Chapter 62. Therapeutic Group Homes

Subchapter A. General Provisions

§6201. Introduction

A. The purpose of this Chapter is to provide for the development, establishment and enforcement of statewide licensing standards for the care of clients in therapeutic group homes (TGHs), to ensure the maintenance of these standards, and to regulate conditions in these facilities through a program of licensure which shall promote safe and adequate treatment of clients of TGHs.

B. TGHs provide a 24 hours per day, seven days per week, structured and supportive living environment. The purpose of a therapeutic group home (TGH) is to provide community-based services in a homelike environment to clients under the age of 21 who are determined to need psychiatric or psychological services.

C. Each TGH shall deliver an array of clinical treatment and related services, including psychiatric supports, integration with community resources, and skill building taught within the context of a safe home-like setting under the supervision of a professional staff person.

D. The goal of a therapeutic group home is to maintain the client's connections to their community, yet receive and participate in a more intensive level of treatment in which the client lives safely in a 24-hour setting.

E. The care and services rendered by a TGH shall include, but not be limited to:

1. behavioral health services;
2. medication management;
3. assistance with independent living skills;
4. recreational services;
5. rehabilitative services; and
6. transportation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:401 (February 2012).

§6203. Definitions

Active Treatment—implementation of a professionally developed and supervised comprehensive treatment plan that is developed no later than seven days after admission and designed to achieve the client’s discharge from inpatient status within the shortest practicable time. To be considered active treatment, the services must contribute to the achievement of the goals listed in the comprehensive treatment plan. Tutoring, attending school, and transportation are not considered active treatment. Recreational activities can be considered active treatment

when such activities are community based, structured and integrated within the surrounding community.

Comprehensive Treatment Plan—the comprehensive plan of care which is developed by the TGH for each client receiving services that includes all of the services each client needs, including medical/psychiatric, nursing, psychological and psychosocial therapies.

Core Mental Health Discipline—academic training programs in psychiatry, psychology, social work and psychiatric nursing.

Department—the Louisiana Department of Health and Hospitals, or "DHH."

DCFS—the Louisiana Department of Child and Family Services.

Direct Care Staff—any member of the staff, including an employee or contractor, that provides the services delineated in the comprehensive treatment plan. Food services, maintenance and clerical staff and volunteers are not considered as direct care staff.

Division of Administrative Law—the Louisiana Department of State Civil Service, Division of Administrative Law or "DAL."

Health Standards Section—the Louisiana Department of Health and Hospitals, Health Standards Section or "HSS."

Human Services Field/Mental Health-Related Field—an academic program with a curriculum content in which at least 70 percent of the required courses for the major field of study are based upon the core mental health disciplines.

Licensed Mental Health Professional (LMHP)—an individual who meets one of the following education and experience requirements:

1. a physician duly licensed to practice medicine in the state of Louisiana and has completed an accredited training program in psychiatry;

2. a psychologist licensed as a practicing psychologist under the provisions of R.S. 28:2351-2370;

3. a medical psychologist licensed to practice under the provisions of R.S. 37:1360.51 et seq.;

4. a social worker who holds a master's degree in social work from an accredited school of social work and is a licensed clinical social worker under the provisions of R.S. 37:2701-2718, as amended;

5. an advanced practice registered nurse licensed as a registered nurse in the state of Louisiana by the Board of Nursing who may practice to the extent that services are within the nurse's scope of practice:

a. is a nurse practitioner specialist in adult psychiatric and mental health and family psychiatric and mental health; or

b. is a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health;

6. a licensed professional counselor who is licensed as such under the provision of R.S. 37:1101-1115;

7. a licensed marriage and family therapist who is licensed as such under the provisions of R.S. 37:1116-1121; or

8. a licensed addiction counselor who is licensed as such under the provisions of R.S. 37:3387.

Licensee—the person, partnership, company, corporation, association, organization, professional entity, or other entity to whom a license is granted by the licensing agency and upon whom rests the ultimate responsibility and authority for the conduct of and services provided by the TGH.

LSUCCC—the Department of Public Safety and Corrections, Louisiana State Uniform Construction Code Council.

Mental Health Professional (MHP)—an individual who is supervised by a LMHP and meets the following criteria as documented by the provider:

1. the individual has a Master of Social Work degree; or

2. the individual has a Master of Arts degree, Master of Science degree or a Master of Education degree in a mental health-related field and has a minimum of 15 hours of graduate level course work and/or practicum in applied intervention strategies/methods designed to address behavioral, emotional and/or mental problems. These hours may have been obtained as a part of, or in addition to, the master's degree.

OSFM—the Department of Public Safety and Corrections, Office of State Fire Marshal.

Passive Physical Restraint—the least amount of direct physical contact required on the part of a staff member to prevent a client from harming himself/herself or others.

Pretreatment Assessment (PTA)—the documented examination of a client which provides clinical information to support the medical necessity of the referral to the therapeutic group home and establishes that TGH services are the most appropriate services to meet the client's needs.

Secretary—the secretary of the Louisiana Department of Health and Hospitals, or his designee.

Supervising Practitioner—the qualified psychiatrist or psychologist who supervises and oversees the therapeutic group home's services and programs.

Therapeutic Group Home (TGH)—a facility that provides community-based residential services to clients under the age of 21 in a home-like setting of no greater than 10 beds under the supervision and oversight of a psychiatrist or psychologist.

Time Out—the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

Validated Complaint—a complaint received by DHH Health Standards Section and found to be substantiated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:402 (February 2012), amended LR 41:1293 (July 2015).

Subchapter B. Licensing

§6207. General Provisions

A. All TGH providers shall be licensed by the Department of Health and Hospitals. The department is the only licensing authority for TGH providers in Louisiana. It shall be unlawful to operate as a therapeutic group home without possessing a current, valid license issued by the department. Each TGH shall be separately licensed.

B. A TGH license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the TGH to which it is issued and only for the specific geographic address of that facility;

3. enable the provider to operate as a TGH within a specific DHH region;

4. be valid for up to one year from the date of issuance, unless revoked, suspended, or modified prior to that date, or unless a provisional license is issued;

5. expire on the expiration date listed on the license, unless timely renewed by the TGH;

6. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

7. be posted in a conspicuous place on the licensed premises at all times.

C. In order for the TGH to be considered operational and retain licensed status, the provider shall meet the following conditions.

1. There shall be adequate direct care staff and professional services staff employed and available to provide services to clients at the TGH at all times.

2. There shall always be at least two employees on duty at the facility at all times.

D. The licensed TGH shall abide by and adhere to any state and federal law, rules, policy, procedure, manual or memorandum pertaining to such facilities.

E. A separately licensed TGH shall not use a name which is substantially the same as the name of another TGH licensed by the department or by DCFS. A TGH provider shall not use a name which is likely to mislead the client or family into believing it is owned, endorsed or operated by the state of Louisiana.

G. No branches, satellite locations or offsite campuses shall be authorized for a TGH.

H. No new TGH shall accept clients until the TGH has written approval and/or a license issued by HSS. If the facility is currently maintaining a license as a child residential facility from DCFS, the facility may remain operational under its DCFS license during the TGH application process.

I. Plan Review. Construction documents (plans and specifications) are required to be submitted and approved by both the OSFM and the Department of Health and Hospitals as part of the licensing procedure and prior to obtaining a license.

1. Applicable Projects. Construction documents require approval for the following types of projects:

a. new construction;

b. any entity that intends to operate and be licensed as a TGH in a physical environment that is not currently licensed by DCFS as a child residential facility; and

c. major alterations.

2. Submission Plans

a. Submittal Requirements

i. One set of the final construction documents shall be submitted to the OSFM for approval. The fire marshal's approval letter and final inspection shall be sent to the DHH.

ii. One set of the final construction documents shall be submitted to DHH, or its designated plan review entity, along with the appropriate review fee and a "plan review application form" for approval.

b. Design Criteria. The project shall be designed in accordance with the following criteria:

i. the latest OSFM adopted edition of the National Fire Protection Agency (NFPA) 101-Life Safety Code;

ii. the latest LSUCCC adopted edition of the *International Building Code*;

iii. the latest edition of the Americans with Disabilities Act (ADA) Standards;

iv. the current DHH licensing standards for therapeutic group home facilities;

v. the latest OPH adopted edition of the *Louisiana State Plumbing Code;*

vi. the latest edition of the State Sanitary Code regulations applicable to residential facilities/group homes;

c. Construction Document Preparation. Construction documents submitted to DHH, or its designated plan review entity, shall be prepared only by a Louisiana

licensed architect or licensed engineer as governed by the licensing laws of the state for the type of work to be performed. These documents shall be of an architectural or engineering nature and thoroughly illustrate the project that is accurately drawn, dimensioned, and contain noted plans, details, schedules and specifications. At a minimum the following shall be submitted:

i. site plans;

ii. floor plans. These shall include architectural, mechanical, plumbing, electrical, fire protection, and if required by code, sprinkler and fire alarm plans;

iii. building elevations;

iv. room finish, door and window schedules;

v. details pertaining to the ADA Standards; and

vi. specifications for materials.

3. Waivers. The secretary of DHH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of or otherwise required under the provisions of the State Sanitary Code. The facility must submit a waiver request in writing to HSS. The facility must demonstrate how patient safety and quality of care offered is not compromised by the waiver, and must demonstrate the undue hardship imposed on the facility if the waiver is not granted. The facility must demonstrate its ability to completely fulfill all other requirements of service. The department will make a written determination of the requests.

a. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related the waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:403 (February 2012).

§6209. Initial Licensing Application Process

A. An initial application for licensing as a TGH shall be obtained from the department. A completed initial license application packet for a TGH shall be submitted to and approved by the department prior to an applicant providing TGH services.

B. Currently licensed DCFS providers that are converting to TGHs must comply with all of the initial licensure requirements, except plan review, and may be eligible for the exception to the bedroom space requirement of this Chapter.

