Department of Human Services

Adopted Permanent Rules Governing Licensure of Residential Treatment Programs for Children With Severe Emotional Disturbance

Rules as Adopted

9545.0905 PURPOSE; OUTCOMES.

Subpart 1. **Purpose.** Parts 9545.0905 to 9545.1125 establish minimum standards that residential treatment programs serving children with severe emotional disturbance must meet to qualify for licensure under Minnesota Statutes, chapter 245A, the human services licensing act. Parts 9545.0905 to 9545.1125 also implement and must be read in conjunction with Minnesota Statutes, sections 245.487 to 245.4888, the Minnesota comprehensive children's mental health act.

Subp. 2. **Outcomes.** Compliance with the standards and requirements in parts 9545.0905 to 9545.1125 requires that services:

A. are provided as specified in an individual treatment plan based on the clinical needs of the child;

B. are developed with assistance from the child's family or legal representative in deciding what services are needed and how they are provided;

C. support the child in gaining the skills necessary to return to the community;

D. support the family in gaining the skills necessary to care for the returning child;

E. are provided by qualified people under the clinical supervision of a mental health professional; and

F. meet the quality of services criteria in Minnesota Statutes, section 245.4876, subdivision 1, that are applicable to residential treatment providers.

Subp. 3. **Variance.** A licensee seeking to provide services not in compliance with parts 9545.0905 to 9545.1125 must first

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obtain a variance under the process in part 9543.1020, subpart 5.

9545.0915 APPLICABILITY.

Subpart 1. **Applicability.** Parts 9545.0905 to 9545.1125 apply to any individual, corporation, limited liability corporation, partnership, voluntary association, other organization, or controlling individual that operates a residential treatment program for children with severe emotional disturbance.

~~Until the commissioner adopts separate rules to license shelter services,~~ Parts 9545.0905 to 9545.1125 apply according to part 9545.1045 to:

A. the shelter services component of programs that provide both residential treatment and shelter services; and

B. providers of freestanding shelter services that do not provide residential treatment services for children with emotional disturbance but hold a current license under parts 9545.0900 to 9545.1090 (OLD RULE 5) on the effective date of parts 9545.0905 to 9545.1125.

Subp. 2. **Exclusions.** Parts 9545.0905 to 9545.1125 do not apply to:

A. programs excluded from licensure under Minnesota Statutes, section 245A.03, subdivision 2;

B. residential programs that serve children with severe emotional disturbance who do not need residential treatment services as determined by the county screening required in Minnesota Statutes, section 245.4885;

C. an acute care hospital licensed under Minnesota Statutes, chapter 144.

9545.0925 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9545.0905 to 9545.1125, the following terms have the meanings given them.

Subp. 2. **Administrative discharge.** "Administrative discharge" means the discharge of a child before the child reaches its treatment goals.

Subp. 3. **Applicant.** "Applicant" has the meaning given in

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Minnesota Statutes, section 245A.02, subdivision 3.

Subp. 4. **Case manager.** "Case manager" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 4.

Subp. 5. **Child.** "Child" means a person under 18 years of age.

Subp. 6. **Child with severe emotional disturbance.** "Child with severe emotional disturbance" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 6.

Subp. 7. **Clinical supervision.** "Clinical supervision" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 7.

Subp. 8. **Commissioner.** "Commissioner" has the meaning given in Minnesota Statutes, section 245A.02, subdivision 5.

Subp. 9. **Cultural competence.** "Cultural competence" means the ability to respond to the unique needs of a population whose culture is different from the dominant culture.

Subp. 10. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 11. **Diagnostic assessment.** "Diagnostic assessment" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 11.

Subp. 12. **Discipline.** "Discipline" means the implementation of reasonable, age-appropriate consequences designed to modify and correct behavior according to a rule or system of rules governing conduct. The rules must be made known to the child, the child's family, or legal representative and staff.

Subp. 13. **Emotional disturbance.** "Emotional disturbance" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 14. **Family.** "Family" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 16, ~~or~~ and, in the case of an Indian child, means a relationship recognized by the Minnesota Indian family preservation act, Minnesota Statutes, sections 257.35 to 257.3579.

Subp. 15. **Functional assessment.** "Functional assessment"

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has the meaning given in Minnesota Statutes, section 245.4871, subdivision 18.

Subp. 16. **Incident.** "Incident" means an occurrence or event that interrupts normal procedures or precipitates a crisis.

Subp. 17. **Individual family community support plan.** "Individual family community support plan" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 19.

Subp. 18. **Individual education plan.** "Individual education plan" has the meaning given in part 3525.0200, subpart 6a.

Subp. 19. **Individual treatment plan.** "Individual treatment plan" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 21.

Subp. 20. **Informed consent.** "Informed consent" means written or documented oral informed consent to the use of a medical treatment or administration of a medication given voluntarily by a child and a child's parent or legal representative except in those rule parts where written informed consent or both written and oral informed consent is specifically required. Consent must be based upon the disclosure to the child and the child's parent or legal representative of the information required according to part 9545.1025, subpart 7.

Subp. 21. **Isolation.** "Isolation" means involuntary confinement, either alone or with a staff member, in a room where the child can be continuously observed but is prevented from leaving by devices or objects positioned to hold the door closed.

Subp. 22. **Legal representative.** "Legal representative" means a guardian appointed by the court to decide on services for a child as specified in Minnesota Statutes, section 525.619, a custodian or guardian as defined in Minnesota Statutes, section 260.015, subdivision 14, or an Indian custodian as defined in Minnesota Statutes, section 257.351, subdivision 8.

Subp. 23. **License.** "License" has the meaning given in Minnesota Statutes, section 245A.02, subdivision 8.

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Subp. 24. **License holder.** "License holder" has the meaning given in Minnesota Statutes, section 245A.02, subdivision 9.

Subp. 25. **Medication assistance.** "Medication assistance" means assisting residents to take medication and monitoring the effects of medication but does not include administering injections. For purposes of this definition, medication means a prescribed substance that is used to prevent or treat a condition or disease, to heal, or to relieve pain.

Subp. 26. **Mental health practitioner.** "Mental health practitioner" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 26.

Subp. 27. **Mental health professional.** "Mental health professional" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 27.

Subp. 28. **Physical holding.** "Physical holding" means intervention intended to hold a child immobile or limit a child's movement by using body contact as the only source of restraint.

Subp. 29. **Physical restraint or restraints.** "Physical restraint" or "restraints" means the use of devices to limit a child's movement or hold a child immobile. The term does not apply to restraints used for medical needs such as braces or splints.

Subp. 30. **Prior authorization for emergency use of isolation or restraints.** "Prior authorization for emergency use of isolation or restraints" means a written statement by a physician, psychiatrist, or licensed psychologist who has reviewed a child's medical history, history of injurious behavior, and other assessments and diagnoses. The statement allows the use of isolation or restraint in a situation where the child poses a threat of harm to self or others.

Subp. 31. **Psychotherapy.** "Psychotherapy" has the meaning given in Minnesota Statutes, section 148A.01, subdivision 6.

Subp. 32. **Psychotropic medication.** "Psychotropic medication" means a medication prescribed by a ~~physician~~ person

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who may lawfully prescribe, according to a child's diagnosis, to treat mental illness and associated behaviors or to control or alter behavior. The major classes of psychotropic medication are antipsychotic~~,~~ (neuroleptic), antidepressant, antianxiety, antimania, stimulant, and sedative/hypnotic. Other miscellaneous classes of medication are considered to be psychotropic medication when they are specifically prescribed to treat a mental illness or to alter behavior based on a child's diagnosis.

Subp. 33. **Punishment.** "Punishment" means an act designed to harm or injure which is inflicted upon a child as a result of the child's behavior.

Subp. 34. **Resident district.** "Resident district" has the meaning given in part 3525.0200, subpart 19a.

Subp. 35. **Residential program.** "Residential program" has the meaning given in Minnesota Statutes, section 245A.02, subdivision 14.

Subp. 36. **Residential treatment.** "Residential treatment" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 32.

