Variance to Minnesota Rules, Chapter 2960 for Children's Psychiatric Residential Treatment Facilities (PRTF)

To license holders the following document is provided as an educational tool to integrate both standards and regulations under the Minnesota Rule 2960 Variance for PRTF and Federal Regulations for PRTF.

Color Codes
"Black" indicates 2960 variance language
"Orange" indicates Federal regulation
" Blue" indicates stakeholder and internal recommendations.

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R2960V.01 PURPOSE.

The purpose is to define PRTF and establish the licensing standards that pertain to the program. The requests for PRTF are further defined within the body of this document.

By granting this variance, the Department relieves license holders from the requirements of Minnesota Rules, Chapter 2960. This variance contains alternative conditions license holders must meet in order to be licensed under chapter 2960 as a Children's Psychiatric Residential Treatment Facility. If there are any conditions under chapter 2960 that license holders are still expected to meet to operate as a Children's Psychiatric Residential Treatment Facility, those conditions are written into this variance, for convenience

R2960V.02 APPLICABLE REGULATIONS.

Subpart 1. In addition to the requirements in this variance, license holders must also comply with all other applicable laws, requirements, and standards, some of which are not enforced as licensing standards. In addition to this variance, the following requirements are enforced by Department of Human Services, Licensing Division:

(1) Minnesota Statutes, chapter 245A;
(2) Minnesota Statutes, sections 626.556, 626.557, and 626.5572;
(3) Minnesota Statutes, chapter 245C; and
(4) Minnesota Rules, chapter 9544.

Subpart 2. License holders must comply with the Code of Federal Regulations, title 42, sections 441.150 to 441.182 and be approved by the designated survey and certification group as meeting the conditions of participation.

License holder must be accredited by a national organization that has been approved by CMS, examples:

(1) Joint Commission on Accreditation of healthcare organizations;
(2) The Commission on Accreditation of Rehabilitation Facilities; or
(3) The Council of Accreditation Services for Families and Children.

R2960V.03 DEFINTIONS.

Subpart 1. **Active Treatment**. "Active Treatment" means implementation of a professionally developed and supervised individual plan of care, designed to achieve the resident's discharge from a PRTF status at the earliest possible time.

Subpart 2. **Case Manager.** "Case manager" means a person who is employed by a county or tribe or an agency contracted with the county or tribe who is responsible to provide the individual with assistance to gain access to needed medical, social, educational, vocational and other necessary services.

Subpart 3**. Clinical Supervision.** "Clinical Supervision" means the mental health professional must provide supervision in the development, modification, and implementation of individual treatment plan and the service components provided by each program. All treatment areas are driven by the mental health professional through clinical oversight, role modeling, review and evaluation of treatment.

Subpart 4. **Commissioner.** "Commissioner" means the Commissioner of Human Services or the commissioner's designated representative including county agencies and private agencies.

Subpart 5. **Critical incident.** "Critical incident" means an occurrence which involves a resident and requires the program to make a response that is not a part of the program's ordinary daily routine. Examples of critical incidents include, but are not limited to, suicide, attempted suicide, homicide, death of a resident, injury that is either life-threatening or requires medical treatment, fire which requires fire department response, alleged maltreatment of a resident, assault of a resident, assault by a resident, client-to-client sexual contact, or other act or situation which would require a response by law enforcement, the fire department, an ambulance, or another emergency response provider.

Subpart 6. **Department**. "Department" means the Minnesota Department of Human Services.

Subpart 7. **Direct Services. "**Direct Services" means providing face-to-face care and treatment, training, supervision, counseling, consultation, or medication administration, assistance and management to individuals served by the program.

Subpart 8. **Family**. "Family" means a person or people committed to the support of the individual receiving services, regardless of whether they are related or live in the same household.

Subpart 9. **Hospital Leave Day**. "Hospital leave day" means when a resident requires admission to a hospital for medical or acute psychiatric care and is temporarily absent from the PRTF.

Subpart 10. **Imminent Risk of Harm**. "Imminent risk of Harm" means a behavior that is likely to cause physical harm to self or others that is highly likely to occur in the immediate future.

Subpart 11. **Individual plan of Care.** "Individual plan of care" means a written plan developed for each resident to improve the resident's condition to the extent that psychiatric residential treatment is no longer necessary.

Subpart 12. **Legal Representative.** "Legal representative" means a guardian, conservator, or guardian ad litem of a child with an emotional disturbance, authorized by the court to make decisions about mental health services for the child.

Subpart 13. **License holder**. "License holder" has the meaning given it in Minnesota Statutes, section 245A.02, subdivision 9.

Subpart 14. **Living Unit.** "Living unit" means a set of rooms that are physically self-contained, have the defining walls extending from floor to ceiling and include bedrooms, living rooms or lounge areas, bathrooms, and connecting areas.

Subpart 15. **Manual Restraint.** "Manual restraint" means the physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.

Subpart 16. **Mechanical restraint.** "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body that limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. Mechanical restraint does not include the following: devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which not, in and of themselves, restrict freedom of movement; or the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manager a medical condition.

Subpart 17. **Mental health practitioner.** "Mental health practitioner" has the meaning given it in Minnesota Statutes, section 245.4871, subdivision 26.

