraint.

(B) If the child's treatment team physician is not available one of the following may order restraint:

(i) Another physician, or if not available,

(ii) A certified nurse practitioner, or a physician assistant, or if not available

(iii). a licensed psychologist, licensed social worker, or licensed clinical social worker.

(2) The child's treatment team physician must be contacted and informed about the use of restraint as soon as possible when one of the licensed individuals in (B) of this paragraph order's a restraint in the treatment team physician's absence.

(3) If a physician is not in the facility at the time of the incident and an alternative licensed individual identified in paragraph (1) (B) above is also not available, a verbal order shall be obtained by a registered nurse or licensed practical nurse. In the absence of a nurse, a licensed occupation therapist or physical therapist may accept the verbal order.

(4) The order shall be obtained while the restraint is being initiated by trained staff or immediately after the emergency

safety situation. Verbal orders must be verified by the ordering individual in the child's record. The ordering individual must be available to staff for consultation, at least by telephone, throughout the period of the restraint.

(5) An order for a restraint shall be entered into the child's record by the ordering individual.

(6) Each order for restraint must include:

(A) The name of the ordering physician or other licensed practitioner identified in §31.206 (c) and permitted by the facility to order restraint.

(B) The date and time the order was obtained.

(C) The specific type of restraint ordered including the length of time for which the physician or other licensed practitioner identified and permitted by the facility to order restraint or authorize its use.

(7) The physician or other licensed individual identified in paragraph (c) (1) above as permitted by the facility to order restraint shall order the least restrictive emergency safety intervention most likely to be effective in resolving the emergency safety situation taking into account on-site staff recommendations.

(8) Drug used as a restraints

Administration of a drug used as a restraint is prohibited except for the administration of drugs ordered by a licensed physician and administered by licensed/certified/registered medical personnel on an emergency basis under the following criteria.

(i) Immediately prior to each incidence of administering a drug on an emergency basis, a licensed physician shall have examined the child and given a written order to administer the drug.

(ii) Immediately prior to each re-administration of a drug on an emergency basis, a licensed physician shall have examined the child and ordered re-administration of the drug.

(9). Each order for restraint must:

(A) Be limited to no longer than the duration of the emergency safety situation.

(B) Under no circumstances exceed 2 hours for children ages 18 to 21; 1 hour for children ages 9 to 17; or 30 minutes for children under age 9.

(d) Application of Restraint.

(1) Only clinical staff trained in the use of emergency safety interventions as specified at §31.60 of this chapter shall be permitted to apply a restraint. These trained individuals must:

(A) Be physically present.

(B) Continually assess and monitor the physical and psychological well-being of the child.

(i) A staff person who is not applying the restraint shall observe and document the physical and emotional condition of the child. Staff must continuously monitor the responsiveness of the child during the time the restraint is applied.

(ii) The position of the physical restraint or the staff person(s) applying the restraint must change at least every 5 consecutive minutes of applying the restraint. This means that the hold(s) must be released.

(C) Ensure the safe use of restraint throughout the duration of the emergency safety intervention taking into account the individualized assessment including both physical and psychological factors of the child.

(D) Release the child from the restraint at the earliest safe time.

(2) The use of restraint must be limited to the duration of the emergency safety situation. An order for a specified time period is for the maximum time the restraint may be in place without direction for continuing the restraint.

(3) If restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraint. At the point in which a new order for restraint has been obtained, all requirements for monitoring and documentation begin as with all new orders.

(4) If the restraint is needed beyond the specified time a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint to receive further instructions.

(5) In the event of a drug used as a restraint:

(A) The child's vital signs shall be monitored at least once each hour and in accordance with the frequency

and duration recommended and documented by the prescribing physician.

(B) The physical needs of the child shall be met promptly.

(6) Within 1 hour of the initiation of the restraint, a physician, CRNP, RN or PA trained in the use of emergency safety interventions permitted by the facility to assess the physical and psychological well being of children must conduct a face-to-face assessment of the physical and psychological well being of the child including but not limited to:

(A) The child's physical and psychological status.

(B) The child's behavior.

(C) The appropriateness of the intervention measures.

(D) Any complications resulting from the intervention.

(e) Medical Treatment for injuries resulting from the use of restraint.

Staff must immediately obtain medical treatment from qualified medical personnel for a child injured as a result of a restraint. It is the responsibility of the facility to assess the child to determine the extent of any injuries and implement plans to administer

appropriate medical care. It is also the responsibility of the facility to attain medical care immediately if the child requires it. Staff that is medically trained to provide emergency first aid care and CPR should be available to provide the emergency medical interventions until further follow-up emergency care can be provided.

(f) Notification of parents or legal guardians.

(1) The facility must notify the parents or legal guardians of the child who has been restrained as soon as possible, but no longer than 5 hours, after the initiation of restraint.

(2) The facility must document in the child's record that the parents or legal guardians, or both if applicable, have been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

(g) Documentation of restraint

(1) Staff documentation for each restraint time-period shall include all of the following:

(A) A description of the emergency safety situation that required the child to be restrained.

(B) The name and title of an individual listed at § 31.211(c) (1) ordering restraint, the date and time the

order was given, the type of restraint ordered and the maximum time for which the restraint was ordered.

This information shall be signed and dated by the ordering individual.

(C) For verbal orders, the name and title of the individual ordering restraint, the time the order was given, the type of restraint ordered and the maximum time for which the restraint was ordered. The licensed staff identified at §31.211(c) (1) accepting the verbal order shall sign and date the orders received. The ordering individual shall counter-sign the order within one business day of the restraint.

(D) The time the restraint actually began and ended.

(E) The name and job title of staff involved in the restraint

(F) The time and results of the 1 hour assessment.

(G) The date and time the team physician was consulted.

(H) The dates times, and methods of attempts to notify the parents or legal guardians of the child, both if applicable, have been made and the date and time of successful notification signed by each individual attempting to contact the parents or legal guardian.

(I) A summary of each post intervention debriefing.

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

(h) Post intervention debriefings.

(1) Within 24 hours after the use of the restraint, all staff involved in the intervention, except when the presence of a particular staff person may jeopardize the well being of the child, shall have a face-to-face meeting with the child to afford the child and staff the opportunity to discuss the circumstances resulting in the use of restraint and strategies to be used by the staff, the child, or others that could prevent the future use of restraint.

(A) Other facility staff, ISPT members and the child's parents or legal guardians, or both if applicable, shall be given the opportunity to participate in the discussion.

(B) The facility must conduct such discussion in a language that is understood by the child's parent or legal guardians, or both if applicable.

(2) Within 24 hours after the use of restraint, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a

debriefing session that includes, at a minimum, a review and discussion of:

(A) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention.

(B) Alternative techniques that might have prevented the use of the restraint.

(C) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint.

(D) The outcome of the intervention, including any injuries that may have resulted from the use of restraint.

(3) Staff must document in the child's record that both debriefing sessions took place and must include in that documentation:

(A) The names of staff present for each discussion.

(B) The names of staff that were excused from the debriefing.

(C) Any changes to the child's treatment plan that result from the debriefings.

§ 31.206. Restrictive procedure records.

(a) A record of each use of a restrictive procedure shall be kept and shall include the following:

- (1) The specific behavior addressed.
- (2) The methods of intervention used to address the behavior, including the all measures from the least intrusive and if these measures were not effective the reasons the methods were not effective.
- (3) The date and time the procedure was used.
- (4) The specific procedure used.
- (5) The staff person who used the procedure.
- (6) The duration of the procedure.
- (7) The staff person who observed the child.
- (8) The child's condition upon completion of the restrictive procedure.

(b) Documentation of compliance with this paragraph shall be kept in the child's record.

SERVICES

§ 31.221. Description of services.

The facility shall have a written service description of services that the facility provides as part of the program. The service description shall include the following:

- (1) The facility location, legal ownership, and administration table of organization.
- (2) Vision, mission and detailed description of how the program will meet the requirements in this chapter and current clinical standards of care.
- (3) The scope and general description of the services provided by the facility.
- (4) The number, ages, needs and any special characteristics of the children the facility serves.
- (5) Specific activities and programs provided by the facility including the staff qualifications and staffing ratios.
- (6) Demonstration of the facility's ability to support, and maximize the quality of life and functional abilities of children with emotional and behavioral issues using gender specific programming as appropriate and including any special characteristics identified for the children the facility intends to serve including neurological disorders such as autism spectrum disorder (ASD) and any co-occurring disorder such as developmental delays or substance abuse or deaf and hard of hearing issues.