Subp. 37. **Shelter services.** "Shelter services" means services provided during time-limited placements of 90 days or less, to children who are in a behavioral or situational crisis, need out-of-home placement in a protective environment, and have an immediate need for services such as assessment, evaluation, or placement planning.

Subp. 38. **Special mental health consultant.** "Special mental health consultant" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 33a.

Subp. 39. **Staff supervision or supervisor.** "Staff supervision" means the oversight responsibility to hire, train, assign duties, evaluate, and direct staff in day to day activities. A "supervisor" has staff supervision responsibility.

Subp. 40. **Time-out.** "Time-out" means an intervention in which a staff member trained in time-out procedures removes the child or the child removes self from an ongoing activity to an

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unlocked room or area which is safe and where the child remains alone or with a staff member until the precipitating behavior abates or stops.

Subp. 41. **Treatment team.** "Treatment team" means a team consisting of the child, the child's parent or legal representative, staff who provide program services, including a mental health professional, case manager, and, if applicable, the child's caretaker, advocate, child psychiatrist, special mental health consultant, or other persons relevant to the child's needs.

Subp. 42. **Updated diagnostic assessment.** "Updated diagnostic assessment" means a written summary by a mental health professional of the child's current mental health status and services needs according to Minnesota Statutes, section 245.4876, subdivision 2.

9545.0935 ~~CONDITIONS OF LICENSURE~~ PROHIBITION AGAINST UNLICENSED SERVICES.

No person, corporation, limited liability corporation, partnership, voluntary association, controlling individual, or other organization can provide residential treatment services to children with severe emotional disturbance unless licensed by the commissioner under parts 9545.0905 to 9545.1125, according to the licensing requirements of parts 9543.1000 to 9543.1060.

9545.0945 PROGRAM AND SERVICE STANDARDS.

Subpart 1. **Program capability.** An applicant or license holder must offer the following services scheduled at accessible times which are appropriate to the child's age or level of functioning to support achieving the following outcomes:

A. individual and group psychotherapy which is designed to achieve the outcomes and meet the specific requirements of the child's individual treatment plan and when possible help the child reintegrate into the family, the community, and a less restrictive setting than residential treatment. The person providing individual and group psychotherapy must at a minimum qualify as a mental health

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practitioner, who is supervised by a mental health professional;

B. crisis assistance services designed to help children and family members recognize factors that precipitate a psychiatric crisis, anticipate behaviors and symptoms, and know the resources to use when crisis is imminent or occurs. Persons providing crisis assistance services must be at least mental health practitioners and must be supervised by a mental health professional;

C. medication education designed to have the child and family understand:

(1) the role of psychotropic medication in the child's treatment and the effect the medication may have on the child's physical and mental health; and

(2) the physical, emotional, or behavioral changes resulting from the child's use, misuse, or refusal to use psychotropic medications prescribed. The person who provides medication education must be licensed as a registered nurse, pharmacist, or ~~licensed~~ physician;

D. instruction in independent living skills designed to strengthen a child's ability to function in a less restrictive environment than a residential treatment center. The services must support the child in carrying out the tasks of daily living, encourage the development of self-esteem, and promote self-sufficiency. Persons providing independent living skills services must either qualify as mental health practitioners or as child care workers who are supervised by a mental health practitioner;

E. recreation, leisure, and play activities designed to achieve these outcomes:

(1) the child develops recreational skills; and

(2) the child and family learn how to plan and participate in recreation and leisure activities.

The persons providing these services must be at least child care workers under the supervision of a mental health practitioner or a recreational therapist;

F. social and interpersonal skills development

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designed to achieve these outcomes:

(1) the child develops and maintains friendships; and

(2) the child communicates and interacts with peers and adults.

The person providing these services must be at least a child care worker under the supervision of a mental health practitioner;

G. vocational skills development services designed to prepare the child for the world of work by exploring the importance of such areas as use of time, acting responsibly, and working within the goal of an organization. Persons providing these services must be at least mental health practitioners or must be child care workers supervised by a mental health practitioner. The license holder may make vocational skills development services available to the child through the school district <u>either on the program's campus or at a site provided by the school district</u>. The license holder shall coordinate vocational skill development services with the child's secondary transition plan developed by the school according to part 3525.2950;

H. instruction in parenting skills designed to achieve the outcome of parents using therapeutic parenting techniques that address management of specific behaviors or learning issues directly related to or resulting from the child's emotional disturbance. Persons providing parenting skills services must be supervised by a mental health practitioner; and

I. family support services designed to achieve the outcomes in subitems (1) to (3):

(1) family members gain insight into family dynamics and resolving conflicts;

(2) family members have broader family support, family goals, and improved family coping skills; and

(3) the child is reintegrated into the family and community.

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The license holder must provide these services at times, including evenings and weekends, that are mutually agreed upon by family and program staff. The person providing family support services must be at least a mental health practitioner.

Subp. 2. **Cultural competence.** The license holder must have services designed to achieve the outcomes in items A to C.

A. The child has opportunities to associate with adult and peer role models with similar cultural and racial backgrounds and participate in positive experiences related to the child's racial or cultural minority group.

B. Program services and treatment services must address cultural differences and special needs of all children. The license holder's development and periodic updating of program services must reflect the advice of representatives of the racial, cultural, or ethnic groups represented by children in treatment. The license holder may use a special mental health consultant to provide or develop program services which respect cultural differences and meet the special needs of cultural or racial groups.

C. Staff must be trained and competent in cultural aspects of mental health treatment for children and their families.

Subp. 3. **Interpretive services.** The license holder must use interpreters and equipment as necessary to ensure that all children admitted to the facility and children's representatives with whom the facility is working are informed in a way they can understand about treatment plans, choices, and rights. The license holder must not use a child as an interpreter.

Subp. 4. **Emergency medical, mental health, and dental services.** The license holder must have a system for meeting emergency medical, mental health, and dental needs of the children. The license holder's access system must ~~assure contact with~~ be capable of getting a telephone or in-person response from a mental health professional, or a physician, within 30 minutes after the emergency is identified.

Subp. 5. **Grievance procedure.** The license holder must

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have a written grievance procedure which allows an interested person, a child or the child's parent, or legal representative to formally complain about any aspect of the child's care during the child's stay in the facility. The license holder's written grievance procedure must provide:

A. that the child and the child's parent or legal representative receive a copy of the grievance procedure prior to or upon admission;

B. that, upon request, the child or child's parent or legal representative receive necessary forms and assistance in filing a grievance; and

C. that the license holder must make a written response within one week of the grievance. The written response must explain what action the license holder took in response to the grievance. A license holder's response to a grievance which alleges abuse or neglect must meet the requirements of the maltreatment of minors act, in Minnesota Statutes, section 626.556.

Subp. 6. **Staffing pattern and minimum staff/children ratio.** The license holder must provide a sufficient number of appropriately trained staff who provide program services to ensure that a child accepted by the facility can have the treatment needs identified in the child's individual treatment plan met while the child stays in the facility. A facility providing treatment in a setting with secure capacity according to part 9545.1035 must meet the staff-to-child ratio of part 9545.1035, subpart 4. A facility licensed according to parts 9545.0905 to 9545.1125 shall not have a ratio of staff who provide program services to children less than the following schedule:

Age of child	Minimum ratio of staff to children during waking hours when children are present
less than six years old	one staff person to three children
six to eight years old	one staff person to four children

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nine to 11 years old	one staff person to six children
12 to 18 years old	one staff person to eight children

During sleeping hours a license holder caring for children younger than nine years old must provide at least one staff person for every seven children present. During sleeping hours a license holder caring for children nine years old or older must provide at least one staff person for every 12 children present.

9545.0955 ADMISSIONS CRITERIA AND PROCESS.

Subpart 1. **Conditions governing admission.** A license holder must admit a child only if the child meets the conditions in items A to F.

A. The child must be under 18 years of age at the time of admission.

B. If public funds are used to pay for the services, the child must be screened by the county prior to admission as required by Minnesota Statutes, section 245.4885, subdivision 1.