C. An applicant must submit a completed initial licensing application packet to the department, which shall include:

1. a completed TGH licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter of the architectural facility plans for the TGH from the department and from the OSFM, and any other office/entity designated by the department to review and approve the facility's architectural plans, if the facility must go through plan review;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health (OPH);

5. a copy of statewide criminal background checks, including sex offender registry status, on all individual owners with a 5 percent or more ownership interest in the TGH, and on all managing employees;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

7. an organizational chart, including the names and position titles of key administrative personnel and the governing body; and

8. a floor sketch or drawing of the premises to be licensed;

9. a letter of intent as to the types of services or specialization that will be provided by the TGH (i.e. sexually offending behaviors, etc.); and

10. any other documentation or information required by the department for licensure.

D. Any person convicted of one of the following felonies is prohibited from being the health care provider, owner, supervising practitioner or clinical director or any managing employee of a TGH. For purposes of these provisions, the licensing application shall be rejected by the department for any felony conviction, guilty plea or nolo contendere plea relating to:

1. the violence, abuse, or negligence of a person;

2. the misappropriation of property belonging to another person;

3. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;

4. a drug offense;

5. crimes of a sexual nature;

6. a firearm or deadly weapon;

7. Medicare or Medicaid fraud; or

8. fraud or misappropriation of federal or state funds.

E. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing

information and will have 90 days from receipt of the notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a PRTF must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

F. Once the initial licensing application packet has been approved by the department, notification of the approval shall be forwarded to the applicant. Within 90 days of receipt of the approval notification, the applicant must notify the department that the TGH is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application has been closed, an applicant who is still interested in becoming a TGH must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

G. Applicants must be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the TGH provider will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:404 (February 2012).

§6211. Types of Licenses

A. The department shall have the authority to issue the following types of licenses.

1. Full Initial License. The department shall issue a full license to the TGH provider when the initial licensing survey finds that the provider is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license for a TGH shall be valid until the expiration date shown on the license, unless the license is revoked, suspended, or modified prior to that time.

2. Provisional Initial License. The department may issue a provisional initial license to the TGH provider when the initial licensing survey finds that the provider is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients. The provisional license shall be valid for a period not to exceed six months.

a. At the discretion of the department, the provisional initial license may be extended for an additional period not to exceed 90 days in order for the TGH to correct the noncompliance or deficiencies.

b. The TGH provider shall submit a plan of correction to the department for approval and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional initial license.

c. A follow-up survey shall be conducted prior to the expiration of the provisional initial license.

i. If all such noncompliance or deficiencies are determined by the department to be corrected on a follow-up survey, a full license will be issued.

ii. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional initial license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed TGH provider who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional Renewal License. The department, in its sole discretion, may issue a provisional license to an existing licensed TGH for a period not to exceed six months.

a. At the discretion of the department, the provisional renewal license may be extended for an additional period not to exceed 90 days in order for the TGH to correct the noncompliance or deficiencies.

b. A provisional renewal license may be issued for the following reasons:

i. the existing TGH has more than five deficient practices or deficiencies cited during any one survey;

ii. the existing licensed TGH has more than three validated complaints in a one year period;

iii. the existing TGH provider has been issued a deficiency that involved placing a client at risk for serious harm or death;

iv. the existing TGH provider has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

v. the existing TGH provider is not in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

c. When the department issues a provisional renewal license to an existing licensed TGH provider, the provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct an on-site follow-up survey at the TGH prior to the expiration of the provisional license.

i. If the on-site follow-up survey determines that the TGH has corrected the deficient practices and has maintained compliance during the period of the provisional

license, the department may issue a full license for the remainder of the year until the anniversary date of the TGH license.

ii. If the on-site follow-up survey determines that the TGH has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional renewal license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee, if no timely informal reconsideration or administrative appeal is filed pursuant to this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:404 (February 2012).

§6213. Changes in Licensee Information or Personnel

A. Any change regarding the TGH's name, "doing business as" name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the change. Any change regarding the TGH name or "doing business as" name requires a change to the facility license and shall require a $25 fee for the issuance of an amended license.

B. Any change regarding the facility's key administrative personnel shall be reported in writing to the department within five days of the change.

1. Key administrative personnel shall include the:

a. supervising practitioner;

b. clinical director; and

c. house manager.

2. The TGH provider's notice to the department shall include the individual's:

a. name;

b. hire date; and

c. qualifications.

C. A change of ownership (CHOW) of a TGH shall be reported in writing to the department at least five days prior to the change of ownership.

1. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all of the application requirements are completed and approved by the department, a new license shall be issued to the new owner.

2. A TGH that is under provisional licensure, license revocation, or denial of license renewal may not undergo a CHOW.

D. A TGH that intends to change the physical address of its geographic location is required to have plan review approval, Office of State Fire Marshal approval, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the relocation of the facility.

1. A written notice of intent to relocate must be submitted to HSS when the plan review request is submitted to the department for approval.

2. Relocation of the TGH's physical address results in a new anniversary date and the full licensing fee must be paid.

E. Any request for a duplicate license must be accompanied by a $25 fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:405 (February 2012), amended LR 41:1293 (July 2015).

§6215. Renewal of License

A. To renew a license, a TGH must submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. a copy of the current on-site inspection report with approval for occupancy from the Office of the State Fire Marshal and the Office of Public Health;

3. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

4. the license renewal fee; and

5. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the TGH license.

D. The renewal of a license does not in any manner affect any sanction, civil fine, or other action imposed by the department against the facility.

E. If an existing licensed TGH has been issued a notice of license revocation, suspension, or termination, and the facility's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012).

§6217. Deemed Status

A. A licensed TGH may request deemed status from the department. The department may accept accreditation in lieu of a routine on-site licensing survey provided that:

1. the accreditation is obtained through an organization approved by the department;

2. all services provided under the TGH license must be accredited; and

3. the provider forwards the accrediting body's findings to the Health Standards Section within 30 days of its accreditation.

B. If approved, accreditation will be accepted as evidence of satisfactory compliance with all of the provisions of these requirements.

C. Occurrence of any of the following may be grounds for the department to perform a licensing survey on an accredited TGH provider with deemed status:

1. any valid complaint in the preceding 12-month period;

2. addition of services;

3. a change of ownership in the preceding 12-month period;

4. issuance of a provisional license in the preceding 12-month period;

5. serious violations of licensing standards or professional standards of practice that were identified in the preceding 12-month period that placed clients at risk for harm;

6. a report of inappropriate treatment or service resulting in death or serious injury; or

7. a change in geographic location.

D. A TGH with deemed status is responsible for complying with all of the provisions of this Rule and is subject to all of the provisions of this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012).

§6219. Licensing Surveys

A. Prior to the initial license being issued to the TGH, an initial licensing survey shall be conducted on-site at the facility to assure compliance with licensing standards. Except for facilities currently maintain a license as a child residential facility from DCFS, a TGH shall not provide services to any resident until the initial licensing survey has been performed and the facility found in compliance with the licensing standards. The initial licensing survey shall be an announced survey.

B. Once an initial license has been issued, the department may conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These surveys shall be unannounced.

C. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices. The department shall issue written notice to the provider of the results of the follow-up survey.

D. An acceptable plan of correction may be required for any survey where deficiencies have been cited.

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. civil fines;

2. directed plans of correction;

3. provisional licensure;

4. denial of renewal; and/or

5. license revocations.

F. Surveyors and staff on behalf of the department shall be:

1. given access to all areas of the facility and all relevant files during any licensing survey or other survey; and

2. allowed to interview any provider staff, resident, or participant as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012), amended LR 41:1293 (July 2015).

§6221. Complaint Surveys

A. The department shall conduct complaint surveys in accordance with R.S. 40:2009.13 et seq., on any TGH, including those with deemed status.

B. Complaint surveys shall be unannounced surveys.

C. An acceptable plan of correction may be required by the department for any complaint survey where deficiencies have been cited. If the department determines other action, such as license revocation is appropriate, a plan of correction may not be required and the facility will be notified of such action.

D. A follow-up survey may be conducted for any complaint survey where deficiencies have been cited to ensure correction of the deficient practices. If the department determines that other action, such as license revocation, is appropriate, a follow-up survey may not be required. The facility will be notified of any action.

E. The department may issue appropriate sanctions, including but not limited to, civil fines, directed plans of correction, and license revocations, for deficiencies and non-compliance with any complaint survey.

F. DHH surveyors and staff shall be given access to all areas of the facility and all relevant files during any complaint survey. DHH surveyors and staff shall be allowed to interview any provider staff, resident, or participant, as necessary or required to conduct the survey.

G. A TGH which has been cited with violations or deficiencies on a complaint survey has the right to request an informal reconsideration of the validity of the violations or deficiencies. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department must receive the written request within 10 calendar days of the facility's receipt of the notice of the violations or deficiencies.

H. A complainant shall have the right to request an informal reconsideration of the findings of the complaint survey or investigation that resulted from his/her complaint. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department must receive the written request within 30 calendar days of the complainant's receipt of the results of the complaint survey or investigation.

I. An informal reconsideration for a complaint survey or investigation shall be conducted by the department as an administrative review. The facility or complainant shall submit all documentation or information for review for the informal reconsideration and the department shall consider all documentation or information submitted. There is no right to appear in person at the informal reconsideration of a complaint survey or investigation. Correction of the violation or deficiency shall not be the basis for the reconsideration. The provider and the complainant shall be notified in writing of the results of the informal reconsideration.

J. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the informal reconsideration shall constitute final action by the department regarding the complaint survey or investigation, and there shall be no right to an administrative appeal.

1. To request an administrative appeal pursuant to R.S. 40:2009.16, the written request for the appeal shall be submitted to the Division of Administrative Law (DAL) and must be received within 30 calendar days of the receipt of the results of the informal reconsideration.

a. The offer of the administrative appeal, if appropriate, as determined by the Health Standards Section, shall be included in the notification letter of the results of the informal reconsideration results. The right to administrative appeal shall only be deemed appropriate and thereby afforded upon completion of the informal reconsideration.

2. The administrative law judge shall not have the authority to overturn or delete deficiencies or violations and shall not have the authority to add deficiencies or violations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:1293 (July 2015).