(i) Staff and clinicians of an RTF that proposes to treat children with ASD should have training specific to the needs of the child or adolescent with ASD as well as knowledge of the particular stressors of the families, such as the chronic nature of the disorder and the isolation from friends and family while dealing with significant behavioral issues.

(ii) Additionally, the RTF director and treatment team should promote treatment that is research-based for persons with ASD as individual psychotherapy, group psychotherapy and family therapy may not address the needs of children and adolescents on the autism spectrum.

(iii) The provider selecting to serve children and adolescents with ASD should emphasize through appropriate instruction the importance of trained staff working with children and adolescents with ASD regarding their unique needs.

(iv) Specific trainings need to be in place for those working with children with ASD in protocols that yield success with children diagnosed with ASD such as, but not limited to Applied Behavior Analysis, targeted social skills instruction, strategies to support sensory needs, and functional behavioral assessment.

(7) Each facility must have a written policy regarding employees of the facility filing legal charges against the residents. The policy must include:

(i) The nature of the emotional and behavioral needs of the children residing at the facility,

(ii) The possibility for injury to staff because of the potential of aggressive behaviors to occur as the result of the clinical condition of the child.

(iii) A procedure for staff that choose to press charges to inform facility management prior to notifying law enforcement.

(8) The program service description and all policies and procedures must be approved by the Department and any changes to the service description, including changes in capacity, must be submitted to the Department for approval prior to implementation.

(9) The Department will review the implementation of the RTF service description in addition to the policies and procedures at the annual site visit.

§ 31.222. Placement process.

(a) Prior to admission, a determination shall be made and documented in writing, that the age, needs and any special characteristics of the child can be appropriately met by the services, activities and programs provided by the facility.

(b) The facility shall have a placement process that assesses, and documents the following for each child, prior to or upon admission:

(1) The service needs of the child.

(2) The child's legal status.

(3) Circumstances that make placement of the child necessary.

(4) How the activities and services provided by the facility will address the bio-psychosocial needs of the child.

(c) Documentation of the prior approval of the administrator of the Interstate Compact on the Placement of Children shall be retained in the record of each resident admitted from outside the Commonwealth of Pennsylvania.

§ 31.223. Development of the ISP.

(a) A preliminary treatment plan addressing the child's behavioral health needs shall be completed within twenty-four hours of admission.

(b) An ISP including a comprehensive treatment plan addressing the behavioral health needs shall be developed for each child within 14 calendar days of the child's admission.

(c) The ISP shall be developed by the ISPT comprised of the child, the child's parent and, if applicable, the child's guardian or custodian, any

person invited by the child and the child's parent, a contracting agency representative, a representative of the county Mental Health/Mental Retardation Program, the prescribing or treating psychiatrist, other clinicians, and, if applicable and with written parental consent if needed, a representative of the responsible school district, the county children and youth agency or juvenile probation office, other agencies which are or should be providing care and services to the child, and the child's Behavioral Health MCO. The treatment plan portion of the ISP addressing the child's behavioral health needs must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to children in, the facility. The team must be capable of:

(1) Assessing the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities.

(2) Assessing the potential resources of the child's family

(3) Setting treatment objectives.

(4) Prescribing therapeutic modalities to achieve the plan's objectives.

(d) The treatment team must include, at a minimum, one of the following combinations:

(1) A board-eligible or board-certified psychiatrist

(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy.

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State.

(e) The team must also include one of the following:

(1) A psychiatric social worker.

(2) A registered nurse with specialized training or one year's experience in treating children with a serious emotional or behavioral disorder.

(3) A licensed occupational therapist and who has specialized training or one year of experience in treating children with a serious emotional or behavioral disorder.

(4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State.

(f) Each RTF is responsible to assign sufficient staff responsible for the implementation of the ISP including the treatment plan for addressing the behavioral health needs of the child.

(g) Reasonable effort shall be made to involve the child and the child's parent and, if applicable, a guardian or custodian, in the development of the ISP at a time and location convenient for the child, the child's parent, the child's guardian or custodian, if applicable, and the facility.

(h) Documentation of reasonable efforts made to involve the child's parent and, if applicable, guardian or custodian, shall be kept.

(i) Persons who participated in the development of the ISP shall sign and date the ISP, with the exception of the child, the child's parent and, if applicable, the child's guardian or custodian, who shall be given the opportunity to sign the ISP. Disagreement with the ISP or refusal to sign the ISP shall be documented in the child's record.

Cross References

This section cited in 55 Pa. Code § 31.224 (relating to review and revision of the ISP).

§ 31.224. Review and revision of the ISP.

(a) A review of each child's progress on the ISP, and a revision of the ISP including the treatment plan addressing the behavioral health needs shall be completed at least every 30 days.

(b) A child's ISP may be reviewed at anytime including at the request of the child or parents. The ISP shall be revised in accordance with subsection (a) if there has been no progress on a goal, if a goal is no longer appropriate or if a goal needs to be added.

(c) A review and revision of the ISP shall be completed in accordance with § 31.223 (b)—(i) (relating to development of the ISP).

(d) The RTF will make reasonable efforts to notify and involve parents, legal guardians, or both, if applicable, about significant changes to the plan, including changes in medication.

§ 31.225. Content of the ISP.

An ISP shall include:

(1) A behavioral health treatment plan with developmentally appropriate goals, objectives, and behavioral interventions proposed to address the child's behavioral health issues in the environments in which the child exhibits a behavioral health treatment need, an explanation of the appropriate settings and time allocations, and a description of any changes or updates from previous treatment plans in sufficient detail that

allows for full understanding of the planned goals, objectives and interventions and their clinical relationship to each other, as well as, the continued clinical need for the service.

- (2) Evaluation of the child's skill level for each goal.
- (3) Monthly documentation of the child's progress on each goal.
- (4) Services and training that meet the child's needs, including the child's needs for safety, competency development and permanency.
- (5) A component addressing family involvement.
- (6) A plan to teach the child health and safety.
- (7) A component addressing how the child's educational needs will be met in accordance with applicable Federal and State laws and regulations.
- (8) The anticipated duration of stay at the facility.
- (9) A discharge or transfer plan.
- (10) Methods to be used to measure progress on the ISP, including who is to measure progress and the objective criteria.
- (11) The name of the person responsible for coordinating the implementation of the ISP.

§ 31.226. Implementation of the ISP.

An ISP shall be implemented as written.

§ 31.227. Copies of the ISP.

(a) Copies of the ISPs, revisions to the ISP and monthly documentation of progress shall be provided to the child if the child is over 14 years of age, the parent, the child's guardian or custodian, if applicable, the contracting agency and persons who participated in the development and revisions to the ISP.

(b) Copies of ISPs, revisions to the ISP and monthly documentation of progress shall be kept in the child's record.

§ 31.228. Behavioral health treatment.

(a) The RTF shall provide behavioral health treatment that is built on the competencies of the child and the family, while addressing specific needs including culture, treatment history, and family relationships. Specific expectations include, at a minimum, the following, all of which shall be provided as needed and documented in the child's record:

(1) Individual psychotherapy, group psychotherapy, family therapy, and other therapeutic interventions as indicated in the treatment plan, which address both the child's presenting behaviors and underlying mental health issues and when clinically indicated co-occurring issues to include mental health and substance abuse. In situations where individual or group psychotherapy modalities are not considered effective treatment

approaches, such as with children with autism spectrum disorder, alternative approaches must be used with reasons documented in the treatment plan.

(2) Promotion of social skills consistent with the child's successful adaptation to both society norms and the child's individual community.

(3) Age-appropriate training about maintenance of good physical health including, with the permission of the parents or legal guardians as applicable, the prevention of sexually transmitted diseases including HIV/AIDS.

(4) Special individualized activities, relevant to the child's medical or physical needs.

(5) Use of psychotropic medication, when indicated, with clinical rationale for each psychotropic medication.

(6) Training in daily living skills and community access skills.