C. If public funds are not used to pay for the services, the child must be screened by a mental health professional using a screening process which is equivalent to that required by Minnesota Statutes, section 245.4885, subdivision 1, prior to admission.

D. The prior-to-admission screening in item B or C must determine that the residential treatment proposed is necessary and appropriate for the child's treatment needs, provides a length of stay as short as possible consistent with the child's need for treatment, and could not be effectively provided in the child's home.

E. The child must not be in need of primary chemical abuse treatment or detoxification at the time of admission.

F. The developmental and mental health needs of the child can be met by the license holder's program.

Subp 2. **Information at time of admission or intake.** At the time of intake or admission, the license holder is

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responsible for placing the information in items A to K regarding the child in the child's file:

A. date of admission;

B. description of presenting problems and circumstances leading to admission;

C. copy of the child's diagnostic and functional assessments and screening required under subpart 1, item B or C;

D. race or cultural heritage, including tribal affiliation, religion, and other cultural factors, including family relationships;

E. history of previous out-of-home placements and previous treatments;

F. history and current status of legal custody;

G. family history, including physical and mental health and social history;

H. medical history, including all available medical records authorized for release to the facility for the last three years;

I. a statement signed by the child's parent or legal representative indicating that the child and parent or legal representative understands and has received prior notification before the implementation of the license holder's policies and procedures regarding discipline and the use of time-out, isolation, and physical holding during the child's treatment;

J. a statement signed by the child, if possible, or the child's parent or legal representative affirming that the license holder has advised the child of the availability of the following advocacy services:

(1) office of the Ombudsman for Mental Health and Mental Retardation; and

(2) other advocacy services which are currently available to the child or the child's parent or legal representative; and

K. a statement signed by the child, if possible, or the child's parent or guardian affirming that the license holder has advised the child and the child's parent or guardian of

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their rights and provided the child and the child's parent or guardian a copy of the patient's Bill of Rights according to Minnesota Statutes, section 144.652, subdivision 1.

9545.0965 EDUCATION PLANNING.

During the child's admission to the facility, the license holder must facilitate the child's school attendance and enroll the child in the local school district or, if appropriate, the child's home school district. If the child has no individual education plan or requires an assessment, the license holder is responsible for referring the child to the local school district or home school district for an assessment of eligibility for special education services.

9545.0975 DEVELOPING AND REVIEWING INDIVIDUAL TREATMENT PLAN.

Subpart 1. **Developing plan.** Within ten working days of admitting a child, the license holder must develop an individual treatment plan that supports achieving the outcomes in items A to E.

A. The development and content of the plan are consistent with the requirements in Minnesota Statutes, section 245.4871, subdivision 21.

B. The plan is based on the diagnostic and functional assessments required in part 9545.0955 and reflects the child's age or level of development and any other assessments completed by the license holder or provided by other agencies such as the county, a mental health center or other community agencies, and the Minnesota state departments of education, health, and corrections.

C. The plan identifies the skills and behaviors the child will need to be successful at home and in school.

D. The plan focuses on changes projected in the child's level of functioning and specifies or documents:

(1) how the child and the child's family will be involved in the treatment process;

(2) outcomes or goals the child is expected to achieve;

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(3) how the license holder will monitor outcomes;

(4) how the treatment team participated in plan development;

(5) who is to receive copies of the plan;

(6) the schedule for accomplishing treatment goals and objectives leading to discharge;

(7) criteria for discharge and projected discharge date;

(8) an assessment of the child's susceptibility to abuse and a statement of the measures to be taken by the license holder to minimize the child's risk of abuse;

(9) where appropriate, the specific number of hours for certain needed treatments or other remedial actions; and

(10) the medically or programmatically indicated reasons for limiting a child's communication and visitation rights.

E. The plan incorporates the child's individual education plan, the case placement plan required of the county by part 9560.0610, and the plan for transition to the community required by Minnesota Statutes, section 245.4882, subdivision 3.

Subp. 2. **Quarterly review of individual treatment plan.** A license holder must review a child's individual treatment plan every 90 days. The quarterly review must document that:

A. treatment team members participated in the review;

B. the summary of the review addresses the success of the original plan, whether the child requires the same, or less, or more treatment than originally projected, whether any prior authorization for the use of isolation or restraint should be continued, and how the original plan and discharge date should be modified if change is indicated;

C. copies of the summary in item B were distributed to the child, the child's family and legal representatives, and the county case manager within ten working days after the review is completed; and

D. the child was advised of the right to appeal

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according to Minnesota Statutes, section 245.4887.

Subp. 3. **Progress notes.** The license holder must record each child's progress at least weekly in the child's file. Notes must be legible, signed, and dated. Notes must address the child's progress toward the goals and objectives identified in the child's individual treatment plan and the child's participation in program services and activities.

9545.0985 CRITERIA FOR CONTINUED STAY, DISCHARGE, AND DISCHARGE PLANNING.

Subpart 1. **Continued stay criteria.** The license holder must have continued stay criteria required by Minnesota Statutes, section 245.4882, subdivision 4. The criteria must include at least the following conditions:

A. the child is less than 18 years old;

B. continuing residential treatment is necessary and appropriate to meet the treatment needs of the child; and

C. the license holder continues to make available the services needed by the child.

Subp. 2. **Discharge criteria.** The license holder must have discharge criteria required by Minnesota Statutes, section 245.4882, subdivision 4. Discharge criteria must include at least the following conditions:

A. the child is ~~at least~~ 18 years old;

B. the child's condition has changed to the extent that residential treatment in the licensed program is no longer appropriate; and

C. the license holder cannot make available the services the child needs to continue a course of treatment which meets the child's needs.

Subp. 3. **Discharge planning criteria.** At least 30 days prior to discharge the treatment team must develop a discharge plan consistent with Minnesota Statutes, section 245.4882, subdivisions 3 and 4. Discharge services must be coordinated with the child's individual family community support plan, individual education plan, and family reunification plan, if

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applicable. For children who are from a racial or cultural minority group, the plan must be developed with advice from a special mental health consultant. The plan must state:

A. the methods, strategies, and resources to be used in assisting the child and the child's family make the transition from residential treatment to less restrictive community-based services. The transition-planning component of the individual treatment plan must recommend:

(1) family community support services and agencies that will be involved with the child and family after the child's discharge from the residential treatment program;

(2) strategies for involving the services identified in subitem (1) with the child and the child's family while the child is in residential treatment; and

(3) strategies for incorporating the transition-planning component of the child's individual education plan into the transition-planning component of the individual treatment plan;

B. the license holder's recommendations for follow-up care in the community;

C. the names of individuals responsible for specific tasks and time lines for completing these tasks; and

D. the recommendations for the continuing care and treatment of a child with ~~serious and persistent mental illness~~ severe emotional disturbance or other needs, who is being discharged because the child has reached the child's 18th birthday.

Subp. 4. **Notice of discharge.** At least 30 days prior to discharging a child, the license holder must prepare a written discharge notice.

A. The license holder must give written notice of the projected discharge date to:

(1) the child;

(2) the child's case manager and parent or legal guardian;

(3) the local education agency in which the child

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is enrolled; and

(4) the receiving education agency to which the child will be transferred upon discharge.

B. The notice must give the following information:

(1) a copy of the child's individual education plan under chapter 3525, if the child has one;

(2) the information about appeals from Minnesota Statutes, section 245.4887; and

(3) the license holder's offer to meet with the county caseworker or person responsible for the child's care after discharge from the facility to review the discharge plan, including the program director's or license holder's recommendation for follow-up care in the community.

Subp. 5. **Administrative discharge.** Prior to making an administrative discharge, the administrator must meet with the treatment team to review the issues involved in the decision. During this review process, which must not exceed five working days, the license holder may arrange a temporary removal of the child to another site. The purpose of the review is to determine whether the license holder, treatment team, and child can develop additional treatment strategies, to resolve the issues leading to the discharge and to permit the child an opportunity to continue treatment services with the license holder. If the review indicates the discharge is warranted, the reasons for it and the alternatives considered or attempted must be documented in the child's file.