§6223. Statement of Deficiencies

A. The following statements of deficiencies issued by the Department to the TGH shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any complaint survey statement of deficiencies issued after the most recent annual survey.

B. Any statement of deficiencies issued by the department to a TGH shall be available for disclosure to the public 30 calendar days after the provider submits an acceptable plan of correction of the deficiencies or 90 calendar days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Unless otherwise provided in statute or in this Chapter, a provider shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

1. Correction of the deficient practice, of the violation, or of the noncompliance shall not be the basis for the reconsideration.

2. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies.

3. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration.

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.11 et seq., and as provided in this Chapter for license denials, revocations, and non-renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

5. The provider shall be notified in writing of the results of the informal reconsideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:1293 (July 2015).

§6225. Cessation of Business

A. Except as provided in §6295 of this Chapter, a license shall be immediately null and void if a TGH ceases to operate.

B. A cessation of business is deemed to be effective the date on which the TGH stopped offering or providing services to the community.

C. Upon the cessation of business, the provider shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the TGH shall:

1. give 30 days' advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the parent(s) or legal guardian or legal representative of each client; and

2. provide for an orderly discharge and transition of all of the clients in the facility.

F. In addition to the advance notice of voluntary closure, the TGH shall submit a written plan for the disposition of client medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's clients' medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If a TGH fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a TGH for a period of two years.

H. Once the TGH has ceased doing business, the TGH shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:1293 (July 2015).

§6227. Denial of License, Revocation of License, or Denial of License Renewal

A. In accordance with the provisions of the Administrative Procedure Act, the department may:

1. deny an application for an initial license;

2. deny a license renewal; or

3. revoke a license.

B. Denial of an Initial License

1. The department shall deny an initial license when the initial licensing survey finds that the TGH provider is noncompliant with any licensing laws or regulations or with any other required statutes, laws, ordinances, rules or regulations and such noncompliance presents a potential threat to the health, safety, or welfare of the clients who will be served by the facility.

2. The department shall deny an initial license for any of the reasons in this Chapter that a license may be revoked or non-renewed.

C. Voluntary Non-Renewal of a License

1. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

2. If a provider fails to timely renew its license, the facility shall immediately cease providing services, unless the provider is actively treating clients, in which case the provider shall:

a. immediately provide written notice to the department of the number of clients that are receiving treatment at the TGH;

b. immediately provide written notice to the prescribing physician and to every client, parent, legal guardian, or legal representative of the following:

i. voluntary non-renewal of the facility's license;

ii. date of closure of the facility; and

iii. plans for orderly transition of the client;

c. discharge and transition of each client within 15 days of voluntary non-renewal; and

d. notify the department of the location where records will be stored and the contact person for the records.

3. If a TGH fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a PRTF for a period of two years.

D. Revocation of License or Denial of License Renewal. A TGH license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the TGH licensing laws, rules and regulations, or with other required statutes, laws, ordinances, rules, or regulations;

2. failure to comply with the terms and provisions of a settlement agreement or education letter with or from the

department, the Attorney General's Office, any regulatory agency, or any law enforcement agency;

3. failure to uphold a client's rights whereby deficient practices result in harm, injury, or death of a client;

4. negligence or failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

5. failure to notify the proper authorities, as required by federal or state law, rules, or regulations, of all suspected cases of the acts outlined in §6227.D.4;

6. knowingly making a false statement in any of the following documentation, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. records, including:

i. clinical;

ii. client; or

iii. provider;

d. matters under investigation by the department or the Office of Attorney General; or

e. information submitted for reimbursement from any payment source;

7. knowingly making a false statement or providing false, forged, or altered information or documentation to department employees or to law enforcement agencies;

8. the use of false, fraudulent or misleading advertising;

9. fraudulent operation of a TGH by the owner, administrator, manager, member, officer, or director;

10. an owner, officer, member, manager, administrator, director, or person designated to manage or supervise client care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court.

a. For purposes of these provisions, conviction of a felony means a felony relating to any of the following:

i. violence, abuse, or neglect of another person;

ii. misappropriation of property belonging to another person;

iii. cruelty, exploitation, or sexual battery of a juvenile or the infirmed;

iv. a drug offense;

v. crimes of a sexual nature;

vi. possession or use of a firearm or deadly weapon; or

vii. fraud or misappropriation of federal or state funds, including Medicare or Medicaid funds;

11. failure to comply with all of the reporting requirements in a timely manner as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey, or to interview provider staff or the residents;

13. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

14. failure to allow or refusal to allow access to facility or resident records by authorized departmental personnel;

15. bribery, harassment, or intimidation of any resident or family member designed to cause that client or family member to use or retain the services of any particular TGH provider;

16. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

17. failure to timely pay outstanding fees, fines, sanctions, or other debts owed to the department; or

18. failure to maintain accreditation, or for a new TGH that has applied for accreditation, the failure to obtain accreditation.

E. If a TGH license is revoked or renewal is denied or the license is surrendered in lieu of an adverse action, any owner, officer, member, director, manager, or administrator of such TGH may be prohibited from opening, managing, directing, operating, or owning another TGH for a period of two years from the date of the final disposition of the revocation, denial action, or surrender.

F. The denial of the license renewal application shall not affect in any manner the license revocation, suspension, or termination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:408 (February 2012), amended LR 41:1294 (July 2015).

§6229. Notice and Appeal of License Denial, License Revocation, License Non-Renewal, and Appeal of Provisional License

A. Notice of a license denial, license revocation or license non-renewal shall be given to the provider in writing.

B. The TGH provider has a right to an informal reconsideration of the license denial, license revocation, or license non-renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The TGH provider shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration must be in writing and shall be forwarded to the Health Standards Section.

2. The request for informal reconsideration must include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the provider shall receive written notification of the date of the informal reconsideration.

4. The provider shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or non-renewal shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The provider shall be notified in writing of the results of the informal reconsideration.

C. The TGH provider has a right to an administrative appeal of the license denial, license revocation, or license non-renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The TGH shall request the administrative appeal within 30 calendar days of the receipt of the notice of the results of the informal reconsideration of the license denial, license revocation, or license non-renewal.

a. The TGH provider may forego its rights to an informal reconsideration, and if so, the facility shall request the administrative appeal within 30 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal.

2. The request for administrative appeal must be in writing and shall be submitted to the DAL or its successor. The request shall include any documentation that demonstrates that the determination was made in error and must include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL or its successor, the administrative appeal of the license revocation or license non-renewal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the DAL issues a final administrative decision.

a. If the secretary of the department determines that the violations of the facility pose an imminent or immediate threat to the health, welfare, or safety of a resident, the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal. The facility shall be notified of this determination in writing.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation, or non-renewal shall not be a basis for the administrative appeal.

D. If an existing licensed TGH has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal. The denial of the license renewal does not affect in any manner the license revocation.

E. If a timely administrative appeal has been filed by the provider on a license denial, license non-renewal, or license revocation, the DAL or its successor shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. If the final DAL decision is to reverse the license denial, the license non-renewal, or the license revocation, the facility's license will be re-instated or granted upon the payment of any licensing fees or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final DAL decision is to affirm the license non-renewal or the license revocation, the provider shall discharge any and all clients receiving services according to the provisions of this Chapter. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where the clients' records will be stored.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new TGH or a provisional license to an existing TGH. The issuance of a provisional license is not considered to be a denial of license, a denial of license renewal, or a license revocation.

G. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal regarding the deficiencies cited at the follow-up survey.

1. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The provider shall request the informal reconsideration in writing, which shall be received by the HSS within five days of receipt of the notice of the results of the follow-up survey from the department.

4. The provider shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

H. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge the clients unless the DAL issues a stay of the expiration.

1. A stay may be granted upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing and upon a showing that there is no potential harm to the residents being served by the provider.

I. If a timely administrative appeal has been filed by a provider with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the DAL or its successor shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. If the final DAL decision is to remove all deficiencies, the provider's license will be reinstated upon the payment of any licensing fees or other fees due to the department, and the payment of any outstanding sanctions due to the department.

2. If the final DAL decision is to uphold the deficiencies and affirm the expiration of the provisional license, the facility shall discharge all clients receiving services. Within 10 calendar days of the final agency decision, the provider shall notify HSS in writing of the secure and confidential location of where the client's records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:409 (February 2012), amended LR 41:1294 (July 2015).

Subchapter C. Administration and Organization

§6233. General Provisions

A. Purpose and Organizational Structure. The purpose of the TGH shall be clearly defined in a statement filed with the department. The statement includes the:

1. program philosophy;

2. program goals and objectives;

3. ages, sex and characteristics of clients accepted for care;

4. geographical area served;

5. types of services provided;

6. description of admission policies; and

7. needs, problems, situations or patterns best addressed by the provider's program; and

8. an organizational chart of the provider which clearly delineates the line of authority.

B. A TGH shall provide supervision and services that:

1. conform to the department's rules and regulations;

2. meet the needs of the clients as identified and addressed in the comprehensive treatment plan;

3. provide for the full protection of clients' rights; and

4. promote the social, physical and mental well-being of clients.

C. A TGH shall make any required information or records, and any information reasonably related to assessment of compliance with these requirements, available to the department.

D. A TGH shall allow designated representatives of the department, in performance of their mandated duties, to:

1. inspect all aspects of the TGH's operations which directly or indirectly impact clients; and

2. conduct interviews with any staff member or client of the provider.

E. A TGH shall make available, upon request, the legal ownership documents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:410 (February 2012).

§6237. Governing Body

A. A TGH shall have an identifiable governing body with responsibility for and authority over the policies and operations of the home.

1. A TGH shall have documents identifying all members of the governing body, their addresses, their terms of membership, officers of the governing body and terms of office of any officers.

2. The governing body shall be comprised of three or more persons and shall hold formal meetings at least twice a year.

3. There shall be written minutes of all formal meetings of the governing body and by-laws specifying frequency of meetings and quorum requirements.