§ 31.229. Education.

(a) Under 22 Pa. Code Chapters 11, 14 and 15 (relating to student attendance; special education services and programs; and protected handicapped students), each child who is of compulsory school age shall participate in a Department of Education-approved school program or an educational program under contract with the local education agency.

(b) The decision regarding the educational portion of the resident's day is to be made on an individualized basis utilizing the least restrictive

environment, with input from all members of the ISPT, by local public education officials and the resident's home school district.

§ 31.230. Discharge planning.

(a) The discharge planning must be child centered, and incorporate short term goals such as participation in sports or community activities or religious organizations, and long term life goals including attainment of independent living and vocational skills and other special skills, such as playing a musical instrument or attending post secondary education.

(b) Ongoing review of discharge progress by the ISPT and treatment team with the opportunity to demonstrate that skills have been mastered shall be documented in the child's record.

(c) Prior to discharge the RTF shall submit documents related to the child's care in their facility to the ambulatory behavioral health agencies providing aftercare.

(d) Within 14 days of discharge, the RTF shall submit the discharge summary to the ambulatory behavioral health agencies providing aftercare.

(e) For any child receiving or who has received psychotropic medication during their RTF stay the clinical rationale for each medication shall be clearly documented on their psychiatric discharge summary or final evaluation.

(f) Prior to the transfer or discharge of a child, the facility shall inform, and discuss with, the child's parent and, if applicable, the child's guardian or custodian, the recommended transfer or discharge. Documentation of the discussion or transmission of the information shall be kept in the child's record.

(g) No later than 10 days after discharge the resident's record shall contain documentation that the administrator of the Interstate Compact on the Placement of Children was notified of the discharge.

Cross References

This section cited in 55 Pa. Code § 31.243 (relating to content of record).

CHILD RECORDS

§ 31.241. Emergency information.

(a) Emergency information for children shall be easily accessible at the facility.

(b) Emergency information for each child shall include the following:

(1) The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.

(2) The name, address and telephone number of the child's physician or source of health care and health insurance information.

(3) The name, address and telephone number of the person able to give consent for emergency medical treatment, if applicable.

(4) A copy of the child's most recent health examination.

§ 31.242. Child records.

(a) A separate record shall be kept for each child.

(b) Entries in a child's record shall be legible, dated and signed by the person making the entry.

§ 31.243. Content of records.

Each child's record shall include:

(1) Personal information including:

(i) The name, sex, admission date, birth date and Social Security Number.

(ii) The race, height, weight, color of hair, color of eyes and identifying marks.

(iii) The dated photograph of the child taken within the past year.

(iv) Language or means of communication spoken and understood by the child and the primary language used by the child's family, if other than English.

(v) Religious affiliation.

(vi) The name, address and telephone number of the person to be contacted in the event of an emergency.

(2) Health records.

(3) Dental, vision and hearing records.

(4) Health and safety assessments.

(5) ISPs.

(6) Restrictive procedure records relating to the child.

(7) Reports of reportable incidents.

(8) Consent to treatment, as specified in § 31.19 (relating to consent to treatment).

(9) Court order, if applicable.

(10) Admission and placement information specified in §§ 31.222 and 31.223 (relating to description of services; and admission).

(11) Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 31.31 (relating to notification of rights).

(12) Service records of the contracting agency.

(13) Education records.

(14) Current treatment plans.

(15) Past treatment plans.

(16) Current and past RTF psychiatric evaluations.

(17) Special consultations or assessments completed or requested as applicable.

(18) Progress notes that document the child's participation in individual therapy, group therapy, family therapy, and other therapeutic interventions.

(19) Summaries of individual service plan reviews and special consultations regarding all aspects of the child's complete daily program.

(20) Documentation of the child's progress toward meeting treatment goals.

(21) Documentation of the family's participation in the planning and treatment and ongoing efforts of the RTF to accommodate family schedules and encourage such participation.

(22) Current psychotropic medications and regular medication reviews with clinical rationale clearly documented for each medication including:

(i) All changes in medication documented in the medication orders.

(ii) Records documenting administration of all prescribed medications indicating dosage, actual administration of the medication, responsible staff administering, and signature of the responsible staff person.

(23) Documentation of goals, outcomes and reviews following therapeutic leave.

(24) Relevant records from other agencies and systems.

§ 31.244. Record retention.

(a) Information in the child's record shall be kept for at least 6 years or until any audit or litigation is resolved.

(b) A child's record shall be kept for at least 6 years following the child's departure or until any audit or litigation is resolved.

(c) The appropriate Department's regional office shall comply with the information set forth in sections (a) and (b).

§ 31.245. Locked records.

A child's record shall be kept in a locked location when unattended.

FACILITIES SERVING NINE OR MORE CHILDREN

§ 31.251. Additional requirements.

This section and § § 31.252—31.257 apply to facilities serving nine or more children. These provisions are in addition to the other provisions of this chapter.

§ 31.252. Sewage system approval.

A facility that is not connected to a public sewer system shall have a written sanitation approval for its sewage system by the sewage enforcement official of the municipality in which the facility is located.

Cross References

This section cited in 55 Pa. Code § 31.251 (relating to additional requirements)

§ 31.253. Evacuation procedures.

Written emergency evacuation procedures and an evacuation diagram specifying directions for egress in the event of an emergency shall be posted in a conspicuous place.

Cross References

This section cited in 55 Pa. Code § 31.251 (relating to additional requirements).

§ 31.254. Exit signs.

(a) Signs bearing the word “EXIT” in plain legible letters shall be placed at exits.

(b) If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction of travel.

(c) Exit sign letters shall be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

Cross References

This section cited in 55 Pa. Code § 31.251 (relating to additional requirements).

§ 31.255. Laundry.

(a) There shall be a laundry area which is separate from kitchen, dining and other living areas.

(b) Soiled linen shall be covered while being transported through food preparation and food storage areas.

Cross References

This section cited in 55 Pa. Code § 31.251 (relating to additional requirements).

§ 31.256. Dishwashing.

(a) Utensils used for eating, drinking, preparation and serving of food or drink shall be washed, rinsed and sanitized after each use by a mechanical dishwasher or by a method approved by the Department of Agriculture.

(b) A mechanical dishwasher shall use hot water temperatures exceeding 140°F in the wash cycle and 180°F in the final rinse cycle or shall be of a chemical sanitizing type approved by the National Sanitation Foundation.

(c) A mechanical dishwasher shall be operated in accordance with the manufacturer's instructions.

Cross References

This section cited in 55 Pa. Code § 31.251 (relating to additional requirements).

§ 31.257. Bedrooms.

A child's bedroom may not be more than 200 feet from a bathtub or shower and a toilet.

Cross References

This section cited in 55 Pa. Code § 31.251 (relating to additional requirements).

SECURE CARE

§ 31.271. Criteria.

Secure care is permitted only for children who are alleged delinquent, or adjudicated delinquent.

CONDITIONS FOR MEDICAL ASSISTANCE PAYMENT

§31. 281. Policy.

(a) Accredited RTFs must meet the Federal requirements at 42 CFR § 440.160 (relating to Inpatient psychiatric services for individuals under age 21); 42 CFR Part 483, Subpart G (relating to Conditions of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21.)

(b) Non-accredited RTFs meeting the definition of an institution for mental diseases under 42 CFR § 435.1009 (relating to Definitions relating

to institutional status; Institutions for mental diseases) may not be enrolled with the Department as an RTF.

(c) The Department provides coverage for medically necessary residential treatment services rendered to eligible children under 21 years of age by enrolled RTF providers either through the fee-for-service or behavioral health managed care system.

(d) Payment is made for services provided to children subject to this chapter and Chapter 1101 (relating to general provisions) for the fee-for-service system.

(e) Payment is made for services provided to children subject to this chapter and Chapter 1101 (relating to general provisions) for the behavioral health managed care system, except the behavioral health managed care organizations may establish their own procedures and rates. At a minimum, the managed care system must provide the same services as the fee-for-service system.

SCOPE OF BENEFITS

§ 31.282. Scope of Benefits

a) Individuals under 21 years of age who have been determined eligible for Medical Assistance coverage are eligible for medically necessary RTF services provided by a participating facility.

b) Individuals under 21 years of age that are State Blind Pension recipients are not eligible for accredited RTF services.