Subp. 6. **Discharge summary.** Within 15 working days after a child's discharge, the license holder must place a written discharge summary in the child's file. The summary must document:

A. a review of the progress the child made while receiving residential treatment services from the licensed program, the reasons for the initial referral and the child's response to goals and objectives identified in the individual treatment plan;

B. a statement describing the child's current

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strengths and needs;

C. an updated diagnostic assessment;

D. a copy of the discharge plan; and

E. the name and address of the caretaker of the child following discharge, the name and address of the case manager, and the names of other agencies that will be providing services for the child and family after discharge.

9545.0995 STANDARDS GOVERNING USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES.

Subpart 1. **Policy.** A facility must not use restrictive techniques prohibited under Minnesota Statutes, section 245.826. A facility must:

A. use positive and least restrictive approaches to changing behavior;

B. permit and control the use of time-out in accordance with the child's individual treatment plan;

C. prohibit the use of isolation and physical restraints except under the conditions specified in this part and in Minnesota Statutes, section 144.651, subdivision 31; and

D. prohibit the following actions:

(1) restricting a child's normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, school, fresh air, adequate exercise, and necessary clothing;

(2) corporal punishment, such as hitting a child with the hands or the fists or with an object; throwing objects at a child; pinching, shaking, kicking, or biting a child, or requiring a child to march, stand, kneel, or otherwise assume and remain in any fixed position as punishment;

(3) humiliating or shaming a child privately or publicly;

(4) any action defined as maltreatment by Minnesota Statutes, section 626.556;

(5) assigning artificial work that is not

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therapeutic and a part of the child's individual treatment plan;

(6) disciplining one child for the behavior or action of another, except for the imposition of restrictions on the child's peer group as a part of a recognized treatment program;

(7) use of restrictive techniques or procedures as punishment, for convenience of staff, to compensate for not having an adequate number of staff, to enforce program rules, or to substitute for program services;

(8) use of physical restraints, except for the transport of a child who is determined by the program director or a mental health professional to present a threat of harm to self or others. No physical restraint may be used which limits the circulation of blood to the extent that the child may be injured. Persons using restraints for transporting a child must be trained in the proper use of restraints for transportation;

(9) restricting the visitation rights of the parents of a child placed in the facility by court order according to Minnesota Statutes, section 260.191, subdivision 1d, beyond the limitations placed on the visitation rights imposed by the order; and

(10) placing restrictions on a child's communications rights beyond the restrictions specified in the child's individual treatment plan.

Subp. 2. **Standards governing use of time-out.** The standards in items A to H apply to the use of time-out by a license holder.

A. Time-out is implemented only as specified in a child's individual treatment plan, is specific to an identified behavior, and is supported by documentation describing how intervention procedures incorporating positive approaches and less intrusive procedures have been tried.

B. Prior notification was provided to the parent or legal representative for the use of time-out according to part 9545.0955, subpart 2, item I.

C. The purpose and terms of termination of the

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time-out have been explained to the child.

D. Time-out is terminated as soon as the precipitating behavior has abated or stopped.

E. Staff members must monitor and assess the child at least every five minutes and document on an appropriate form the child's condition at least every 15 minutes. The assessment must determine if the child can return to ongoing activity.

F. If time-out is implemented for more than 15 minutes, the child must have access to bathroom facilities.

G. Time-out procedures are implemented in the child's room or other area commonly used as living space whenever possible rather than in a room set aside specifically for time-out.

H. When time-out is used:

(1) the child must not be prevented from leaving the room by a locked door or other devices or objects positioned to hold the door closed; and

(2) the room must provide a safe environment, be well-lighted, well-ventilated, and clean, and have an observation window or other device to permit direct monitoring of the child.

Subp. 3. **Emergency use of isolation or physical holding.** A license holder must limit the use of isolation or physical holding to emergency situations involving a likelihood that the child will physically harm the child's self or others.

Subp. 4. **Policies on emergency use.** The license holder must have and implement policies and procedures that specify how emergency use of isolation or physical holding will be monitored and how the requirements of subparts 5 to 9 will be met.

Subp. 5. **Standards governing emergency use of physical holding.** A license holder must use physical holding only under the conditions in this subpart. The license holder must have the approval of a mental health professional at the time of the incident if seeking the approval of the mental health professional does not continue ~~or increase~~ the likelihood of harm to the patient or others. The license holder must also

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have prior authorization of a physician, psychiatrist, or mental health professional in the child's file. Less restrictive measures must be ineffective or not feasible. Staff members using physical holding must be trained in using physical holding. The standards in items A to E must be met when a program uses physical holding with a child.

A. The child must be told at the clinically appropriate time by the person doing the physical holding why the procedure is being used and what is expected of the child for termination of the physical holding.

B. There must be an ongoing assessment of the child's condition which is documented in at least 15 minute intervals and an attempt to terminate the physical holding according to item C.

C. The physical holding must be terminated as soon as the threat of harm to self or others abates or stops.

D. Upon the termination of physical holding the child must be assessed to determine if the child can be returned to an ongoing activity.

E. The child must be treated respectfully throughout the procedure.

Subp. 6. **Standards governing emergency use of isolation.** Isolation must be used only: with the approval of a mental health professional if possible at the time of the incident; with prior authorization of a physician, psychiatrist, or mental health professional in the child's file; and when less restrictive measures are ineffective or not feasible. The standards in items A to I must be met by a license holder when isolation is used with a child.

A. The child must be told at the clinically appropriate time by the person monitoring the child why the isolation is being used and what is expected of the child for termination of the isolation.

B. The child must be within hearing range at all times and be observed by staff at least every five minutes during isolation.

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C. There must be ongoing assessment of the child's condition which is documented in at least 15-minute intervals.

D. The isolation must end as soon as the threat of harm to self or others abates.

E. At the end of isolation the child must be assessed by the person observing the child to determine if the child can be returned to an ongoing activity.

F. The child must be treated respectfully throughout the procedure.

G. Staff members must be trained in using the isolation technique.

H. The room used for isolation must be well lighted, well ventilated, clean, have an observation window allowing the direct monitoring of the child in isolation, have fixtures which are tamper proof, with electrical switches located immediately outside the door, and have doors that open out and are unlocked or are locked with keyless locks that have immediate release mechanisms.

I. All dangerous objects must be removed from the child prior to the child's placement in isolation.

Subp. 7. **Documentation.** When emergency use of physical holding or isolation occurs, the license holder must document:

A. the precipitating behavior;

B. less restrictive measures used unsuccessfully or considered but not used because they were judged to be ineffective or not feasible;

C. the start and ending time of isolation or physical holding;

D. that the child was offered access to bathroom facilities when needed;

E. that efforts were made to terminate the isolation or physical holding at least once every 15 minutes;

F. that a mental health professional was consulted if possible before the isolation or physical holding was used and an approval signed by the mental health professional was placed in the child's file within 24 hours of the approval;

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G. the names of the staff members involved in implementing the isolation or physical holding;

H. the description of the isolation or physical holding used;

I. that the mental health professional and the staff have reviewed the child's individual treatment plan within one week to determine whether revised treatment strategies are necessary to reduce the child's risk of harm to self or others;

J. that the staff attempted to inform the child's parent or legal representative and case manager within one working day of the emergency use of isolation or physical holding;

K. that the prior notification statement required by part 9545.0955, subpart 2, item I, is in the child's file; and

L. any injury and any medical treatment to the child that occurred during the isolation or physical holding.

Subp. 8. **Administrative review.** The program administrator or the administrator's designee must complete an administrative review within one working day after the emergency use of physical holding or isolation. The administrative review must be conducted by someone other than a person actually involved in the incident or the person's immediate supervisor. The record of the administrative review must state whether:

A. documentation required by subpart 7 is recorded;

B. prior authorization is on file and a mental health professional approved the emergency use;

C. standards governing use of physical holding or isolation established by this part were met;

D. the individuals implementing the procedure are properly trained under the requirements in parts 9545.1095 and 9545.1105; and

E. the reviewer has made recommendations to the license holder for action to correct deficiencies, if any, indicated by the review conducted according to this subpart.