B. The governing body of a TGH shall:

1. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

2. ensure that the provider is adequately funded and fiscally sound;

3. review and approve the provider's annual budget;

4. designate qualified persons to act as supervising practitioner and clinical director and delegate sufficient authority to these persons to manage the facility;

5. formulate and annually review, in consultation with the clinical director and supervising practitioner, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

6. annually evaluate the supervising practitioner's and clinical director's performance;

7. meet with designated representatives of the department whenever required to do so;

8. inform the department, or its designee, prior to initiating any substantial changes in the services provided by the provider; and

9. ensure statewide criminal background checks in accordance with R.S. 15:587.1.

C. A TGH provider shall maintain the following documents:

1. minutes of formal meetings and by-laws of the governing body;

2. documentation of the provider's authority to operate under state law;

3. all leases, contracts and purchases-of-service agreements to which the provider is a party;

4. insurance policies;

5. annual budgets and audit reports; and

6. a master list of all the community resources used by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:-410 (February 2012).

§6239. Policies and Procedures

A. The TGH shall have written policies and procedures approved by the owner or governing body, which must be implemented and followed, that address at a minimum the following:

1. confidentiality and confidentiality agreements;

2. security of files;

3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;

4. personnel;

5. client rights;

6. grievance procedures;

7. client funds;

8. emergency preparedness;

9. abuse and neglect;

10. incidents and accidents, including medical emergencies;

11. universal precautions;

12. documentation;

13. admission and discharge procedures;

14. bedroom assignment for clients; and

15. behavior management.

B. A TGH shall have written personnel policies, which must be implemented and followed, that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members, whether directly employed, contract or volunteer;

2. written job descriptions for each staff position, including volunteers;

3. policies that shall, at a minimum, be consistent with Office of Public Health guidelines, to indicate whether, when and how staff have a health assessment;

4. an employee grievance procedure;

5. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment, whether that abuse or mistreatment is done by another staff member, a family member, a client or any other person;

6. a nondiscrimination policy;

7. a policy that requires all employees to report any signs or symptoms of a communicable disease or personal illness to their supervisor or the Clinical Director as possible to prevent the disease or illness from spreading to other clients or personnel.

C. A TGH shall maintain the requirements for financial viability under this rule at all times.

D. Behavior Management

1. The provider shall develop and implement written policies and procedures for the management of behaviors to be used on facility-wide level, insuring that procedures begin with the least restrictive, most positive measures and follow a hierarchy of acceptable measures. The policies and procedures shall be provided to all provider staff and shall include:

a. appropriate and inappropriate behaviors of clients;

b. consequences of inappropriate behaviors of clients;

c. the phases of behavior escalation and appropriate intervention methods to be used at each level.

d. documentation in the client's record of the use of any behavioral management measures.

E. House Rules and Regulations. A provider shall have a clearly written list of rules and regulations governing conduct for clients in care and shall document that these rules and regulations are made available to each staff member, client and, where appropriate, the client's parent(s) or legal guardian(s). A copy of the House rules shall be given to clients and, where appropriate, the client's parent(s) or legal guardian(s) upon admission and shall be posted and accessible to all employees and clients.

F. Limitations on Potentially Harmful Responses or Punishments. A provider shall have a written list of prohibited responses and punishments to clients by staff members and shall document that this list is made available to each staff member, client and, where appropriate, the client's parent(s) or legal guardian(s).

1. This list shall include the following prohibited responses/punishments:

a. any type of physical hitting or other painful physical contact except as required for medical, dental or first aid procedures necessary to preserve the child's life or health;

b. physical, chemical and mechanical restraints;

c. requiring a client to take an extremely uncomfortable position;

d. verbal or psychological abuse, ridicule or humiliation;

e. withholding of a meal, except under a physician's order;

f. denial of sufficient sleep, except under a physician's order;

g. requiring a child to remain silent for a long period of time;

h. denial of shelter, warmth, clothing or bedding;

i. assignment of harsh physical work.

j. physical exercise or repeated physical motions;

k. excessive denial of usual services;

l. denial of visiting or communication with family or legal guardian;

m. extensive withholding of emotional response;

n. any other cruel, severe, unusual, degrading or unnecessary punishment.

2. A provider shall not punish groups of clients for actions committed by an individual.

3. Children shall neither punish nor supervise other children except as part of an organized therapeutic self government program that is conducted in accordance with written policy and is supervised directly by staff. Such programs shall not be in conflict with regulations regarding behavior management.

4. Punishment shall not be administered by any persons who are not known to the client.

G. Restraints

1. A TGH shall develop and implement a written policy which prohibits the use of any form of mechanical, physical or chemical restraints. TGH providers may have a policy that allows passive physical restraint, but it shall be utilized only when the child's behaviors escalate to a level of possibly harming himself/herself or others.

2. The TGH's policy shall provide that passive physical restraints are only to be performed by two trained staff personnel in accordance with an approved curriculum. A single person restraint can be initiated in a life threatening crisis with support staff in close proximity to provide assistance.

H. Time-Out Procedures

1. A provider using time-out rooms for seclusion of clients for brief periods shall have a written policy governing the use of time-out procedures. This policy shall ensure that:

a. the room shall be unlocked;

b. time-out procedures are used only when less restrictive measures have been used without effect. Written documentation of less restrictive measures used shall be required;

c. emergency use of time-out shall be approved by the clinical director for a period not to exceed one hour;

d. time-out used as an individual behavior management plan shall be part of the overall plan of treatment;

e. the plan shall state the reasons for using time-out and the terms and conditions under which time-out will be terminated or extended, specifying a maximum duration of the use of the procedure that shall under no circumstances exceed eight hours;

f. when a child is in time-out, a staff member shall exercise direct physical supervision of the child at all times;

g. a child in time-out shall not be denied access to bathroom facilities, water or meals.

I. Copies of the behavior management policy, the prohibited response and punishment policy, including restraint prohibitions and time out procedures, shall be provided in triplicate upon admission. The child and parent(s) or legal guardian(s) shall sign all three copies. The child and parent(s) or legal guardian(s) shall retain one copy each and the provider shall retain the other copy in the child's record.

J. Copies of the behavior management policy, the prohibited response and punishment policy, including restraint prohibitions and time out procedures, shall be provided in duplicate to each new employee upon hiring. The employee shall sign both copies. The employee shall retain one copy and the provider shall retain the other copy in the employee's personnel record.

K. A TGH shall comply with all federal and state laws, rules and regulations in the development and implementation of its policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:411 (February 2012).

§6241. Personnel Records

A. A TGH shall have a personnel file for each staff member who provides services for the TGH in the facility. Each record shall contain:

1. the application for employment and/or resume;

2. reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

3. any required medical examinations;

4. evidence of current applicable professional credentials/certifications according to state law or regulations;

5. annual performance evaluations;

6. personnel actions, other appropriate materials, reports and notes relating to the individual's employment with the center; and

7. the employee’s starting and termination dates.

B. The staff member shall have reasonable access to his/her file and shall be allowed to add any written statement that he/she wishes to make to the file at any time.

C. A TGH shall retain the staff member’s personnel file for at least three years after the staff member’s termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:412 (February 2012).

Subchapter D. Provider Responsibilities

§6247. Staffing Requirements

A. There shall be a single organized professional staff that has the overall responsibility for the quality of all clinical care provided to clients, for the ethical conduct and professional practices of its members, as well as for accounting therefore to the governing body. The manner in which the professional staff is organized shall be consistent with the TGH’s documented staff organization and policies and shall pertain to the setting where the TGH is located. The organization of the professional staff and its policies shall be approved by the TGH’s governing body.

B. The staff of a TGH must have the appropriate qualifications to provide the services required by its clients comprehensive treatment plans. Each member of the direct care staff may not practice beyond the scope of his/her license or certification.

C. Staffing Ratios

1. All staffing shall be adequate to meet the individualized treatment needs of the clients and the responsibilities of the staff. Staffing schedules shall reflect

overlap in shift hours to accommodate information exchange for continuity of client treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child.

2. A TGH shall have a minimum of two staff on duty per shift in each living unit, with at least one staff person awake during overnight shifts with the ability to call in as many staff as necessary to maintain safety and control in the facility, depending upon the needs of the current population at any given time.

3. A ratio of not less than one staff to five clients is maintained at all times; however, two staff must be on duty at all times with at least one being direct care staff when there is a client present.

D. The staff shall have the following acceptable hours and ratios:

1. Supervising Practitioner. The supervising practitioner's hours shall be adequate to provide the necessary direct services and to meet the administrative and clinical responsibilities of supervision and of directing the care in a TGH. The number of hours the supervising practitioner needs to be on-site is dependent upon the size of program and the unique needs of each individual client.

2. Clinical Director. The clinical director shall have adequate hours to fulfill the expectations and responsibilities of the clinical director.

3. Nurse. The TGH shall have at least one licensed nurse available to meet the nursing health care needs of the clients and who is on-call 24 hours a day and can be on-site within 30 minutes as needed.

4. Therapist. Each therapist shall be available at least three hours per week for individual and group therapy and two hours per month for family therapy.

5. Direct Care Staff. The ratio of direct care staff to clients served shall be 1:5 with a minimum of two staff on duty per shift for a 10 bed capacity. This ratio may need to be increased based on the assessed level of acuity of the youth or if treatment interventions are delivered in the community and offsite.

E. Orientation

1. All staff shall receive orientation prior to being assigned to provide client care without supervision.

2. Orientation includes, but is not limited to:

a. confidentiality;

b. grievance process;

c. fire and disaster plans;

d. emergency medical procedures;

e. organizational structure;

f. program philosophy;

g. personnel policy and procedure;

h. detecting and mandatory reporting of client abuse, neglect or misappropriation;

i. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

j. basic skills required to meet the health needs and problems of the client;

k. crisis intervention and the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations;

l. the safe use of time out and passive physical restraint (including a practice element in the chosen method); and

m. recognizing side effects of all medications including psychotropic drugs.

F. Training. All staff shall receive training according to facility policy at least annually and as deemed necessary depending on the needs of the clients. The TGH must maintain documentation of all training provided to its staff. The TGH shall meet the following requirements for training.