PROVIDER PARTICIPATION

§31.291. General participation requirements for RTF.

(a) The Department will regulate participation in the medical assistance program and may refuse to enter into a provider agreement with an applicant or to terminate a provider agreement with a participating provider to protect and advance the best interests of the Department.

(b) In addition to the participation requirements established in Chapter 1101 (relating to General provisions), an RTF shall:

(1) Have a program description approved by the Department which reflects the services and location where the facility services are provided.

(2) Be licensed by the Department as an RTF under this chapter.

(3) Have in effect, if accredited, a utilization review plan that meets the requirements set forth at 42 CRF Part 456, Subpart D (relating to Utilization Control: Mental Hospitals) and provide psychiatric services that meet the requirements of 42 CFR Part 441, Subpart D (relating to Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or programs).

(4) Be in compliance, if accredited, with Federal restraint and seclusion requirements and attest annually by July 21 or each year to compliance with 42 CFR Part 483, Subpart G (relating to Conditions of Participation) on the Department specified form.

(5) Provide the Department with requested fiscal information in accordance with the Department's Cost Manual.

(6) Use an accounting system, which properly allocates costs, and maintains adequate statistical data to support the basis of the cost allocation. All allocations shall be made using the methodology identified in the Department's Cost Manual.

(7) Be enrolled in the Department's medical assistance program as an accredited RTF or a non-accredited RTF provider.

(8) Have a maximum of 16 beds per living unit, if non-accredited.

(9) Have a transfer agreement with an acute care hospital and inpatient psychiatric hospital.

(10) If accredited, maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a child and adolescent residential facility, or by the Commission on Accreditation of Rehabilitation Facilities (CARF), or by the Council on Accreditation of Services for Families and Children Service, Inc. (COA), or by any other accrediting body approved by the Department and published in the Pennsylvania Bulletin as a public notice.

§ 31.292. Participation requirements for out-of- state RTFs.

Out-of-state accredited and non-accredited RTFs shall:

(1) Be licensed and participate in the Medicaid Program of the state in which the facility is located, if that state recognizes facilities which provide equivalent services.

(2) Have a program description that meets the requirements in this chapter.

(3) Meet the requirements established in §31.291 (relating to general participation requirements.)

§ 31.293. Participation requirements for secure care RTFs.

(a) Secure care RTF's shall meet all requirements in § 31.291 (General Participation Requirements for RTFs).

(b) Only a locked facility serving children with a serious emotional or behavioral disorder adjudicated or alleged delinquent and court-committed to a secure facility, which does not meet the definition of a public institution at 42 CFR §435.1009 (relating to Definitions relating to institutional status) or a privatized institution under the administrative control of a government unit may enroll as a secure care RTF.

(c) The service description approved by the Department must contain information regarding the security of the facility.

§ 31.294. Participation requirements for RTFs to treat children for drug and alcohol diagnoses concurrent with a serious emotional or behavioral disorder.

(a) All requirements in §31.291. (General participation requirements for RTFs) shall be met.

(b) The facility shall be licensed by the Department of Health to provide drug and alcohol treatment services. Facilities that contract with a licensed drug and alcohol facility to provide substance abuse treatment services are not required to meet the requirement outlined in (b).

(c) The facility shall comply with the Department's current requirements for co-occurring competent service provision including but not limited to universal screening and assessment for co-occurring disorders, referral protocols for appropriate interventions, the employment of qualified professionals to treat co-occurring disorders, and certification as a co-occurring competent facility..

§ 31.295. Ongoing responsibilities of providers.

In addition to the ongoing responsibilities established in Chapter 1101 (relating to general provisions) RTFs shall:

(1) Maintain compliance with state and federal regulations, policies and procedures. Where there are conflicting standards between this chapter, Department regulatory or policy clarification bulletins, or state and federal regulations, the more stringent standards apply.

(2) Maintain current agreements with general and psychiatric hospitals, community-based mental health services, drug and alcohol services and to the extent possible, other RTFs for the prompt and appropriate transfer or referral of children who require or may be expected to require care in another setting.

(3) Begin discharge planning at the point of admission to:

(i) Establish and implement the child's discharge plan, as appropriate.

(ii) Maintain contact and agreements with the child's community-based mental health services, drug and alcohol services, interagency service planning team and the Juvenile Probation Office and Court as appropriate,

to facilitate continuity of care upon discharge and availability of services to children returning to their community on therapeutic leave or upon discharge.

(4) Promptly furnish complete and accurate copies of any requested child records and fiscal records to the Department or its agents, or to federal and state auditors.

(5) Retain complete, accurate, legible and auditable clinical, medical and fiscal records for each child for 6 years from the child's discharge or until the Department's audit is final, whichever is later.

(6) Maintain separate child statistics and fiscal records, based on the Department's Cost Manual, on the cost of and charges for services provided to children at each campus where any covered services are provided.

(7) Notify the Department of any planned service description changes and obtain written Department approval for service description changes or revisions prior to making a change or changes to the program.

(8) Notify the Department of program site changes.

(9) Accredited RTFs shall submit a new attestation of compliance letter with the restraint and seclusion requirements when responsible facility management changes.

(10) If the Medicaid state survey agency determines the accredited RTF is out of compliance with the 42 CFR Part 483, Subpart G (relating to Condition of Participation for the Use of Restraint or Seclusion in

Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21) and will be closed, the accredited RTF shall notify the Department of the facility's plans for the orderly transfer of children from the closing RTF to another, within 5 days of notification by the state survey agency.

§ 31.296. Changes of ownership or control.

(a) If the RTF changes ownership and the new owner wishes to participate in the medical assistance program, the facility shall submit a written application on the form provided by the Department for participation as a provider of services.

(b) When a facility changes ownership, the Department will approve enrollment by the new owner if the following conditions are met:

(1) The new ownership meets applicable State and Federal statutes and regulations.

(2) The Department determines the new owner to be eligible to participate in the medical assistance program as described under § 31.291 (relating to General participation requirements.)

PAYMENT FOR RESIDENTIAL TREATMENT FACILITY SERVICES

§ 31.301. General payment policy.

(a) Payment for RTF services is subject to this chapter and Chapter 1101 (relating to general provisions).

(b) If a child is readmitted to the same RTF within 5 days, the readmission will not be considered a new admission for medical assistance program purposes, but rather a continuation of the original admission.

(c) Behavioral health services provided during the RTF stay (except staff psychiatrist professional component physician costs are included in the prospective per diem payment for facility services and shall not be billed separately or in addition to the prospective per diem payment rate, by the RTF or any other entity with which the facility may have an agreement to provide these services.) The prospective per diem rate for accredited RTF also includes room and board. In a non-accredited RTF the room and board is not included in the per diem rate.

(d) The prospective per diem payment rate does not include services listed under §31.307(c), (relating to Non-compensable services and items). Non-behavioral health services, which are medically necessary and are not covered by the prospective per diem payment rate, may be billed by a provider enrolled in the medical assistance program to provide physical health services.

(e) All admissions are subject to a retrospective review by the Department in addition to the prior authorization review. If the medical record documentation does not support the medical need for the admission or continued stay, or if care rendered is found to be inadequate,

inappropriate, or harmful to the child, payment may be denied for all or part of the stay. Suspected cases of fraudulent practices by the RTF may be referred for further investigation to the Office of the Attorney General, Medicaid Fraud Control Unit.

§ 31.302. Department delegation of responsibility to behavioral health managed care organizations.

The Department may delegate specific responsibilities to the behavioral health managed care organizations including, but not limited to, rate setting, medical necessity review, and the establishment of operational procedures.

§ 31.303. Limitations on payment.

(a) Payment for therapeutic leave:

(1) In order to be compensable, the leave must be part of the treatment program and appropriately documented in the child's medical record. If the child has juvenile probation involvement, home passes shall be requested 10 days in advance and must receive prior and final approval of the juvenile probation office. Documentation must include a physician order for the therapeutic leave, a description of the desired outcome, the date and time the child went on therapeutic leave, prescribed medications, the date and time of return, and a written summary conducted after the leave with the child and family or legal guardian. The summary shall describe the treatment objective(s) of the leave and the outcome.