Subp. 9. **Committee review.** At least quarterly, the license holder must review patterns of emergency use of physical

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holding and isolation and use of time-out. The review must be done by a committee comprised of administrative staff, child care staff, and a mental health professional. The review must consider:

A. the administrative reviews required in subpart 8;

B. any patterns or problems indicated by similarities in the time of day, day of the week, and individuals involved with emergency use of isolation or physical holding or use of time-out or any other relevant factors;

C. any injuries resulting from physical holding or isolation;

D. corrective actions judged to be needed to correct deficiencies in the program's implementation of isolation and physical holding; and

E. results of the corrective actions in item D.

9545.1005 DISCIPLINE; RULES OF CONDUCT.

Subpart 1. **Policies and procedures governing discipline.** The objective of discipline is not to punish the child for specific behavior but to teach appropriate skills and help the child learn accountability and self control from the experience of being disciplined. The license holder must have and utilize written policies and procedures for implementing, documenting, and monitoring the use of discipline. These policies and procedures must be made available to parents, referring agencies, and staff. The policies and procedures governing discipline must specify:

A. only age-appropriate techniques will be used;

B. the methods of discipline that staff are to use, including methods for managing stress and reducing impulsive behavior;

C. discipline that will result from specific behaviors;

D. which staff are authorized to use disciplinary actions and the types of actions authorized;

E. how the license holder will ensure that a child's

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individual treatment plan takes precedence over general disciplinary procedures if there is a conflict between an individual's plan and the procedures;

F. how the license holder's quality assurance plan will provide for documenting and monitoring the use of discipline and evaluating the effectiveness of the discipline;

G. that the plan is approved by a mental health professional and the program director for use by program staff; and

H. that the plan is reviewed and approved annually by a mental health professional and the program director. The review must include results of quality assurance activities required in part 9545.1055.

Subp. 2. **Rules of conduct.** A license holder must have rules of conduct for children in the program.

A. The rules of conduct must indicate or describe:

(1) what the program considers to be appropriate and inappropriate behaviors;

(2) the consequences that will be applied in recognizing and rewarding appropriate behavior and modifying inappropriate behavior;

(3) the circumstances for the emergency use of restraint and isolation; and

(4) that an individual treatment plan takes precedence over the rules of conduct if there is a conflict.

B. No later than at the time of admission, the license holder must explain and provide a copy of the program's rules of conduct to the child and the child's parent or legal representative. The license holder must obtain a signature from the child, if the child is older than seven years, and the child's parent or legal representative indicating they have received a copy of and understand the rules of conduct. If the child or the child's legal guardian requires an interpreter to understand the rules of conduct, the license holder must make interpreted copies of the rules and an interpreter available.

C. The license holder must post the rules of conduct

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in a place where they are visible and accessible to the children in the program.

9545.1015 COMPLIANCE WITH MALTREATMENT OF MINORS ACT.

Subpart 1. **Notice to children and families.** Prior to or at the time of admission, the license holder must inform the child and child's family of the license holder's obligations under Minnesota Statutes, section 626.556, and the policies and procedures in place to meet the obligations.

Subp. 2. **Notice to staff.** During orientation and annual training and any time a staff person requests the written material, the license holder must distribute to staff members written material that explains staff obligations under Minnesota Statutes, section 626.556, and the program policies and procedures to be followed to meet the obligations.

Subp. 3. **Policies and procedures.** The license holder must develop policies and procedures to follow if a staff person is suspected of maltreatment. Policies and procedures must be reviewed and revised annually by the program director and license holder. The review and revisions must be based on such factors as whether the governing statutes have changed in the year since the last review and on the program's quality assurance review of incident reports and reports of maltreatment over the past year.

9545.1025 USE OF PSYCHOTROPIC MEDICATIONS.

Subpart 1. **Conditions governing use of psychotropic medications.** When psychotropic medications are administered to a child in a facility licensed under parts 9545.0905 to 9545.1125, the license holder is responsible for seeing that the conditions in items A to C are met.

A. Use of the medication must be included in the child's individual treatment plan and is based on the prescribing physician's diagnosis and the diagnostic and functional assessments defined in Minnesota Statutes, section 245.4871.

B. The license holder must document the following in

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the child's individual treatment plan:

(1) a description in observable and measurable terms of the symptoms and behaviors that the psychotropic medication is to alleviate;

(2) data collection methods the license holder will use to monitor and measure changes in the symptoms and behaviors that are to be alleviated by the psychotropic medication; and

(3) the criteria to ~~prompt~~ cause review by the physician for possible dosage increase, and decrease, or medication discontinuation.

C. Psychotropic medication must not be administered as punishment, for staff convenience, as a substitute for a behavioral or therapeutic program, or in quantities that interfere with learning or other goals of the individual treatment plan.

Subp. 2. **Monitoring side effects.** The license holder must monitor for side effects if a child is prescribed psychotropic medication and must have the prescribing physician or a pharmacist list possible side effects. The license holder under the direction of a ~~licensed~~ registered nurse or physician must document and check for side effects at least weekly for the first month after a child begins taking a new psychotropic medication or an increased dose of a currently-used psychotropic medication and at least quarterly thereafter. In addition to appropriate physical or laboratory assessments as determined by the physician, standardized checklists or rating scales such as the Monitoring of Side Effects Scale (MOSES), Systematic Assessment for Treatment Emergent Effects (SAFTEE) or other scales developed for a specific drug or drug class must be used as monitoring tools. The license holder must provide the assessments to the physician for review.

Subp. 3. **Monitoring for tardive dyskinesia.** The license holder must monitor for tardive dyskinesia if a child is prescribed antipsychotic medication or amoxapine. The license holder under the direction of a licensed nurse or physician must

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document and check for tardive dyskinesia at least once every three months. A child prescribed antipsychotic medication or amoxapine for more than 90 days must be checked for tardive dyskinesia at least 30 and 60 days after discontinuation of the antipsychotic medication or amoxapine. Monitoring must include use of a standardized rating scale and examination procedure such as the Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS). The license holder must provide the assessments to the physician for review.

Subp. 4. **Standards governing administration of psychotropic medications.** An employee other than a physician, registered nurse, or licensed practical nurse who is responsible for medication assistance must provide a certificate verifying successful completion of a trained medication aide program for unlicensed personnel offered through a post-secondary institution or shall be trained <u>according to a formalized training program offered by the license holder, which must be taught and supervised</u> by a registered nurse to provide medication assistance. The specific medication administration training provided by a registered nurse to unlicensed personnel must be documented and placed in the unlicensed employees' personnel records. A registered nurse must provide consultation and review of the license holder's administration of medications at least weekly. The consultation shall review the license holder's compliance with subparts 5 and 6.

Subp. 5. **Psychotropic medication review.** If a child is prescribed a psychotropic medication, the license holder must conduct a psychotropic medication review as frequently as required by the physician, but at least monthly for the first six months and at least quarterly thereafter. The license holder must consider and document the following items at the quarterly review and provide the information to the physician for review:

A. symptoms and behaviors of concern and any corresponding diagnosis;

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B. data collected since the last review;

C. level of symptoms and behaviors and whether this level meets the criteria prompting physician review for possible dosage increase or decrease;

D. any side effects observed and actions taken;

E. status of other therapies or interventions being used and how they relate to decisions about the child's psychotropic medications;

F. the status of the child's goals in the individual treatment plan and ~~whether~~ the effect of psychotropic medication on these goals ~~are adversely effected by the psychotropic medication~~; and

G. any factors such as illness or environmental changes which were considered and reviewed.

Subp. 6. **Informed consent.** The license holder must obtain informed consent before any nonemergency administration of psychotropic medication. To the extent possible, the child shall be informed and involved in the decision-making.