1. Staff shall have ongoing education, training and demonstrated knowledge of at least the following:

a. techniques to identify staff and client behaviors, events, and environmental factors that may trigger emergency safety situations;

b. the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;

c. the safe use of time out for behavior management, including the ability to recognize any adverse effects as a result of the use of time out; and

d. the safe use of passive physical restraint (including a practice element in the chosen method).

2. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required within 30 days of hire.

3. Training shall be provided only by staff who are qualified by education, training, and experience.

4. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

5. Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

6. All training programs and materials used by the facility must be available for review by HSS.

G. Staff Evaluation. The TGH shall complete an annual performance evaluation of all staff members. For any person who interacts with clients, the provider's performance evaluation procedures shall address the quality and nature of a staff member's relationships with clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:413 (February 2012), amended LR 41:1294 (July 2015).

§6249. Personnel Qualifications and Responsibilities

A. Professional Staffing Standards. The following are the minimum staffing requirements for TGHs.

1. Supervising Practitioner

a. A supervising practitioner shall be one of the following:

i. a physician with an unrestricted license to practice in Louisiana and who meets all of the following qualifications:

(a). an unrestricted drug enforcement agency (DEA) and Louisiana controlled substance license;

(b). if the physician holds an additional license(s) in another state or jurisdiction, that license(s) must be unrestricted and be documented in the employment record;

(c). board-certification in general psychiatry; and

(d). satisfactory completion of a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director, which includes the exact dates of training and verification that all ACGME requirements have been satisfactorily met. If training was completed in a psychiatric residency program not accredited by the ACGME, the physician must demonstrate that he/she meets the most current requirements as set forth in the American Board of Psychiatry and Neurology's Board policies, rules and regulations regarding information for applicants for initial certification in psychiatry;

ii. a psychologist/medical psychologist must have the following:

(a). an unrestricted license to practice psychology in Louisiana issued by the Louisiana State Board of Examiners of Psychologists under R.S. 37:2351 et seq., or an unrestricted license to practice medical psychology issued by the Louisiana State Board of Medical Examiners under R.S. 37.1360.51 et seq.;

(b). unrestricted DEA and Louisiana controlled substance licenses, if the supervising practitioner is a medical psychologist;

(c). demonstrated competence and experience in the assessment, diagnosis, and treatment of children and adolescents who have mental and emotional disorders or disabilities, alcoholism and substance abuse. Acceptable competence/experience is specialized training at the internship or post-doctoral level before licensure and/or being in the independent practice of child/adolescent psychology in private practice, as a consultant, or within an outpatient or inpatient treatment facility for a period of at least two years post-licensure.

b. A supervising practitioner's responsibilities shall include, but are not limited to:

i. reviewing the referral PTA and completing an initial diagnostic assessment at admission or within 72 hours of admission and prior to service delivery;

ii. assuming accountability to direct the care of the client at the time of admission and during the entire TGH stay;

iii. supervising the development of a comprehensive treatment plan in the seven days following admission.

iv. providing clinical direction in the development of the comprehensive treatment plan;

v. at least every 28 days or more often as necessary, providing:

(a). a face-to-face assessment/service to the client;

(b). a review of the need for continued care; and

(c). continued supervision of the comprehensive treatment plan;

vi. providing crisis management including supervision and direction to the staff to resolve any crisis of the client's condition;

vii. monitoring and supervising an aggressive plan to transition the client from the program into less intensive treatment services as medically necessary;

viii. providing 24-hour on call coverage, seven days a week;

ix. assuming professional responsibility for the services provided and assure that the services are medically appropriate.

2. Clinical Director

a. A clinical director shall be an LMHP.

b. The clinical director must have the appropriate qualifications to meet the responsibilities of the clinical director and the needs of the TGH's clients. A clinical director may not practice beyond his/her scope of practice license.

c. If the TGH treats clients with both mental health and substance abuse conditions, then the clinical director

must have the training and experience necessary to practice in both fields.

d. Practitioners who meet the criteria of the clinical director may also serve as the TGH's therapist.

e. The responsibilities of a clinical director include, but are not limited to:

i. overseeing, implementing, and coordinating treatment services;

ii. continually incorporating new clinical information and best practices into the program to assure program effectiveness and viability;

iii. overseeing the process to identify, respond to, and report crisis situations on a 24-hour per day, 7 day per week basis;

iv. clinical management for the program in conjunction with and consultation with the supervising practitioner;

v. assuring confidentiality and quality organization and management of clinical records and other program documentation; and

vi. applying and supervising the gathering of outcome data and determining the effectiveness of the program.

3. TGH Therapist

a. A TGH therapist shall be an LMHP or an individual with a Master's degree in social work, counseling, psychology or a related human services field.

b. The role and the responsibilities of the TGH Therapist include but are not limited to:

i. reporting to the clinical director and supervising practitioner for clinical and non-clinical guidance and direction;

ii. communicating treatment issues to the clinical director and to the supervising practitioner as needed;

iii. providing individual, group, family, psychotherapy and/or substance abuse counseling;

iv. assisting in developing/updating treatment plans for clients in TGH care in conjunction with the other multidisciplinary team members;

v. providing assistance to direct care staff and implementing the treatment plan when directed by the clinical director;

vi. providing clinical information to the multidisciplinary team and attending treatment team meetings; and

vii. providing continuous and ongoing assessments to assure clinical needs of clients and parents(s)/caregivers(s) are met.

4. Nursing Services

a. The TGH shall have a licensed registered nurse who shall supervise the nursing services of the TGH. He/She must be operating within his/her scope of practice and have documented experience and training in the treatment of children or adolescents.

b. All nursing services must be furnished by licensed nurses. All nursing services furnished in the TGH shall be provided in accordance with acceptable nursing professional practice standards.

c. The responsibilities of the registered nurse include, but are not limited to:

i. providing a nursing assessment within 24 hours of admission for each client;

ii. establishing a system of operation for the administration and supervision of the clients' medication and medical needs;

iii. training staff regarding the potential side effects of medications, including psychotropic drugs;

iv. coordinating psychiatric and medical care per physician's direction; and

v. monitoring and supervising all staff providing nursing care and services to clients.

d. The responsibilities of all nurses include, but are not limited to:

i. reporting to the clinical director for programmatic guidance;

ii. reporting to the supervising practitioner as necessary regarding medical, psychiatric, and physical treatment issues;

iii. reviewing all medical treatment orders and implementing orders as directed;

iv. serving as a member of the multidisciplinary treatment team;

v. administering medications and monitoring the clients' responses to medications;

vi. providing education on medication and other health issues as needed;

vii. abiding by all state and federal laws, rules, and regulations; and

viii. identifying and assessing the clients for dental and medical needs.

5. House Manager

a. The house manager shall have the following qualifications:

i. be at least 21 years of age and at least 3 years older than the oldest client; and

ii. possess one of the following:

(a). a Bachelor's degree in a human services field and one year of documented employment with a health care provider that treats clients with mental illness; or

(b). two years of course work toward a Bachelor's degree in a human services field and two years of documented employment with a health care provider that treats clients with mental illness.

b. The house manager's responsibilities include, but are not limited to the following:

i. supervising the activities of the facility when the professional staff is on call, but not on duty;

ii. identifying, respond to, and report any crisis situation to the clinical director on a 24-hour, seven day per week basis;

iii. reporting incidents of abuse, neglect and misappropriation to the clinical director;

iv. assessing situations related to relapse;

v. coordinating and consulting with the clinical director as needed; and

vi. providing access to appropriate medical care when needed.

6. Direct Care Staff

a. All direct care staff shall have at least the following qualifications:

i. a high school diploma or equivalent;

ii. at least 18 years of age, but must also be at least three years older than all clients under the age of 18;

iii. a minimum of two years of experience working with children, be equivalently qualified by education in the human services field, or have a combination of work experience and education with one year of education substituting for one year of experience;

iv. not have a finding on the Louisiana State Nurse Aide Registry and the Louisiana Direct Service Worker Registry against him/her;

v. be certified in crisis prevention/management (example: CPI, Mandt, etc.);

vi. be proficient in de-escalation techniques; and

vii. be certified by the state of Louisiana.

b. The responsibilities of direct care staff include, but are not limited to:

i. completing the required program orientation and training, and demonstrating competency prior to being assigned to direct care;

ii. having a clear understanding of the treatment plan;

iii. assisting clients in developing social, recreational, and other independent living skills as appropriate;

iv. being aware of safety issues and providing safety intervention within the milieu;

v. reporting all crisis or emergency situations to the clinical director or his/her designee in the absence of the clinical director;

vi. reporting to the therapist or clinical director as necessary regarding treatment issues;

vii. understanding the program philosophy regarding behavior management and applying this philosophy in daily interactions with clients in TGH care; and

viii. having the ability to effectively implement de-escalation techniques.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:414 (February 2012), amended LR 41:1294 (July 2015).

4. staff who can access such funds.

B. If the TGH manages a client's personal funds, the facility must furnish a written statement listing the client's rights regarding personal funds to the client and/or his/her legal or responsible representative.

C. If a client chooses to entrust funds with the facility, the TGH shall obtain written authorization from the client and/or his/her legal or responsible representative for the safekeeping and management of the funds.

D. The TGH shall:

1. provide each client with an account statement upon request with a receipt listing the amount of money the facility is holding in trust for the client;

2. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction;

3. provide a list or account statement regarding personal funds upon request of the client; and

4. not commingle the clients' funds with the provider's operating account.

E. If the TGH is managing funds for a client and he/she is discharged, any remaining funds shall be refunded to the client or his/her legal or responsible representative within five business days of notification of discharge. Upon the death of a client, any remaining funds shall be refunded to the client's legal or responsible representative within five business days of the client's death.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:417 (February 2012).

§6255. Quality Improvement Plan

A. A TGH provider shall have a quality improvement (QI) plan which puts systems in place to effectively identify issues for which quality monitoring, remediation, and improvement activities are necessary. The QI plan shall include plans of action to correct identified issues including monitoring the effect of implemented changes and making needed revisions to the action plan.