(2) Payment for compensable therapeutic leave will be at the provider's approved prospective per diem rate for each day of therapeutic leave which meets the requirements of this chapter.

(3) The facility is responsible clinically and fiscally for behavioral health services the child may require while on compensable therapeutic leave.

(4) Compensable therapeutic leave is limited to a maximum of 48 therapeutic leave days per calendar year, per child. This limit applies whether the child is in continuous or intermittent treatment at one or more RTFs during the calendar year.

(5) A facility may grant therapeutic leave in excess of 48 days; however, the Department will not make payment for therapeutic-leave days exceeding the maximum annual limit.

(b) Payment for hospital-reserved bed days:

(1) Payment to an RTF to reserve a bed due to the child's hospitalization will only be made if the child is admitted to a licensed hospital or hospital unit accredited by the JCAHO as a hospital and the hospitalization occurs during a certified RTF stay.

(2) Payment for reserved bed days is limited to 15 days per calendar year (per child) whether the child was in continuous or intermittent treatment at one or more residential facilities during the calendar year. If the child does not return to the RTF, the child shall be deemed discharged on the date of admission to the hospital.

(3) Hospital reserved-bed days in excess of 15 days per calendar year, per child are non-compensable. If no other entity makes payment to reserve the bed for the non-compensable days, the child shall be returned to the first available comparable RTF bed when ready for discharge from the hospital.

(4) Payment for compensable reserved bed days will begin on the date of admission to the hospital and will be paid at one-third of the provider's approved prospective per diem payment rate.

(5) If the reserved-bed day limitation has not been exceeded, and the child is admitted to a hospital or hospital unit as specified in paragraph (1), the facility shall accept the child back when ready for discharge and return the child to the same or comparable residential bed.

(c) Absence without authorization.

(1) Absence without authorization from the RTF is not compensable and shall be recorded as non-covered days on an invoice to the Department unless the conditions in paragraph (2) are met.

(2) The Department will recognize up to 2 days of unauthorized absence from the facility during a certified stay as covered days. All other days are non-covered. The following conditions shall be met for the 2 days to be covered.

(i) Upon determination that the child is absent without authorization, the facility shall immediately file a police report and notify the juvenile probation office if the child has a probation officer. The facility shall also

conduct a search of the facility buildings, grounds and off-site areas where the staff believes the child might have gone.

(ii) If the child cannot be located within two hours of the initial determination that the child is missing, the facility must notify:

(A) The County MH/MR Office, and

(B) The CCYA, if the child is in its custody

(C) The supervising juvenile court, if the child is under the supervision of the juvenile court

(D) the child's responsible family member or legal guardian, as appropriate.

(iii) Attempts to locate the child include at least 4 to 6 hours of off-facility grounds search during each 24-hour period that the child is absent without authorization.

(iv) When the child is found or returns voluntarily, the facility must notify all previously notified parties that the child is no longer absent without authorization.

(v) All actions taken to locate the child during the absence and required notifications shall be documented in the child's medical record.

Documentation of on-site and off-site searches must specify the date and hours of search, where the search was conducted, any pertinent findings, and be signed by staff that conducted the search.

(3) If the child is readmitted to the same RTF within 5 days, the readmission will not be considered a new admission for program purposes but rather, a continuation of the original admission.

(d) Limitation on payment during strike or disaster situations requiring child evacuation.

(1) The facility shall immediately notify: the Department, the appropriate Behavioral Health MCO, the appropriate regional field office of OMHSAS and OCYF, the CCYA and the JPO as appropriate, and the child's family or guardian or both upon learning of an impending strike or disaster situation requiring evacuation from the facility. For these situations, the notifications shall be by phone or fax followed by a written notice.

(2) The facility shall provide a written list of the children in the facility whose care is paid by the Department to OMHSAS, CCYA, and OCYF within 3 to 5 days of learning of the strike or disaster. The list shall identify each child by name, county with custody (if applicable), medical assistance identification number, and as either mental health only or in the custody of OCYF, or under the supervision of the juvenile court, and information identifying where the child has or will be transferred.

(3) If a child is transferred as a result of a strike or disaster, the transferring facility is responsible to transfer the child to the closest participating facility capable of providing the needed service. In JPO cases, the JPO must approve the transfer and may choose to place the child in a detention or other appropriate setting. Payment will be made to

the participating receiving facility at the receiving facility's per diem payment rate based upon the admission or continued stay approval obtained by the transferring facility.

(e) Related Party Transactions.

(1) A provider may include in its allowable costs, services and supplies furnished to the provider by a related party as defined in this manual, at an amount equal to the cost of such services and supplies to the related party.

(2) The cost of services and supplies procured by the provider through a related party transaction may not exceed the cost of comparable services and supplies if purchased elsewhere. The purpose of this principle is to avoid payment of artificially inflated costs, which may be generated from less than arms-length bargaining.

(3) The related party's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services and supplies to the provider. The intent is to treat the costs incurred by the related party as if they were incurred by the provider. In the example of a provider renting or leasing a building from a related party, the rent or lease payments made to the related party by the provider are not allowable costs to the provider. The provider would include in its allowable cost the costs of depreciation, mortgage interest, real estate taxes, and insurance attributable to the building rented or leased as incurred by the related party. The effect of this is to treat the building as if it were owned by the provider.

§ 31.304. Reportable costs.

The Department uses the Department's Cost Manual and Medicare cost principles as established by the Social Security Act (42 U.S.C.A. § 301-1399) as a basis for determining what cost items are allowable for purposes of medical assistance reimbursement.

§ 31.305. Non-reimbursable costs.

Non-reimbursable costs under the medical assistance program include:

- (1) Costs exceeding the limits established by the Department.
- (2) Costs related to the provision of a non-compensable service or item.
- (3) Costs related to days of care determined by the Department not to be medically necessary or appropriate.
- (4) Costs for legal services relating to litigation against the Commonwealth, including administrative appeals, if the litigation is ultimately decided in favor of the Commonwealth.
- (5) Administrative costs in excess of 13% or other medical assistance eligible costs based upon the Department's Cost Manual.
- (6) Costs for which Federal Financial Participation is precluded by statute, except as may be expressly provided for otherwise in this chapter.
- (7) Education costs associated with the child's Individual Educational Plan, Individual Family Service Plan and the Individual Service Plan which are or should be paid for by the child's school district.
- (8) Costs related to direct medical education, residency programs and education field placements.

(9) Costs, services or items which are non-reimbursable under this chapter include,

(i) Advertising (excluding employment opportunities).

(ii) Charitable contributions.

(iii) Employee recognition, such as gifts, awards, dinners.

(iv) Employee social functions, such as picnics, athletic teams.

(v) Excessive benefits (non-standard).

(vi) Fund raising and marketing expenses.

(vii) Life insurance (provider is beneficiary).

(viii) Lobbying.

(ix) Meals for visitors.

(x) Political activities.

(xi) Related party rental, leases or other payments in excess of the Department's Cost Manual provision.

(xii) Reorganization costs.

(xiii) Taxes- Federal, state or local income and excess profits.

(xiv) Taxes from which exemptions are available to the provider.

(xv) Bad debts and contractual adjustments.

(xvi) Barber and beautician costs.

(xvii) Client allowances.

(xviii) Clothing and shoes.

(xix) Living expenses for live-in employees, including lodging, meals and personal laundry.

(xx) Meals for employees, except for employee meals provided as part of client training activities.

(xxi) Penalties, fines or late charges assigned by any source, whether or not related to the provider.

(xxii) Personal hygiene Items.

(xxiii) Personal travel for employees, including personal use of provider vehicle.

(xxiv) Room and board costs for non-accredited RTF providers §31.306. Annual cost reporting.

(a) The facility's cost report shall:

(1) Be prepared using the accrual method of accounting.

(2) Contain complete and accurate information necessary for the proper determination of costs payable under the program.

(3) Cover a fiscal period of 12 consecutive months, from July 1 to June 30, except as noted in paragraph.

(4) Cover the period from the date of approval for participation by the Department to June 30, when the facility begins operations after the start of the fiscal year.

(b) The facility shall submit the completed cost report form in compliance with the Department's Cost Manual to the Department by September 30 of each year. The Department may grant a 30-day extension upon receipt of a written request from the residential treatment facility.