A. Informed consent is required either orally or in writing before the nonemergency administration of any psychotropic medication except for antipsychotic (neuroleptic) medication where informed consent must be in writing. If oral informed consent is obtained for a nonantipsychotic medication, the following items must occur and be documented by the license holder:

(1) an explanation why written informed consent could not be initially obtained;

(2) that the oral consent was witnessed and the name of the witness;

(3) the communication of all items in subpart 7; and

(4) an explanation that written informed consent material is immediately being sent by the license holder to the child's parent or legal representative, that the oral consent expires in one month, and that the medication must be discontinued one month from the date of the telephone consent if

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written consent is not received.

B. Informed consent for any psychotropic medication must be renewed in writing within six months of the initiation and at least yearly thereafter.

C. Informed consent must be obtained from an individual authorized to give consent. Individuals authorized to give consent are specified in subitems (1) to (4).

(1) If the child has a legal representative or conservator authorized by a court to give consent for the child, consent is required from the legal representative or conservator.

(2) If subitem (1) does not apply, consent is required from at least one of the child's parents. If the parents are divorced or legally separated, the consent of a parent with legal custody is required, unless the separation or marriage dissolution decree otherwise delegates authority to give consent for the child.

(3) If the commissioner is the child's legal representative, consent is required from the county representative designated to act as legal representative on the commissioner's behalf.

(4) If the child is an emancipated minor according to Minnesota Statutes, section 144.341, or the child has been married or borne a child, the child may give consent under Minnesota Statutes, section 144.342.

D. Informed consent is not necessary in an emergency situation where the physician determines that the psychotropic medication is needed to prevent serious and immediate physical harm to the individual or others. In the event of the emergency use of psychotropic medication, the license holder must:

(1) inform and document that the individual authorized to give consent was informed orally and in writing within 24 hours ~~of~~ or on the first working day after the emergency use of the medication;

(2) document the specific behaviors constituting the emergency, the circumstances of the emergency behaviors, the alternatives considered and attempted, and the results of the

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use of the emergency psychotropic medication; and

(3) arrange for an interdisciplinary team review of the individual treatment plan within seven days of the emergency to determine what actions, if any, are required in light of the emergency. If a psychotropic medication continues to be required, written informed consent is required within 30 days or a court order must be obtained.

Subp. 7. **Information to be communicated in obtaining consent.** The information in items A to G must be provided both orally and in writing in nontechnical language to the child's parent, legal representative, and, to the extent possible, the child. The information must include:

A. the diagnosis and level of severity of the symptoms and behaviors for which the psychotropic medication is prescribed;

B. the expected benefits of the medication, including the level to which the medication is to change the symptoms and behavior and an indication of the method used to determine the expected benefits;

C. the pharmacological and nonpharmacological treatment options available and the course of the condition with and without the treatment options;

D. specific information about the psychotropic medication to be used including the generic and commonly known brand name, the route of administration, the estimated duration of therapy, and the proposed dose with the possible dosage range or maximum dose;

E. the more frequent as well as less frequent or rare but serious risks and side effects of the psychotropic medication including how the risks and possible side effects will be managed;

F. an explanation that consent may be refused or withdrawn at any time and that the consent is time-limited and automatically expires as described in subpart 6; and

G. the names, addresses, and phone numbers of appropriate professionals to contact should questions or

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concerns arise.

Subp. 8. **Refusal to consent to administration of psychotropic medication.** If the authorized person refuses consent for a psychotropic medication, the conditions in items A to C apply.

A. The psychotropic medication shall not be administered or, if the refusal involves a renewal of consent, the psychotropic medication for which consent had previously been given shall be discontinued according to a written plan as expediently as possible taking into account withdrawal side effects.

B. A court order must be obtained to override the refusal.

C. Refusal to consent to use of a specific psychotropic ~~medications~~ medication in and of itself is not grounds for discharge. Any decision to discharge a child shall be reached only after the alternatives to the specific psychotropic medication have been attempted and only after an administrative review of the proposed discharge has occurred.

9545.1035 TREATMENT IN A SETTING WITH SECURE CAPACITY.

Subpart 1. **Definition.** "Treatment in a setting with secure capacity" means a residential mental health intensive treatment program offered to a child whose diagnostic assessment indicates that the persistent pattern of the child's mental health presents a likely threat of harm to self or others which would best be treated in a setting which prevents the child from leaving the program. The setting may be within a building or part of a building secured by locks.

Subp. 2. **Limitations on admissions to a residential mental health program offering treatment in a setting with secure capacity.** Before accepting a child for admission to a residential mental health program offering treatment in a setting with secure capacity, the license holder must determine that the child meets the following criteria:

A. the child's record includes a written statement

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that a diagnostic assessment conducted according to Minnesota Statutes, section 245.4871, subdivision 11, has established the child's need for residential mental health treatment in a setting with secure capacity; and

B. the child has an individual treatment plan which:

(1) meets the requirements of part 9545.0975;

(2) identifies the need for treatment in a setting with secure capacity;

(3) identifies the relationship of treatment in a setting with secure capacity to the child's overall treatment goals;

(4) identifies the treatment goals the child should meet to be placed in a less restrictive treatment setting;

(5) includes a plan for discharge from treatment in a setting with secure capacity to a less restrictive environment; and

(6) is reviewed weekly by the program director to determine the level of treatment needed, unless the child's individual treatment plan specifically states that the child's prognosis or court imposed conditions merit review of the plan at less frequent intervals. In any case, the interval for the review of the individual treatment plan may not exceed the 90-day review required in part 9545.0975, subpart 2.

Subp. 3. **Prohibited placements.** A facility must not admit a child for treatment in a setting with secure capacity as a disposition resulting from adjudication of an offense under the juvenile code without meeting the diagnostic assessment requirements of subpart 2, item A, nor transfer a child from an unsecured part of a residential facility to a secure capacity part of the same facility as punishment for violating the rules of conduct of the treatment facility.

Subp. 4. **Staff ratio.** During waking hours the part of a facility providing treatment in a setting with secure capacity must provide at least a ratio of one treatment staff member to three children. The staff to child ratio for the treatment in a

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setting with secure capacity part of the facility does not apply during waking hours when the children are out of that part of the facility attending school. During sleeping hours the part of the facility providing treatment in a setting with secure capacity must provide at least two treatment staff persons to nine children. At least one of the two staff persons required during sleeping hours must be awake and present in that part of the facility. If the required second staff member is not awake and present in the secure capacity setting, the program must assure that the second staff person is in the immediate vicinity and may be readily contacted either visually, by telephone, or by radio to come to the immediate assistance of the staff person in the secure capacity setting part of the facility.

Subp. 5. **Additional staff training.** In addition to the training required in part 9545.1105, staff providing treatment in a setting with a secure capacity must have at least eight hours of additional training annually in subjects which will improve staff's ability to deal with children who present a risk of harm to self or others.

Subp. 6. **Notice to commissioner and compliance with codes.** A facility must, prior to offering mental health treatment in a setting with secure capacity, notify the commissioner of its intent to do so and comply with any additional health, fire, or building code requirements which the commissioner, state fire marshal, or the Department of Health may require.

Subp. 7. **Limitations on the use of rooms for isolation.** The license holder must ensure that the requirements of part 9545.0995 regarding isolation are met if a child is locked in a room in the part of the facility offering mental health treatment in a setting with a secure capacity.

9545.1045 SHELTER SERVICES.

Subpart 1. **Applicability of subparts 2 to 10.** ~~Until the commissioner adopts rules specifically developed to govern the licensure of shelter services available to children in a variety~~

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~~of residential settings,~~ The requirements in this part apply to shelter services provided by a residential treatment program licensed under parts 9545.0905 to 9545.1125. The number of beds that a license holder designates for shelter services must be specified in the application for licensure and on the program license.

Subp. 2. **Description of services.** An application for licensure under parts 9545.0905 to 9545.1125 that includes shelter services must provide a written description of services which meet the requirements of part 9545.0945, subparts 1, items E and F, and 2 to 6. The description must state how the applicant will provide program services, address cultural needs, collaborate with community services, and work with families to meet children's needs, except under circumstances where contact with the family is prohibited by the court or contraindicated by the child's condition and documented in the child's record.