B. The QI plan shall include:

1. a process for obtaining input annually from the client/guardian/authorized representatives and family members, as applicable. This process shall include, but not be limited to:

a. satisfaction surveys done by mail or telephone;

b. focus groups; and

c. other processes for receiving input regarding the quality of services received;

2. a 10 percent sample review of client case records on a quarterly bases to assure that:

§6253. Client Funds and Assets

A. The TGH shall develop and implement written policies and procedures governing the maintenance and protection of client funds. These policies and procedures shall have provisions which include, but are not limited to, the following:

1. the amount each client can have;

2. the criteria by which clients can access their money;

3. the procedure for disbursement; and

a. individual treatment plans are up to date;

b. records are complete and current; and

c. the treatment plans have been developed and implemented as ordered.

3. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or the clients of the TGH receiving services which includes, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

4. a process to review and resolve individual client issues that are identified; and

5. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above.

C. The QI program outcomes shall be documented and reported to the supervising practitioner for action, as necessary, for any identified systemic problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:417 (February 2012).

Subchapter E. Admission, Transfer, and Discharge

§6259. Admission Requirements

A. A TGH shall have written admissions policies and criteria which shall include the following:

1. intake policy and procedures;

2. admission criteria and procedures;

3. policy regarding the determination of legal status, according to appropriate state laws, before admission;

4. the age of the populations served;

5. the services provided by the TGH; and

6. criteria for discharge.

B. The written description of admissions policies and criteria shall be provided to the department upon request, and made available to the client and his/her legal representative.

C. A TGH shall not refuse admission to any client on the grounds of race, national origin, ethnicity or disability.

D. A TGH shall admit only those clients whose needs, pursuant to the pretreatment assessment and comprehensive treatment plan, can be fully met by the TGH.

E. When refusing admission to a client, the TGH shall provide a written statement to the client with the reason for the refusal. This shall be provided to the designated representative(s) of the department upon request.

F. Pretreatment Assessment. To be admitted into a TGH, the individual must have received a pretreatment assessment by the Medicaid Program, or its designee, that recommends admission into the TGH. The TGH must ensure that requirements for pretreatment assessment are met prior to treatment commencing. The referral PTA shall contain clinical information to support medical necessity to the therapeutic group home and to establish that TGH is the most appropriate service to meet the client's treatment needs.

G. The TGH shall use the pretreatment assessment to develop an initial plan of care to be used upon admission until a comprehensive treatment plan is completed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:417 (February 2012).

§6261. Transfer and Discharge Requirements

A. The goal of the therapeutic group home is to return the client to a less restrictive level of service as early as possible in the development of the plan.

B. Discharge planning begins at the date of admission, and goals toward discharge shall be continually addressed in the multi-disciplinary team meetings and when the comprehensive treatment plan is reviewed. Discharge may be determined based on the client no longer making adequate improvement in this facility (and another facility being recommended) or the client no longer having medical necessity at this level of care.

C. Continued TGH stay should be based on a clinical expectation that continued treatment in the TGH can reasonably be expected to achieve treatment goals and improve or stabilize the client’s behavior, such that this level of care will no longer be needed and the client can return to the community.

D. Transition should occur to a more appropriate level of care if the client is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care (e.g., client’s behavior and/or safety needs requires a more restrictive level of care or, alternatively, client’s behavior is linked to family functioning and can be better addressed through a family/home-based treatment).

E. Voluntary Transfer or Discharge. Upon notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services, the TGH shall have the responsibility of planning for a client’s voluntary transfer or discharge.

1. The transfer or discharge responsibilities of the TGH shall include:

a. holding a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are known, in order to

facilitate a smooth transfer or discharge, unless the client declines such a meeting;

b. providing a current comprehensive treatment plan. Upon written request and authorization by the client or authorized representative, a copy of the current comprehensive treatment plan shall be provided to the client or receiving provider;

c. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary on the health, developmental issues, behavioral issues, social issues, and nutritional status of the client. Upon written request and authorization by the client or authorized representative, a copy of the discharge summary shall be disclosed to the client or receiving provider. The written discharge summary shall be completed within five working days of the notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services. The provider's preparation of the discharge summary shall not impede or impair the client's right to be transferred or discharged immediately if the client so chooses; and

d. not coercing or interfering with the client's decision to transfer. Failure to cooperate with the client's decision to transfer to another provider will result in adverse action by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:418 (February 2012).

Subchapter F. Services

§6265. General Provisions

A. Upon admission, the TGH must conduct an Initial Diagnostic Interview. A nursing assessment shall be completed by a Registered Nurse within 24 hours of admission.

B. The TGH shall develop and implement an initial plan of care after completion of the initial diagnostic interview and utilizing the information contained in the pretreatment assessment to implement care for the client up to and until the comprehensive treatment plan is developed.

C. The TGH shall ensure that requirements for pretreatment assessment are met prior to treatment commencing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:418 (February 2012).

§6267. Comprehensive Treatment Plan

A. Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting. The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 28 days.

B. The multi-disciplinary team shall be made up of at least the supervising practitioner, clinical director, registered nurse, and therapist. The client and the client's guardian/family shall be included as treatment planning members in the development of the comprehensive treatment plan and in the update of treatment goals.

C. In the event the supervising practitioner is not present at a treatment team meeting during a review of a comprehensive treatment plan, the supervising practitioner must review and sign the comprehensive treatment plan within 10 calendar days following the meeting.

D. The provider must have an original completed, dated and signed team meeting document with signatures of all who attended as well as evidence of invitations extended to the meeting, such as copies of letters, emails or service logs.

E. The multi-disciplinary team shall identify any barriers to treatment and modify the plan in order to continue to facilitate active movement toward the time-limited treatment goals identified in the plan.

F. The TGH shall use a standardized assessment and treatment planning tool such as the *Child and Adolescent Needs and Strengths* (CANS).

G. Each client's treatment plan shall identify individualized strength-based services and supports. The individualized, strengths-based services and supports:

1. are identified in partnership with the client and his or her family and support system to the fullest possible extent and if developmentally appropriate;

2. are based on both clinical and functional assessments;

3. are clinically monitored and coordinated, with 24-hour availability;

4. are implemented with oversight from a licensed mental health professional; and

5. assist with the development of skills for daily living and support success in community settings, including home and school.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:418 (February 2012), amended LR 41:1295 (July 2015).

4. other medical and dental services as needed.

B. The TGH is required to provide at least 16 hours of active treatment per week to each client. This treatment shall be provided and/or monitored by qualified staff.

C. The TGH shall have a written plan for insuring that a range of daily indoor and outdoor recreational and leisure opportunities are provided for clients. Such opportunities shall be based on both the individual interests and needs of the client and the composition of the living group.

1. The provider shall be adequately staffed and have appropriate recreation spaces and facilities accessible to clients.

2. Any restrictions of recreational and leisure opportunities shall be specifically described in the treatment plan, together with the reasons such restrictions are necessary and the extent and duration of such restrictions.

D. The TGH shall have a program to ensure that clients receive training in independent living skills appropriate to their age and functioning level. This program shall include instruction in:

1. hygiene and grooming;

2. laundry and maintenance of clothing;

3. appropriate social skills;

4. housekeeping;

5. budgeting and shopping;

6. cooking; and

7. punctuality, attendance, and other employment related matters.

E. The TGH shall have a written description regarding the involvement of the client in work including:

1. the description of any unpaid tasks required of the client;

2. the description of any paid work assignments including the pay scales for such assignments;

3. the description of the provider's approach to supervising work assignments;

4. assurance that the conditions and compensation of such work are in compliance with applicable state and federal laws; and

5. all work assignments shall be in accordance with the client's treatment plan.

F. The provider shall assign as unpaid work for the client only housekeeping tasks similar to those performed in a normal family home. Any other work assigned shall be compensated at a rate and under such conditions as the client might reasonably be expected to receive for similar work in outside employment.

G. When a client engages in off-grounds work, the provider shall maintain written documentation that:

1. such work is voluntary and in accordance with the client's treatment plan;

2. the clinical director approves such work;

3. such work is supervised by qualified personnel; and

4. the conditions and compensation of such work are in compliance with applicable state and federal laws;

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:419 (February 2012), amended LR 41:1295 (July 2015).

§6271. Medications

A. All TGHs that store and/or dispense scheduled narcotics shall have a site-specific Louisiana controlled substance license and a United States Drug Enforcement Administration (DEA) controlled substance registration for the facility in accordance with the Louisiana Uniform Controlled Dangerous Substance Act and Title 21 of the *United States Code*.

B. The facility shall have written policies and procedures that govern the safe administration and handling of all prescription and nonprescription medications.

C. The provider shall have a written policy governing the self-administration of all medications. Such policy shall include provisions regarding age limitations for self-administration, multi-disciplinary team recommendations, and parental consent, if applicable. Those clients that have been assessed to be able to safely self-administer medications shall be monitored by qualified staff to ensure medication is taken as prescribed in the comprehensive treatment plan.

D. The provider shall ensure that medications are either self-administered or administered by qualified persons according to state law.

E. The provider shall have a written policy for handling medication taken from the facility by clients on pass.

F. The provider shall ensure that any medication given to a client for therapeutic and medical purposes is in accordance with the written order of a physician.

1. There shall be no standing orders for prescription medications.

2. There shall be standing orders, signed by the physician, for nonprescription drugs with directions from the physician indicating when he/she is to be contacted. Standing orders shall be updated annually by the physician.

3. Copies of all written orders shall be kept in the client's file.

G. The TGH shall develop and implement procedures for all discontinued and/or expired medications and containers with worn, illegible or missing labels.

H. All medications shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

1. Medications used externally and medications taken internally shall be stored on separate shelves or in separate cabinets.