(c) If the provider does not submit a cost report by September 30 of each year, or later if an extension is granted by the Department under the procedures of the cost report, the Department will establish an interim per diem payment rate for the provider equal to the lowest rate for any RTF for the current fiscal year. This rate will begin on the first day after the required report is due and continue until the last day of the calendar month in which the required report is received.

§ 31.307. Non-compensable services and items.

(a) Payment is not made to an RTF for:

(1) Experimental or investigation procedures or clinical trial research and services that are not in accordance with customary standards of medical practice or are not commonly used.

(2) A day of care solely for the purpose of performing evaluations, diagnostic tests or tests not related to a diagnosis that requires this level of care.

(3) Any service if payment is available from another public agency, insurance or health program, or any other source.

(4) Services not ordinarily provided to the general public.

(5) Methadone maintenance.

(6) A day of care during which the child was absent from the facility unless the absence met the criteria at § 31.303 (relating to limitations on payment):

(i) Absences without authorization.

- (ii) Elopement.
- (iii) Left against medical advice.
- (iv) Hospitalization.
- (v) Therapeutic leave.
- (vi) Administrative leave of any kind.

(7) Custodial care related or unrelated to court commitments. Payment for services provided to children confined to a facility under a court commitment for any reason will be made only if medical necessity exists for residential treatment facility services.

(8) Diagnostic or therapeutic procedures for experimental, research, or educational purposes.

(9) Unnecessary admissions and days of care due to conditions which do not require psychiatric residential treatment care.

(10) A day of care for a child who no longer requires this level of treatment.

(11) A day of care for a child who does not have a current DSM diagnosis including Axes I-V or ICD-9-CM diagnosis along with Axes III-V of the most current DSM supported by clinical documentation.

(12) A day of care not certified in accordance with the Department's admission and continued stay review process described at § 31. 314 (relating to admission certification and continued stay certification request.)

- (13) A day of care caused by a delay in requesting or performing necessary diagnostic studies or consultations.
- (14) A day of care on or after the effective date of a court-commitment to another facility.
- (15) A day of care due to a delay in applying for a court-ordered commitment.
- (16) A day of care provided to a child who is suitable for an alternate non-residential treatment type or level of care, regardless of whether the child is under voluntary or involuntary commitment.
- (17) The day of discharge or transfer to another facility.
- (18) A day of care disallowed by the inspection of care requirements specified at § 31.331 (relating to Inspection of care reviews: general).
- (19) A day of care where requirements were not met under 42 CFR Part 441, Subpart D (relating to inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs).
- (b) The Department does not pay RTFs for services or items provided in conjunction with the provision of a service or item in subsection (a), even if the attending physician or facility's utilization review (UR) committee determines that the stay was medically necessary.
- (c) When provided to a child in a RTF, the following services and items are not included in the per diem and may not be included as a facility cost:
- (1) Health care, which is not related to behavioral health.
 - (2) Prescription drugs.

- (3) Ambulance services.
- (4) Staff psychiatrist professional component services.
- (5) Clothing, allowances, and personal care items.
- (6) Diagnostic procedures or laboratory tests.
- (7) Dental.
- (8) Inpatient hospitalization.
- (9) Emergency room visits.
- (10) Transportation and living costs associated with on-campus family visits.

§ 31.308. Third-party liability.

(a) RTFs shall utilize available third-party resources for all services a child receives while in the facility.

(b) If expected payment by a third-party resource is not received, the facility may bill the Department for services certified by the Department and provided to the child.

(c) If the facility receives reimbursement from a third-party subsequent to payment from the Department, the facility shall repay the Department by submitting a replacement of prior claim, according to instructions in the Department's Provider Handbook and Billing Guide.

(d) If a child or the legal representative of a child requests a copy of the record of payment or amounts due, the facility shall submit a copy of the invoice and the request to the Department's Office of Administration, at the

address specified in the Department's Provider Handbook and Billing Guide.

(e) Except as specified in subsection (f), if a child is entitled to insurance benefits, the Department pays the lesser of either:

(1) The facility's per diem payment rate multiplied by the number of covered days, minus any third party resources available to the child for the care, including any Medicare Part B payment.

(2) The amount of the insurance plan's deductible and coinsurance minus any other third party resource available to the child for care, including any Medicare Part B payment.

(f) If the third party resources available to a child for care equal or exceed the facility's per diem rate multiplied by the number of compensable days, the Department will not make payment for the RTF care.

(g) The facility shall utilize resources available through Medicare Part B for those services provided in the RTF that are covered and approved for payment by Medicare Part B.

§ 31.309. Payment for out-of-state RTF services.

(a) The Department will pay for compensable services as established under this chapter, furnished by out-of-state RTFs enrolled to participate in the medical assistance program only if one of the following applies:

(1) The facility is in a state contiguous to Pennsylvania and located closer to the child's residence than an in-state facility.

(2) The out-of-state facility provides a specific program that is not available in the Commonwealth. Documentation shall be provided verifying that a particular RTF is the only facility equipped to provide the type of care that the child requires.

(3) Placement is not available in the Commonwealth for services, which have been approved within the state. In this instance three in-state facilities must be contacted and unable to accept the child before the child may be placed out-of-state.

(b) The prospective per diem payment rate for services provided by an out-of-state facility as established at §31.302 (relating to Payment methods and rates) cannot exceed the lesser of:

(1) The facility's home-state Medicaid per diem payment rate for equivalent services.

(2) The average bed-weighted prospective per diem payment rate for RTFs located in Pennsylvania adjusted, if appropriate, for specialized care not available within Pennsylvania, based on the Department's Cost Manual.

(3) The statewide bed-weighted average Pennsylvania per diem rate for inpatient psychiatric hospitals if the facility is an accredited RTF.

(c) The Department will pay the rate established in accordance with this section minus any payments from the child, a legally responsible relative or a third-party resource for the services a child receives while in the facility.

(d) The Department's payment rate will not include costs which are precluded from recognition by Medicare payment principles.

§ 31.310. Billing requirements.

(a) The facility shall submit invoices to the Department under the instructions in the Department's Provider Handbook and billing guides and subsequent instructions issued by the Department.

(b) The Department will not pay for RTF services if the facility submits the invoice for payment for those services later than 180 days following the last certified day of care on the invoice, unless granted an exception by the Department.

(c) All original and resubmitted claims, including replacement claims, must be received for final adjudication within 365 days following the last date of service on the invoice.

(d) If the service spans 2 fiscal years, a separate invoice must be prepared for each fiscal year.

(e) If the service spans 2 differing per diem payment rates, a separate invoice must be prepared for each time period covered by the differing rates.

(f) Except as specified in §31.307 (c) (relating to Non-compensable services and items), services and items provided to the child while in the facility are included in the prospective per diem and shall be included in the RTF services bill and shall not be invoiced separately.

§ 31.311. General payment conditions.

- (a) The child must be eligible for RTF services on the date of service.
- (b) The child must have a documented need for services requiring placement in an RTF.
- (c) The child's admission and treatment in the facility must be in accordance with State and Federal regulations governing admission, continued stay, and service provisions in an RTF.
- (d) The interagency service planning team assessment as to the child's need for admission or the child's treatment team assessment for continued treatment in an RTF must be based upon evaluations that include a face-to-face examination of the medical, psychiatric, social, behavioral and developmental aspects of the child's situation and reflect the medical necessity and effectiveness of RTF care for the child.
- (e) The facility must comply with the prior authorization process and continued stay process specified in the Department's Utilization Review Manual for RTFs which include continued interagency service planning team involvement.
- (f) The service shall be approved prior to admission or continued stay unless the service meets the conditions specified at § 31.314 (relating to admission certification and continued stay request).
- (g) The child shall receive documented active treatment provided by mental health professionals at a frequency and intensity to justify 24-hour, out-of-home care instead of outpatient services which support the child in the home community.

§ 31.312. Evaluations and treatment plans.

(a) Team members specified at §31.224. (d) and (e) (relating to development of the ISP) must perform and prepare within the scope of their practice medical, psychiatric and psycho-social evaluations within the following time frames:

(1) Within a maximum of 30 days prior to the Department's receipt of an admission certification request or continued stay request; or

(2) Before authorization for payment, if the child becomes eligible for medical assistance after admission.