Subp. 3. **Initial assessment.** When a shelter services program admits a child, the license holder must:

A. meet the requirements governing admission in part 9545.0955, subpart 1, items A and E;

B. assess the child's vulnerability to maltreatment and develop a plan to reduce the child's risk of maltreatment while in the shelter; and

C. assess the child's situation, condition, and immediate needs as a basis for developing the immediate needs plan required in subpart 5. The assessment in this item is in lieu of the information taken at the time of admission required under part 9545.0955, subpart 2.

Subp. 4. **Physical examination.** Within 24 hours of admitting a child to shelter services, the license holder must arrange for a qualified professional as specified in items A to D to conduct a basic health screening to determine whether the child needs a physical examination by a licensed physician or dental examination by a dentist. If the need is determined, the license holder ~~is responsible for making~~ must notify the child's case manager of the need to make an appointment with a licensed

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physician or dentist to complete the required examination within three working days of admission. A qualified professional is:

A. a certified pediatric nurse practitioner;

B. a licensed nurse trained to do child and teen checkups;

C. a certified family nurse practitioner; or

D. a registered nurse experienced in the care of children in a shelter facility under the direction of a physician.

Subp. 5. **Immediate needs plan.** Within 24 hours of admitting a child, the license holder must develop a plan for meeting the child's immediate needs. The immediate needs plan in this subpart may be used in lieu of the individual treatment plan in part 9545.0975, subpart 1. The plan must:

A. identify what is immediately needed to help stabilize or ameliorate the child's situation, behavior, or condition based on the assessment in this subpart and subpart 4;

B. specify short-term objectives and methods for meeting the needs identified in item A; and

C. indicate shelter services program responsibilities for meeting needs identified in the placement plan developed by the county.

Subp. 6. **Diagnostic assessment.** If the license holder has reason to believe that a child has or may have severe emotional disturbance, the license holder must, within 72 hours of recognition of the need for the assessment or screening, refer the child to the county for a diagnostic assessment as required in Minnesota Statutes, sections 245.4876, subdivision 2, and 245.4871, subdivision 11.

Subp. 7. **Follow-up contact.** If the county does not respond to the referral in subpart 6 within three working days, the license holder must make a second request of the county.

Subp. 8. **Individual stabilization plan.** Within five working days after a child is admitted, the license holder must complete an individual stabilization plan ~~and recommend a discharge plan~~ for the child. The stabilization plan must be

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based on the license holder's assessment of the child's needs and must include a schedule for meeting the needs and the name of the person or agency responsible for meeting the needs.

Subp. 9. **Discharge recommendations.** The discharge requirements of this subpart may be used in lieu of discharge requirements contained in part 9545.0985 for a child who is receiving shelter care services under this part.

A. The license holder must prepare discharge recommendations for a child residing in shelter more than ~~five~~ ten days. The discharge recommendations must address the services, supports, and referrals necessary to return the child to the family when possible or to another setting as an alternative to the family. In addition to the discharge summary required under part 9545.0985, subpart 6, the license holder must forward all medical, behavior, and incident notes regarding the child to the child's subsequent caregiver or county case manager.

B. If a child is in a shelter facility less than ~~five~~ ten days, the license holder must prepare a discharge summary which, at a minimum, meets the requirement of part 9545.0985, subpart 6, item E.

Subp. 10. **Limitations on length of stay.** The license holder must apply for a variance according to part ~~9545.0935~~ 9545.0905, subpart 3, to retain a child in shelter care beyond 90 days. If a child must remain in the shelter longer than 30 days, the treatment team must review the necessity of the child remaining in the facility and consider alternative placement plans. The license holder must document the reason for not including a member of the treatment team in the review process. The determination of the treatment team must be placed in the child's file and a copy sent to the entity placing the child in the program.

9545.1055 QUALITY ASSURANCE.

The license holder must develop a quality assurance plan based on program goals and objectives, and the goals and

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objectives for client outcomes. The plan must provide for monitoring and evaluating:

A. the use of all treatment modalities;

B. incidents or accidents involving children or personnel;

C. emergency use of isolation and physical holding;

D. patterns of grievances raised by children and families; and

E. problems with administration of medications.

The quality assurance plan must use a client satisfaction survey that obtains responses from the children, their family members, case managers, referring agencies, and court staff. The plan must state how often the license holder will gather the information and the actions to be taken in response to the information.

9545.1065 PERSONNEL POLICIES AND PROCEDURES.

Subpart 1. **Policy requirements.** The license holder must have written personnel policies that are available to all employees. The personnel policies must:

A. comply with federal, state, and local laws and regulations;

B. assure that ~~employee retention, promotion, job assignment, or pay~~ the employee's terms and conditions of employment are not affected by a good faith communication between an employee and the Minnesota Department of Health, the Minnesota Department of Human Services, or other agencies investigating complaints regarding a child's rights, treatment, alleged maltreatment, health, or safety concerns;

C. contain job descriptions that specify the following:

(1) position title;

(2) qualifications;

(3) tasks and responsibilities;

(4) degree of authority to execute job responsibilities; and

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(5) standards of job performance related to specified job responsibilities;

D. provide for annual job performance appraisals, based on the standards of job performance in the job description;

E. specify the behaviors that constitute grounds for disciplinary action, suspension, or dismissal, and the policies about employee mental health and chemical use problems;

F. prohibit sexual involvement with clients according to Minnesota Statutes, chapter 148A;

G. prohibit maltreatment of minors as specified under Minnesota Statutes, section 626.556;

H. include a code of ethical conduct for all employees and volunteers which states the license holder's expectations for the ethical behavior of all employees and volunteers;

I. set forth a staff grievance procedure; and

J. specify a program of orientation for all new staff based on a written plan that provides for regular training which is related to the specific job functions for which the employee was hired, the program's orientation policies and procedures, and the needs of the children to be served.

Subp. 2. **Recruitment.** The license holder must have a written plan for recruiting and employing staff members who are ~~representative~~ knowledgeable regarding the issues of the racial, cultural, and ethnic groups, and sex of the population served by the program.

Subp. 3. **Personnel records.** The license holder must maintain personnel records on all staff. The personnel records for each person must have the information in items A and B:

A. the most recent notice issued by the commissioner under part 9543.3060, subpart 5. If the current notice is more than two years old, the personnel file must also include documentation that the license holder has made a timely application for a background study as required by Minnesota Statutes, section 245A.04, subdivision 3; and

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B. documentation that the staff person's education, training, licensure, and experience is commensurate with the position for which the program employs or contracts with the person.

9545.1075 CLINICAL SUPERVISION BY A MENTAL HEALTH PROFESSIONAL.

Subpart 1. **Mental health professional consultation.** The license holder must ensure that the residential program employs or contracts with a mental health professional to provide consultation relating to the planning, development, implementation, and evaluation of program services.

Subp. 2. **Supervision of staff.** A mental health professional must provide at least weekly face-to-face clinical supervision to staff persons providing program services to a child as follows: to mental health practitioners for program services in part 9545.0945, subpart 1, items A to D, F, G, and I; to a recreational therapist if the therapist supervises the program service in part 9545.0945, subpart 1, item E; to a registered nurse if needed for program services in part 9545.0945, subpart 1, item C; and to child care workers for program services in part 9545.0945, subpart 1, item H. The mental health professional:

A. must provide clinical supervision of staff either individually or as a group;

B. must document the clinical supervision of staff;

C. must advise the program director about the planning, development, and implementation of staff development and evaluation; and

D. may provide consultation in lieu of clinical supervision to other mental health professionals under contract or employed by the program to provide program services to a child.

Subp. 3. **Supervision of treatment.** A mental health professional must:

A. supervise the diagnostic assessment of each child in the program and the development of each child's individual

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treatment plan;

B. document involvement in the treatment planning process by signing the individual treatment plan;

C. supervise the implementation of the individual treatment plan and the ongoing documentation and evaluation of each child's progress, including the quarterly progress review; and

D. document on a weekly basis a review of all the program services provided for the child in the preceding week.

The license holder must ensure that a mental health professional can be reached for consultation about a mental health emergency, at least by phone, within 30 minutes.