2. All medications, including those that are refrigerated, shall be kept under lock and key.

I. Any TGH using psychotropic medications shall have written policies and procedures concerning the use of psychotropic medications including:

1. when used, there is medical monitoring to identify specific target symptoms;

2. procedures to ensure that medications are used as ordered by the physician for therapeutic purposes and in accordance with accepted clinical practice;

3. procedures to ensure that medications are used only when there are demonstrable benefits to the client unobtainable through less restrictive measures;

4. procedures to ensure continual physician review of medications and discontinuation of medications when there are no demonstrable benefits to the client;

5. an ongoing program to inform clients, staff, and where appropriate, client's parent(s) or legal guardian(s) on the potential benefits and negative side-effects of medications and to involve clients and, where appropriate, their parent(s) or legal guardian(s) in decisions concerning medication; and

6. training of staff to ensure the recognition of the potential side effects of the medication.

J. Current and accurate records shall be maintained on the receipt and disposition of all scheduled drugs. An annual inventory, at the same time each year, shall be conducted for all Schedule I, II, III, IV and V drugs.

K. Medications are to be administered only upon written orders, electromechanical facsimile, or oral orders from a physician or other legally authorized prescriber, taken by a licensed nurse.

L. All drug containers shall be labeled to show at least the client's full name, the chemical or generic drug's name, strength, quantity and date dispensed unless a unit dose system is utilized. Appropriate accessory and cautionary statements as well as the expiration date shall be included.

M. Medications and biologicals that require refrigeration shall be stored separately from food, beverages, blood, and laboratory specimens.

N. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician. An entry shall be made in the client's record.

O. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the clinical director, the Louisiana Board of Pharmacy, DHH Controlled Dangerous Substances Program and to the Regional Drug Enforcement Administration (DEA) office, as appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:419 (February 2012).

§6273. Food and Diet

A. The TGH shall ensure that all dietary services are provided in consultation with a Louisiana licensed registered dietician. The registered dietician shall be available regarding the nutritional needs, the special diets of individual clients and to assist in the development of policies and procedures for the handling, serving and storage of food.

B. The provider shall have written policies and procedures that ensure that a client is, on a daily basis, provided with food of such quality and in such quantity as to meet the recommended daily dietary allowances adjusted for age, gender and activity of the Food Nutrition Board of the National Research Council and doesn’t deny any rights of the client.

C. Meals, whether prepared by the facility or contracted from an outside source, shall meet the following conditions:

1. menus shall be written in advance, shall provide for a variety of nutritional foods and shall be reviewed and approved by a licensed registered dietician;

2. records of menus, as served, shall be filed and maintained for at least 30 days;

3. modified diets shall be prescribed by a physician;

4. food preparation areas and utensils shall be maintained in accordance with state and local sanitation and safe food handling standards. Pets are not allowed in food preparation and serving areas; and

5. the clinical director or house manager shall designate one staff member who shall be responsible for meal preparation/serving if meals are prepared in the facility.

D. Drinking water shall be readily available.

E. Dining areas shall be adequately equipped with tables, chairs, eating utensils and dishes designed to meet the functional needs of clients.

F. All food shall be procured, stored, prepared, distributed, and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink according to State Sanitary Code. Refrigerator temperatures shall be maintained according to State Sanitary Code. Hot foods shall leave the kitchen or steam table according to State Sanitary Code.

G. The provider shall ensure that any prescribed modified diet for a client shall be implemented and planned, prepared and served by persons who have received

instruction from the registered dietician who has approved the menu for the modified diet.

H. The provider shall ensure that a client is provided at least three meals or their equivalent daily at regular times with not more than 14 hours between the evening meal and breakfast on the following day. Specific times for serving meals shall be established and posted.

I. Bedtime nourishments shall be offered nightly to all clients, unless contraindicated by the client's medical practitioner, as documented in the client's comprehensive treatment plan.

J. The provider shall ensure that the food provided to a client in care of the provider is in accordance with his/her religious beliefs.

K. No client shall be denied food or force-fed for any reason except as medically required pursuant to a physician's written order. A copy of the order shall be maintained in the client's file.

L. When meals are provided to staff, the provider shall ensure that staff members eat the same food served to clients in care, unless special dietary requirements dictate differences in diet.

M. The provider shall ensure that food served to a client that is not consumed is discarded.

N. Written reports of inspections by the Office of Public Health shall be posted in the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:420 (February 2012).

§6275. Transportation

A. A TGH provider shall arrange for or provide transportation necessary for implementing the client’s treatment plan.

B. Any vehicle used to transport clients, whether such vehicle is operated by a staff member or any other person acting on behalf of the facility, shall be:

1. properly licensed and inspected in accordance with state law;

2. maintained in a safe condition;

3. operated at a temperature that does not compromise the health, safety or needs of the client; and

4. operated in conformity with all of the applicable motor vehicle laws.

C. The facility shall have documentation of current liability insurance coverage for all owned and non-owned vehicles used to transport clients. The personal liability insurance of a facility’s employee shall not be substituted for the required coverage.

D. Any staff member of the facility, or other person acting on behalf of the facility, who is operating a vehicle for the purpose of transporting clients shall be properly licensed to operate that class of vehicle in accordance with state law.

E. Upon hire, the facility shall conduct a driving history record of each employee, and annually thereafter.

F. The facility shall not allow the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the vehicle.

G. The facility shall ascertain the nature of any need or problem of a client which might cause difficulties during transportation. This information shall be communicated to agency staff responsible for transporting clients.

H. The following additional arrangements are required for transporting non-ambulatory clients and those who cannot otherwise be transferred to and from the vehicle.

1. A ramp device to permit entry and exit of a client from the vehicle shall be provided for vehicles. A mechanical lift may be utilized, provided that a ramp is also available in case of emergency, unless the mechanical lift has a manual override.

2. Wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners.

3. The arrangement of the wheelchairs shall not impede access to the exit door of the vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:421(February 2012).

Subchapter G. Client Protections

§6279. Client Rights

A. A TGH must develop and implement policies to protect its client’s rights and to respond to questions and grievances pertaining to these rights. A TGH and its staff shall not violate a client’s rights.

B. A client shall be granted at least the following rights:

1. the right to be informed of the client's rights and responsibilities in advance of furnishing or discontinuing client care;

2. the right to have a family member, chosen representative and/or his or her own physician notified promptly of admission to the TGH;

3. the right to receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or source of payment;

4. the right to be treated with consideration, respect and recognition of their individuality, including the need for privacy in treatment;

5. the right to receive, as soon as possible, the services of a translator or interpreter, if needed, to facilitate

communication between the client and the TGH's health care personnel;

6. the right to participate in the development and implementation of his/her treatment plan;

7. the right to make informed decisions regarding his/her care by the client or in the case of a minor, the client's parent, guardian or responsible party, whichever is applicable in accordance with appropriate laws and regulations;

8. the right to be informed of his/her health status, and be involved in care planning and treatment;

9. the right to be included in experimental research only when he/she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent client or a minor client in accordance with appropriate laws and regulations. The client may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

10. the right to be informed by the attending physician and other providers of health care services about any continuing health care requirements after the client's discharge from the TGH. The client shall also have the right to receive assistance from the physician and appropriate TGH staff in arranging for required follow-up care after discharge;

11. the right to consult and communicate freely and privately with his/her parent(s) or legal guardian(s), if permitted in the comprehensive treatment plan;

12. the right to consult freely and privately with legal counsel;

13. the right to make complaints without fear of reprisal;

14. the right to communicate via a telephone, as allowed by the comprehensive treatment plan;

15. the right to send and receive mail as allowed by the comprehensive treatment plan;

16. the right to possess and use personal money and belongings, including personal clothing, subject to rules and restrictions imposed by the TGH;

17. the right to visit or be visited by family and friends subject only to reasonable rules and to any specific restrictions in the client's treatment plan. The reasons for any special restrictions shall be recorded in the client's treatment plan;

18. the right to have the individual client's medical records, including all computerized medical information, kept confidential;

19. the right to access information contained in his/her medical records within a reasonable time frame, subject to restrictions imposed in the comprehensive treatment plan;

20. the right to be free from all forms of abuse and harassment;

21. the right to receive care in a safe setting;

22. the right to be informed in writing about the TGH's policies and procedures for initiation, review and resolution of client complaints;

23. the right to have access to appropriate educational services consistent with the client's abilities and needs, taking into account his/her age and level of functioning;

24. the right to indoor and outdoor recreational and leisure opportunities;

25. the right to attend religious services in accordance with his/her faith. Clients shall not be forced to attend religious services; and

26. the right to choose a provider, the right to be discharged from his current provider and be transferred to another provider, and the right to discontinue services altogether unless prohibited by court order.

C. In addition to the rights listed herein, clients have the rights provided in the Louisiana Mental Health Law and the Louisiana Children's Code.

D. A TGH shall provide a copy of the client's rights to each client upon admission and shall have documentation of each client who received a copy of them.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:421 (February 2012).

§6281. Grievances

A. The provider shall have a written grievance procedure for clients designed to allow clients to make complaints without fear of retaliation. The procedure shall include, but not be limited to:

1. a time line for responding to grievances;

2. a method of responding to grievances;

3. a procedure for filing a grievance; and

4. staff responsibilities for handling grievances.

B. The provider shall have documentation reflecting that the client and the client's parent(s) or legal guardian(s) are aware of and understand the grievance procedure.

C. The provider shall have documentation reflecting the resolution of the grievance in the client's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:422 (February 2012).

Subchapter H. Physical Environment

§6285. General Provisions

A. Location of Therapeutic Group Homes. To ensure a more home-like setting, the TGH shall be located in a residential community to facilitate community integration

through public education, recreation, and maintenance of family connections. The setting must be geographically situated to allow ongoing participation of the child's family. The child or adolescent must attend a school in the community (e.g., a school integrated with children not from the institution and not on the institution's campus). In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

B. The living setting shall more closely resemble normal family existence than would be possible in a larger facility or institution.

C. Providers shall develop an environment conducive to the client safely restoring previous levels of functioning and enhancing existing levels of functioning. In addition the provider shall maintain a community-based non-institutional environment.

D. The TGH shall have an effective pest control plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:422 (February 2012).