(b) Team members specified at § 31.224 (d) and (e) (relating to development of the ISP) shall, within their scope of practice, prepare the treatment plan. The plan shall document the active treatment to be provided and be designed to achieve the child's discharge at the earliest possible time. Accredited RTF treatment plans must be in compliance with 42 CFR § 441.155(b) (relating to Individual plan of care), and 42 CFR § 456.180(b) (relating to Individual written plan of care) based upon face-to-face contact.

(c) A written report of each evaluation, treatment plan portion of the ISP and update must be entered in the child's record. Accredited RTF reports must also meet the time-frames specified at 42 CFR § 456.181 (relating to Reports of evaluations and plans of care).

§ 31.313. Information required to request admission or continued stay.

(a) Certification of need for RTF services must be included in the documentation specified in subsection (b) and certified by:

- (1) The interagency service planning team, prior to admission.
- (2) The child's treatment team in concert with the interagency service planning team for continued stay.

(b) The treatment team must certify that:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the child.

(2) Proper treatment of the child's psychiatric condition requires services on an inpatient basis under the direction of:

(i) A physician for an accredited RTF

(ii) A physician or psychologist for non-accredited RTF services.

(ii) The service can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed.

(c) Documentation prepared by the treatment team specified in subsection (a) and used by the RTF utilization review committee to request admission certification or continued stay certification in accord with the Department's Utilization Review Manual must include all of the following.

(1) The Department-designated form signed by the prescribing physician or designee for an accredited RTF stay, or signed by the prescribing licensed physician, licensed psychologist, or designee for a non-accredited RTF stay.

(2) The most recent psychiatric evaluation signed by the treating psychiatrist for accredited RTF stays, or by the licensed physician, licensed psychologist, or designee for a non-accredited RTF stay. The evaluation must be performed no more than 30 days before the planned admission date or the date the request was received by the Department. The child must have a face-to-face psychiatric evaluation that supports a DSM diagnosis, Axis I through V or an ICD-9-CM diagnosis along with Axis III through V of the most current DSM.

(3) The child's current or proposed treatment plan which meets the requirements of § 31.312 (relating to evaluations and treatment plans).

(4) The child's current or proposed plan of care summary.

(5) The completed Department form which describes services considered and tried prior to the recommendation for RTF services and indicates whether the County MH/MR Office recommends admission or continued stay in the facility.

§ 31.314. Admission certification and continued stay certification request.

(a) Admission certification – Admission certification is requested according to the process in the Department Utilization Review Manual and contains information required in § 31.313 (relating to information required to request admission or continued stay.)

(1) Mental health-only admission - The admission must be prior authorized by the Department and occur within 30 days of the date the Department approves the admission. If the admission does not occur, a

new certification request must be completed to update the status of the child and certify that RTF care is still medically necessary.

(2) CCYA or JJ Placement –

(i) The certification request for a child receiving service through the CCYA or under the jurisdiction of the juvenile court is the same as paragraph (a)

(1), unless the CCYA or the juvenile court determines the child needs immediate placement. For immediate placements all of the following criteria shall be met:

(A) The child has a DSM-IV (or subsequent version) diagnosis, Axes I through V or ICD-9-CM (or subsequent version) diagnosis, along with Axes III through V, and is not in a mental health or substance abuse crisis.

(B) The child requires placement because of child-safety or protection issues.

(C) The interagency service planning team recommends RTF placement to meet the child's treatment needs.

(ii) If the child is admitted to an RTF in accordance with (i) of this subsection, all information to support the admission must be received by the Department within 20 days of the child's admission.

(iii) If the Department denies the admission certification, the Department will not make payment for RTF services for the child.

(b) Recertification for continued stay.

(1) The request for continuation of stay must be made 30 days prior to the expiration of the certified length of stay.

(2) Either of the following conditions apply to request for delayed coverage:

(i) The request must be made within 30 days of the date the child was determined eligible for medical assistance.

(ii) The request must be made within 30 days of the notification by a third-party resource, originally expected to cover the child's treatment, that the requested service is not covered or coverage is exhausted.

(3) Exception- This process does not apply to a period of service which was not covered by another payor because the service was not medically necessary, or the other entity's payment policies were not followed and, therefore, resulted in a rejection.

(c) Non-accredited RTF expedited review.

(1) Non-accredited RTFs are not the appropriate placement or treatment resource when dealing with a clinical mental health emergency crisis. If a crisis situation exists, it should be handled through the county MH/MR office. Mental health services to promote stabilization may be requested through the county in order to deal with a clinical crisis. If the situation warrants a more expeditious review, the county MH/MR administrator or designee must agree to the need for such a review. The prescriber must submit the proper documentation required by §31.313 (relating to information required to request admission or continued stay) to the Department.

(2) When the county MH/MR administrator or designee agrees to the need for an expedited review, the county administrator notifies the Department's OMHSAS field office staff who within one workday make a decision to approve or deny the request for expediting the case and notify the prescriber of the decision as to whether the case warrants expediting.

(3) If the field office staff denies the request to expedite the case, the routine prior authorization review process will take place.

(4) When the field office staff agrees to the need for an expedited review, the field office staff will fax a completed copy of the Request for Expedited Services to the Department.

§ 31.315. Certification determination.

(a) Accredited RTFs.

(1) The documentation for the certification request and information given to the Department must include accurate and detailed medical information to establish medical necessity for the admission or continued stay.

(2) The request will not be accepted until all required information is available. If the required information is not present, the request will be returned to the county case manager to assure completion and resubmission.

(3) The Department will certify or deny the admission certification request or continued stay certification request based upon medical necessity and compensability for services within a maximum of 21 days of each request.

The request will be deemed approved if a determination is not made within 21 days.

(4) Department approval is for medical necessity of care and does not assure the child is, will be, or will continue to be eligible for medical assistance services on the date service is provided.

(b) Non-accredited RTFs.

(1) The documentation for the certification request and accompanying information must include accurate and sufficiently detailed medical information to justify the medical necessity of the admission or continued stay at the RTF level of care. Unless the request for certification is incomplete, the Department will render a determination to approve or deny the request for certification within 21 days of receipt by the Department. A request for an expedited review that meets the condition in §31.314 (c) (relating to expedited review) will be approved or denied within 3 days of the official contact with the appropriate Department staff.

(2) If the Department designated request form and supporting documentation are incomplete:

(i) Within 18 days of Department receipt, staff will contact either:

(A) The child's assigned mental health, CCYF or JJ case manager when the missing information is administrative or process oriented.

(B) The prescribing physician, psychologist or designee when the missing information is medically-oriented.

(ii) If the requested information is received by the Department within the established time frame, a decision to approve or reject the request will be made within 16 days of the receipt of the additional information or the request will be deemed approved.

(iii) If the Department does not receive the requested information by the established deadline for submission of information the request will be denied for lack of documentation.

(3) Prior to issuing a denial a request for admission or continued stay based upon medical necessity or place of service, a second review will be conducted by the Department's medical consultant.

(4) Written notification of the decision will be sent to the service provider, prescribing physician or psychologist, the county MH/MR office and if applicable, the CCYA or the Juvenile Probation Office, the child's case manager, and the child or child's parents or legal guardian.

§ 31.316. Effective date of coverage.

(a) Admissions

(1) Mental health-only admission.

(i) The effective date of coverage will be the date of admission provided the admission occurs within 30 days of the date of the approval decision made by the Department. The accredited RTFs shall advise the Department of the actual admission date. For non-accredited RTF's, if the child is not admitted on the date indicated on the request form, the prescriber or provider may request a change in the begin and end date.

(ii) If the request is not approved by the Department prior to admission due to incomplete approvable information, certification will begin on the date complete and approvable information is provided to the Department.

(2) CCYA or JJ placement.

(i) If prior authorization for the admission is received from the Department, the effective date of coverage is as specified in paragraph (1).

(ii) If the child is placed by the CCYA or juvenile court under §31.313 (a) (2) (relating to CCYA or JJ placement) and approvable information is submitted to the Department within 20 days of admission to the facility, the certified days are effective on the date of admission.