9545.1085 STAFF QUALIFICATIONS.

Subpart 1. **General staff qualifications.** Staff that provide, supervise, or directly administer program services must:

A. be at least 21 years old;

B. have at least a high school diploma or a general education degree (GED); and

C. provide documentation of cultural competence training.

Staff and contract consultants holding positions that require licensure, certification, or registration by Minnesota must provide evidence of current licensure, certification, or registration.

Subp. 2. **Administrator.** The license holder must designate an individual as administrator. The administrator must have at least a bachelor's degree in the behavioral sciences, health administration, public administration, or a related field <u>such as special education or education administration</u>. The administrator must be responsible for ongoing operation of the program, and maintenance and upkeep of the facility.

Subp. 3. **Program director.** The license holder must designate an individual as program director. The program must have at least one program director for every 50 children receiving program services. The positions of program director

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and administrator may be filled by the same person if the person meets the qualifications in items A and B. The program director must have the qualifications described in items A and B:

A. a master's degree in the behavioral sciences or related field with at least two years of work experience providing services to children with severe emotional disturbance or have a bachelor's degree in the behavioral sciences or a related field with a minimum of four years of work experience providing services to children with severe emotional disturbance; and

B. one year of experience or training in program administration and supervision of staff.

Persons who do not meet the qualifications in this part, but were employed on January 1, 1994, as administrators and program directors in programs licensed under parts 9545.0900 to 9545.1090, will be considered qualified for these positions until July 1, ~~1999~~ 2001.

9545.1095 STAFF ORIENTATION.

Subpart 1. **Initial orientation training for staff who provide program services.** A staff member who provides program services must complete orientation training related to the specific job functions for which the person was hired and the needs of the children the person is serving. During the first 45 calendar days of employment, and before assuming sole responsibility for care of children, staff who provide program services must complete training on:

A. the maltreatment of minors act, Minnesota Statutes, section 626.556, and the license holder's policies and procedures related to this statute;

B. client rights;

C. emergency procedures;

D. policies and procedures concerning approved physical holding and isolation techniques, de-escalation techniques, physical and nonphysical intervention techniques;

E. rules of conduct and policies and procedures

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related to discipline of children served;

F. psychiatric emergencies and crisis services; and

G. problems and needs of children with severe emotional disturbance and their families.

No staff person may participate in the use of physical holding, isolation, or other restrictive procedures with a child prior to completing approved training in item D.

Subp. 2. **Orientation training for staff who do not provide program services.** Facility staff who do not provide program services must receive orientation training in subpart 1, items A to C and G.

9545.1105 INDIVIDUAL STAFF DEVELOPMENT.

Subpart 1. **Individual staff development and evaluation plan.** The license holder must ensure that an annual individual staff development and evaluation plan is developed and implemented for each person who provides, supervises, or directly administers program services. The plan must:

A. be developed within 90 days after the person begins employment and at least annually thereafter;

B. meet the staff development needs specified in the person's annual employee evaluation; and

C. address training relevant to specific age, developmental, cultural, and mental health needs of the children the person serves.

Subp. 2. **Amount of annual training.** The license holder shall ensure that all staff who provide, supervise, or directly administer program services complete the amount of training specified in this part.

A. A staff member who works an average of half-time or more ~~than half-time~~ in a year shall receive at least ~~40~~ 24 hours of training per year.

B. A staff member who works an average of less than half-time in a year shall complete at least ~~20~~ 16 hours of training per year.

C. A staff member who is licensed as required by part

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9545.1085, subpart 1, shall complete the training required to maintain the staff member's license.

D. The orientation required in part 9545.1095 may be counted as annual training.

Subp. 3. **Content of quarterly training.** The license holder must ensure that all staff providing program services review at least three of the following at least quarterly:

A. de-escalation techniques;

B. physical and nonphysical intervention policies and procedures and techniques to address aggressive behaviors that place a child in imminent danger to self or others;

C. assignment of persons to specific tasks and responsibilities in an emergency situation;

D. instructions on using alarm systems and emergency equipment;

E. when and how to notify appropriate persons outside the facility; and

F. evacuation routes and procedures.

Subp. 4. **Content of annual training.** The license holder must ensure that all staff and volunteers of the facility annually review the maltreatment of minors act, Minnesota Statutes, section 626.556, and all policies and procedures related to the act. The license holder must also ensure that 75 percent of the required hours of annual training address the following subjects:

A. treatment modalities for children with severe emotional disturbance;

B. treatment modalities for children with severe emotional disturbance with special needs;

C. cultural and ethnic diversities and culturally specific treatment;

D. individual needs of children and their families;

E. psychotropic medications and their side effects;

F. assessment and individual treatment planning;

G. symptoms of children's diseases;

H. family systems;

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I. children's psychological, emotional, intellectual, and social development;

J. suicide prevention;

K. facility security; and

L. crisis de-escalation.

Subp. 5. **First aid training required.** A license holder must ensure that staff who provide program services have documentation of current American Red Cross Standard First Aid certification.

Subp. 6. **Cardiopulmonary resuscitation (CPR) training required.** A license holder must ensure that child care staff who provide program services have a current American Red Cross Community CPR certificate.

Subp. 7. **Orientation and training record.** The license holder must ensure that staff orientation under part 9545.1095 and training under this part are documented. The record must include the date orientation or training was completed, the topics covered, the name of the presenter, the number of hours spent on each topic, and the signature of the staff receiving the training.

9545.1115 PHYSICAL PLANT.

Subpart 1. **Compliance with board and lodging requirements.** ~~Until the Minnesota Department of Health adopts chapter 4665 governing~~ For the physical plant, food preparation, and nutrition requirements for facilities licensed under parts 9545.0905 to 9545.1125, the license holder must:

A. comply with parts 4625.0100 to 4625.2300 regarding physical plant conditions and practices;

B. comply with parts 4625.2401 to 4625.4701 regarding food handling practices for food service;

C. ensure that meal plans are reviewed and approved by a qualified dietitian at least annually. Additionally, the license holder shall evaluate and meet the dietary needs identified in a child's functional assessment. A program that accepts a child who has a medically prescribed therapeutic diet

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must document that the diet is provided as ordered by the physician; and

D. provide foods and beverages that are palatable, of adequate quantity and variety, attractively served at appropriate temperatures, and prepared by methods which conserve nutritional value. All meals provided must be planned, prepared, and served by persons who have received instruction in food-handling techniques and practices.

~~Subp. 2. Compliance with supervised living facility requirements. When applicable, facilities licensed under parts 9545.0905 to 9545.1125 must meet the physical plant, food preparation, and nutrition rule requirements of chapter 4665 as determined by the commissioner of the Minnesota Department of Health, to ensure that each child is adequately housed, receives treatment in a safe, sanitary, and healthful environment, and receives adequate quantities of properly prepared, nutritious food.~~

9545.1125 EMERGENCY PREPAREDNESS.

Subpart 1. **Written plan required.** A facility must have a written plan which specifies actions and procedures for responding to fire, serious illness, severe weather, missing persons, and other emergencies. The program administrator must review the plan with staff and residents. The plan shall be developed with the advice of the local fire and rescue authority and other emergency response authorities. The plan shall specify responsibilities assumed by the license holder for assisting residents who require emergency care or special assistance to residents in emergencies.

Subp. 2. **First aid kit required.** Every facility shall have on the premises a first aid kit approved in writing by a physician for use for residents and staff. The kit shall be kept in a place readily available to all staff responsible for the health or well-being of residents.

REPEALER. Upon the effective date of this rule, Minnesota Rules, parts 9545.0900, 9545.0910, 9545.0920, 9545.0930,

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9545.0940, 9545.0950, 9545.0960, 9545.0970, 9545.0980, 9545.0990, 9545.1000, 9545.1010, 9545.1020, 9545.1030, 9545.1040, 9545.1050, 9545.1060, 9545.1070, 9545.1080, and 9545.1090, are repealed.

EFFECTIVE DATE. Minnesota Rules, parts 9545.0905 to 9545.1125, shall be effective six months after the notice of adoption is published in the state register.

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