§6287. Interior Space

A. The arrangement, appearance and furnishing of all interior areas of a TGH shall be similar to those of a normal family home within the community.

B. The provider shall ensure that there is evidence of routine maintenance and cleaning programs in all areas of the home.

C. A home shall have a minimum of 60 square feet of floor area per client in living areas accessible to the clients and excluding halls, closets, bathrooms, bedrooms, staff or staff's family quarters, laundry areas, storage areas and office areas.

D. Client Bed Rooms

1. Single rooms must contain at least 80 square feet and multi-bed rooms shall contain at least 50 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment. Rooms shall have at least a 7 1/2 foot ceiling height over the required area. In a room with varying ceiling height, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space.

2. Any client bedrooms shall not contain more than two beds.

a. Exception. If a child residential facility currently licensed by DCFS is converting to a TGH and has more than two clients per bedroom, then the converted TGH may have bedroom space that allows no more than four clients per designated bedroom.

3. There shall be at least three feet between beds.

4. There shall be sufficient and satisfactory separate storage space for clothing, toilet articles and other personal belongings of clients.

5. There shall be a door for privacy to each individual bedroom. The doors shall not be equipped with locks or any other device that would prohibit the door from being opened from either side.

6. There shall be a functional window in each bedroom.

7. The provider shall ensure that sheets, pillow, bedspread and blankets are provided for each client.

8. Each client shall have his/her own dresser or other adequate storage space for private use and designated space for hanging clothing in proximity to the bedroom occupied by the client.

9. No client over the age of five years shall occupy a bedroom with a member of the opposite sex.

10. The provider shall ensure that the age of client sharing bedroom space is not greater than four years in difference unless contraindicated based on diagnosis, the treatment plan or the behavioral health assessment of the client.

11. Each client shall have his/her own bed. A client's bed shall be longer than the client is tall, no less than 30 inches wide, of solid construction and shall have a clean, comfortable, nontoxic fire retardant mattress.

E. Dining Areas

1. The facility shall have dining areas that permit clients, staff and guests to eat together in small groups.

2. A facility shall have dining areas that are clean, well lit, ventilated and attractively furnished.

F. Bathrooms

1. A facility shall have wash basins with hot and cold water, flush toilets, and bath or shower facilities with hot and cold water according to client care needs. Plumbing fixtures delivering hot water shall be protected by an approved scald control mechanism at the fixture.

2. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene unless clients are individually given such items. Clients shall be provided individual items such as hair brushes and toothbrushes.

3. Tubs and showers shall have slip proof surfaces.

4. A facility shall have toilets and baths or showers that allow for individual privacy unless the clients in care require assistance.

5. Toilets, wash basins and other plumbing or sanitary facilities in a facility shall, at all times, be maintained in good operating condition and shall be kept free of any materials that might clog or otherwise impair their operation.

6. A TGH shall have at least one separate toilet, lavatory, and bathing facility for the staff.

7. In a multi-level home, there shall be at least one toilet bowl with accessories, lavatory basin and bathing facility reserved for client use on each client floor.

8. The TGH shall meet the following ratios:

a. one lavatory per six clients;

b. one toilet per six clients; and

c. one shower or tub per six clients.

9. Bathrooms shall contain shatterproof mirrors secured to the walls at convenient heights and other furnishings necessary to meet the clients' basic hygienic needs.

G. Kitchens

1. Kitchens used for meal preparations shall have the equipment necessary for the preparation, serving, storage and clean up of all meals regularly served to all of the clients and staff. If clients prepare meals, additional equipment and space is required. All equipment shall be maintained in proper working order.

2. The provider shall ensure that all dishes, cups and glasses used by clients are free from chips, cracks or other defects and are in sufficient number to accommodate all clients.

3. There shall be trash containers in the kitchen and dining area. Trash containers in kitchens and dining area shall be covered.

H. Laundry. The provider shall have a laundry space complete with washer and dryer.

I. Staff Quarters. The provider utilizing live-in staff shall provide adequate, separate living space with a private bathroom for these staff.

J. Administrative and Counseling Area

1. The provider shall provide a space that is distinct from client's living areas to serve as an administrative office for records, secretarial work and bookkeeping.

2. The provider shall have a designated space to allow private discussions and counseling sessions between individual clients and staff, excluding, bedrooms and common living areas.

K. Furnishings

1. The provider shall have comfortable customary furniture as appropriate for all living areas. Furniture for the use of clients shall be appropriately designed to suit the size and capabilities of the clients.

2. The provider shall promptly replace or repair broken, run-down or defective furnishings and equipment.

L. Doors and Windows

1. The provider shall provide insect screens for all windows that can be opened. The screens shall be in good repair and readily removable in emergencies.

2. The provider shall ensure that all closets, bedrooms and bathrooms are equipped with doors that can be readily opened from both sides.

3. Windows or vents shall be arranged and located so that they can be opened from the inside to permit venting of combustion products and to permit occupants direct access to fresh air in emergencies. The operation of windows shall be restricted to inhibit possible escape or suicide. If the home has an approved engineered smoke control system, the windows may be fixed. Where glass fragments pose a hazard to certain clients, safety glazing and/or other appropriate security features shall be used. The windows shall be covered for privacy, and the coverings shall pose no safety hazard for the clients living in the home.

M. Storage

1. The provider shall ensure that there are sufficient and appropriate storage facilities.

2. The provider shall have securely locked storage space for all potentially harmful materials. Keys to such storage spaces shall only be available to authorized staff members.

N. Electrical Systems

1. The provider shall ensure that all electrical equipment, wiring, switches, sockets and outlets are maintained in good order and in safe condition.

2. The provider shall ensure that any room, corridor or stairway within a facility shall be well lit.

O. Heating, Ventilation and Air Conditioning

1. The provider shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of all clients.

2. The provider shall not use open flame heating equipment or portable electrical heaters.

3. All gas heating units and water heaters must be vented adequately to carry the products of combustion to the outside atmosphere. Vents must be constructed and maintained to provide a continuous draft to the outside atmosphere in accordance with the recommended procedures of the American Gas Association Testing Laboratories, Inc.

4. All heating units must be provided with a sufficient supply of outside air so as to support combustion without depletion of the air in the occupied room.

P. Smoking shall be prohibited in all areas of the TGH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:422 (February 2012).

§6291. Equipment

A. Equipment shall be clean and in good repair for the safety and well-being of the clients.

B. Therapeutic, diagnostic and other client care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. Methods for cleaning, sanitizing, handling and storing of all supplies and equipment shall be such as to prevent the transmission of infection.

D. After discharge of a client, the bed, mattress, cover, bedside furniture and equipment shall be properly cleaned. Mattresses, blankets and pillows assigned to clients shall be in a sanitary condition. The mattress, blankets and pillows used for a client with an infection shall be sanitized in an acceptable manner before they are assigned to another client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:424 (February 2012).

Subchapter I. Facility Operations

§6293. Safety and Emergency Preparedness

A. General Safety Practices

1. A provider shall not maintain any firearms or chemical weapons at any time.

2. A facility shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers and labeled as to the contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of clients, staff and visitors.

3. Adequate supervision/training shall be provided where potentially harmful materials such as cleaning solvents and/or detergents are used.

4. A facility shall ensure that a first aid kit is available in the facility and in all vehicles used to transport clients.

5. Medication shall be locked in a secure storage area or cabinet.

6. Fire drills shall be performed at least once a month.

B. Emergency Preparedness

1. A disaster or emergency may be a local, community-wide, regional or statewide event. Disasters or emergencies may include, but are not limited to:

a. tornados;

b. fires;

c. floods;

d. hurricanes;

e. power outages;

f. chemical spills;

g. biohazards;

h. train wrecks; or

i. declared health crisis.

2. Continuity of Operations. The provider shall have a written emergency preparedness plan to maintain continuity of the agency’s operations in preparation for, during and after an emergency or disaster. The plan shall be designed to manage the consequences of all hazards, declared disasters or other emergencies that disrupt the provider’s ability to render care and treatment, or threatens the lives or safety of the clients.

3. The provider shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency. The plan shall include, at a minimum:

a. provisions for the evacuation of each client, delivery of essential services to each client, whether the client is in a shelter or other location;

b. provisions for the management of staff, including provisions for adequate, qualified staff as well as for distribution and assignment of responsibilities and functions;

c. provisions for back-up staff;

d. the method that the provider will utilize in notifying the client's family or caregiver if the client is evacuated to another location either by the provider or with the assistance or knowledge of the provider. This notification shall include:

i. the date and approximate time that the facility or client is evacuating;

ii. the place or location to which the client(s) is evacuating which includes the name, address and telephone number; and

iii. a telephone number that the family or responsible representative may call for information regarding the provider's evacuation;

e. provisions for ensuring that supplies, medications, clothing and a copy of the service plan are sent with the client, if the client is evacuated; and

f. the procedure or methods that will be used to ensure that identification accompanies the client. The identification shall include the following information:

i. current and active diagnosis;

ii. medication, including dosage and times administered;

iii. allergies;

iv. special dietary needs or restrictions; and

v. next of kin, including contact information.

4. If the state, parish or local Office of Homeland Security and Emergency Preparedness (OHSEP) orders a mandatory evacuation of the parish or the area in which the agency is serving, the agency shall ensure that all clients are evacuated according to the agency's emergency preparedness plan.

5. The provider shall not abandon a client during a disaster or emergency. The provider shall not evacuate a client to a shelter without ensuring staff and supplies remain with the client at the shelter, in accordance with the client's treatment plan.

6. Emergency Plan Review and Summary. The provider shall review and update its emergency preparedness plan at least annually.

7. The provider shall cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and shall provide information as requested.

8. The provider shall monitor weather warnings and watches as well as evacuation order from local and state emergency preparedness officials.

9. All TGH employees shall be trained in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for all personnel.

10. Upon request by the department, the TGH shall submit a copy of its emergency preparedness plan and a written summary attesting how the plan was followed and executed. The summary shall contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of all injuries and deaths of clients that occurred during execution of the plan, evacuation or temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:424 (February 2012).