(iii) If the child was placed by the CCYA or the juvenile court but the documentation package is not received by the Department within 20 days of admission to the facility, the effective date of the approval will be the date complete and approvable information is received by the Department.

(b) Continued stay.

(1) Recertification for a continued stay.

(i) If an approvable recertification request is received by the Department 30 days prior to the expiration of the certified length of stay, the effective date is the first day after the last day previously certified stay.

(ii) If the recertification request is received by the Department less than 30 days prior to the expiration of the certified length of stay, and the stay is approved after the expiration of the previously approved stay, each day of delay in requesting an extension subsequent to the last previously certified

stay shall result in the reduction of a corresponding number of days approved.

(2) Delayed coverage.

(i) If the child was not determined eligible for medical assistance subsequent to admission, the effective date of the approval will be the date the continued stay certification was requested and approved if the request is made after eligibility was determined, or the date the child is determined eligible for medical assistance coverage if the request was initiated before eligibility was determined.

(ii) If other insurance was expected to pay in full for the service but failed to materialize, the effective date will be the later of either:

(A) The admission date.

(B) The date the child became eligible for services after the admission.

(iii) If other insurance was expected to pay in full for the service but coverage was exhausted; the effective date will be the later of:

(A) The date coverage was exhausted,

(B) The date the request for certification was received by the Department.

(C) The date the child became eligible for services after the admission.

UTILIZATION CONTROL

§ 31.321. Scope of claim review process.

All RTF services provided to children are subject to the UR procedures set forth in this chapter and Chapter 1101 (relating to the General provisions). Accredited RTF facilities are also subject to 42 CFR

Part 456, Subpart A (relating to General provisions), Subpart B (relating to Utilization Control: All Medicaid Services), and Subpart D (relating to Utilization Control: Mental Hospitals).

§ 31.322. Admission certification review.

(a) The Department approves or disapproves the child's need for admission and need for continued services through its utilization review process.

(b) The Department regularly monitors the facility's utilization review program to determine whether it is operating in accordance with the admission review process and §§ 31.321 through 31.324 (Utilization Control). Monitoring is carried out through review of admissions, continued stays, child records and claims paid by the Department.

§ 31.323. Facility utilization review.

(a) RTFs shall have a facility utilization review plan. Accredited RTF under this chapter shall also be in compliance with 42 CFR Part 456 Subparts B and D (relating to utilization control: all Medicaid services and mental hospitals).

(b) The RTF's utilization review committee shall: conduct the required review(s), ensure that complete documentation is obtained, and that the certification request is given to the Department within the appropriate time frames specified at §31.314. (relating to admission certification and continued stay certification request.)

(c) The RTF shall have a utilization review committee composed of two or more physicians, one of whom is knowledgeable in the diagnosis and treatment of mental diseases, and assisted by other professional personnel.

(d) The RTF utilization review committee may not include any individual who is directly responsible for the care of children whose care is being reviewed; or has a financial interest in any mental hospital.

(e) The facility shall conduct reviews of children's need for admission and continued need for residential treatment services.

(f) The facility shall maintain the original signed copy and continued stay copies of the request documentation package, and the notification of the number of days certified with the child's medical record. Another copy of the notification of days certified will be kept with the facility's billing records.

(g) The accredited RTF's utilization review committee representative shall notify the Department according to the schedule established by the Department:

(1) Of a child's admission to the facility.

(2) Of a child's discharge from the facility.

(h) The facility shall maintain utilization review records for a minimum of 6 years from the date of submission of that year's end cost report or until the cost report is audited by the Auditor General, whichever is later.

(i) The facility shall submit copies of utilization review records and documents, medical records, and psycho-social records, certification of days approved or denials and discharge planning information to the Department upon request.

(j) The facility utilization review committee shall review cases that the Department has identified as being a questionable utilization of RTF services or that contain non-compensable services or items as listed in § 31.307 (relating to non-compensable services and items).

§ 31.324. Adverse determinations.

(a) On each case for which the utilization review committee denies admission or continued stay, an adverse determination letter shall be sent to the county MH/MR office, the OCYF, the CCYA with custody, and the supervising juvenile probation office. For accredited RTFs, in addition to the agencies specified above, the UR committee shall provide written notice to the entities listed at 42 CFR § 456.237 (relating to Notification of adverse decision.)

(b) The adverse determination letter shall include:

- (1) The child's name.
- (2) The child's age.
- (3) The child's full medical assistance identification number.
- (4) The facility's name.
- (5) The admission date.
- (6) The discharge date, if known.

(7) The diagnoses on the copy sent to the Department and the county MH/MR office.

(c) The facility's UR committee shall send the adverse determination letter no later than either the last day of the approved length of stay or the day after the determination, whichever is earlier.

(d) Each month, the facility UR committee shall complete and submit a summary report of adverse determinations in accordance with the instructions in the Department's Utilization Review Manual for RTFs.

(e) The facility UR committee shall mail the monthly summary report specified in subsection (d) no later than 15 days after the end of the month.

INSPECTION OF CARE REVIEWS

§ 31.331. Inspection of care reviews: general.

(a) Unannounced on-site visit(s) will be conducted by the State Medicaid Agency to accredited RTF as deemed appropriate by the Department to determine if the facility continues to meet medical assistance certification standards.

(b) The facility shall provide a list of all medical assistance children in the facility on the date of the review to the program office conducting the review. The facility shall also make the medical records of these children and personal contact with the child readily available to the individual or team reviewing the facility.

(c) The Department will determine through its inspection whether state and Federal regulations are met.

§ 31.332. Inspection of care reports.

(a) The Department or designated agent will report to the facility according to the Department's reporting guidelines.

(b) If the inspection of care team recommends alternate care for a child:

(1) The CAO will notify the child or the child's representative and the facility administrator of the intended denial of payment authorization.

(2) If the child or the child's representative requests a fair hearing within 10 days from the date the notice is mailed, payment for RTF care will continue pending the outcome of the hearing.

(3) If a request for a fair hearing is entered after day 10, payment is discontinued effective with the day the inspection of care team recommended alternative care pending the outcome of the hearing.

(4) The child or the child's representative has 30 days from the date the notice is mailed to grieve the decision or request a fair hearing. The facility does not have the right to grieve or request a fair hearing unless it is acting as the child's representative.

(5) If the Department is sustained in its action, and payment had continued pending the outcome of the hearing, the Department will recover from the facility any payment that would not have been made if the action of the Department had not gone through the fair hearing or grievance process. The period for which the Department will recover excess payment begins

on the effective date specified on the notice and ends with the date that the appropriate change in the level of care is made.

(c) If the report from the inspection of the care team cites deficiencies, all of the following apply:

(1) The facility shall submit a written response to the identified Department office within 30 days of the control date shown on the summary report. The response shall outline the facility's planned course of action including acceptable time frames for correcting deficiencies.

(2) The inspection of care team will conduct follow-up visits to determine if the deficiencies have been corrected.

(3) The facility is subject to sanctions up to and including termination from the MA program.

ADMINISTRATIVE SANCTIONS

§ 31.341. Provider abuse.

If the Department determines that a provider has billed for services inconsistent with this chapter, provided services outside the scope of customary standards of medical practice, or otherwise violated the standards set forth in the provider agreement, the provider shall be subject to the sanctions in Chapter 1101 (relating to general provisions).

§31.342. Administrative sanctions.

(a) If the facility UR committee fails to conduct a continued stay review or fails to notify the Department within 30 days of the expiration of the previously assigned length of stay, the Department will not certify those

days between the expiration of the previously assigned length of stay and the date the request for continued stay is received.

(b) If the Department determines that services or items provided by the facility were not provided according to standards of practice for the particular discipline providing the service were not medically justified or were unnecessary, inappropriate, or otherwise non-compensable, the Department will deny payment for those and related services and items and recover payments already made for those and related services and items.

PROVIDER RIGHT OF APPEAL

§ 31.351. Provider right of appeal.

(a) RTFs, as the providers of service, have the right to appeal adverse actions of the Department under Chapter 1101 (relating to general provisions).

(b) RTF staff and subcontractors of mental health and substance abuse services shall not have the right to an appeal.

(c) If a facility appeals a decision by the Department to fully or partially deny payment for a child, the Department will withhold the denied payments pending a decision on the appeal.