Subpart 18**. Mental health professional**. "Mental health professional" has the meaning given it in Minnesota Statutes, section 245.4871 subdivision 27, 1 through 6.

Subpart 19. **Monthly**. "Monthly" means at least once every calendar month.

Subpart 20. **Person-centered planning**. Person-centered planning means a strategy used to facilitate team-based plans for improving a person's quality of life as defined by the person, the person's family, and other members of the community, and that focuses on the person's preferences, talents, dreams, and goals.

Subpart 21. **Positive support strategy**. "Positive support strategy" means a strength-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skill or alternative strategies and behaviors without the use of restrictive interventions.

Subpart 22. **Psychiatric practitioner**. "Psychiatric practitioner" means a physician licensed under Minnesota Statutes, chapter 147, who is certified by the American Board of Psychiatry and Neurology or is eligible for board certification. A psychiatric registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, and is certified as a clinical nurse specialist or a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization.

Subpart 23. **Registered nurse (RN)**. "Registered nurse" or "RN" has the meaning the individual has specialized training or one year's experience in treating mentally ill individuals.

Subpart 24. **Seclusion**. "Seclusion" means (i) removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to

hold the door closed or otherwise prevent the person from leaving the room; or (ii) otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return.

Subpart 25. **Serious injury.** "Serious injury" means any significant impairment of the physical condition of the resident as determined by a qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Subpart 26 **Staff or staff member**. "Staff" or "staff member" means a person who works under the direction of the license holder regardless of their employment status. This includes but is not limited to interns, consultants, individuals who work part-time, and individuals who do not provide direct care services, but does not include volunteers.

Subpart 27. Therapeutic leave day. "Therapeutic leave day" means for the purpose of preparing for discharge and reintegration.

Subpart 28. **Time Out.** "Time out" means the restriction of a resident for a period of time to a designated area that is staff directed from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

Subpart 29. **Treatment team**. "Treatment team" means the individual, staff, family and designated agency as applicable who provide services under this variance to individuals.

Subpart 30. **Volunteer**. "Volunteer" means a person who, under the direction of the license holder, provides services or an activity without pay to an individual served by the license holder.

Subpart 31. **Weekly**. "Weekly" means at least once every calendar week. The license holder must define the calendar week.

R2960V.04 RESIDENT RIGHTS.

Subpart 1. **Basic rights**. A resident has basic rights including, but not limited to, the rights in this subpart. The license holder must ensure that the rights in items A to R are protected:

A. right to reasonable observance of cultural and ethnic practice and religion;
B. right to a reasonable degree of privacy;
C. right to participate in development of the resident's treatment and case plan;
D. right to positive and proactive adult guidance, support, and supervision;
E. right to be free from abuse, neglect, inhumane treatment, and sexual exploitation;
F. right to needed medical care;
G. right to nutritious and sufficient meals and sufficient clothing and housing;
H. right to live in clean, safe surroundings;
I. right to receive a public education;
J. right to reasonable communication and visitation with adults outside the facility, including parents, extended family members, siblings, a legal guardian, a caseworker, an attorney, a

therapist, a physician, a religious advisor, a case manager, or another important person in the resident's life, in accordance with the resident's treatment plan;

K. right to daily bathing or showering and reasonable use of materials, including culturally specific appropriate skin care and hair care products or any special assistance necessary to maintain an acceptable level of personal hygiene;

L. right of access to protection and advocacy services, including the state-appointed ombudsman and federal protection and advocacy program, parent, guardian and/or legal representative present for debriefing after the use of seclusion and restraint.

M. right to retain and use a reasonable amount of personal property;

N. right to courteous and respectful treatment;

O. if applicable, the rights stated in Minnesota Statutes, sections 144.651 and if applicable Minnesota Statutes, section 253B.04.

P. right to be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

Q. right to be informed of and to use a grievance procedure; and

R. right to be free from restraint and seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation

Subpart 2. **Basic rights information**. The license holder must meet the requirements of this subpart.

A. Upon admission, the license holder must document that that license holder provided the resident a copy of the resident's basic rights information and explain these rights to the resident in a language that the resident can understand. Within five days, the license holder must give the resident's parent, legal guardian, or custodian a written copy of the resident's basic rights information.

B. A copy of the resident's rights must be available where it can be readily accessed by staff and the resident.

Subpart 3. **Resident and family grievance procedures**.

A. The license holder must develop and follow a written grievance procedure that allows a resident, the resident's parent or legal representative, a resident's legal guardian, or a concerned person in the resident's life to make a formal complaint, provide suggestions, or express a concern about any aspect of the resident's care during the resident's stay in the facility. The license holder and staff must not attempt to influence a resident's statement about the facility in the grievance document or during an investigation resulting from the grievance. The written grievance procedure must require, at a minimum, that:

(1) the license holder must give the person who wants to make a grievance the necessary forms and any assistance needed to file a grievance;

(2) the license holder must identify the person who is authorized to resolve the complaint and to whom an initial resolution of the grievance may be appealed and, upon request, a license holder must carry a grievance forward to the highest level of administration of the facility;

(3) a person who reports a grievance must not be subject to adverse action by the license holder as a result of filing the grievance; and

(4) a person filing a grievance must receive a written response within five days.

B. If a grievance is filed, the license holder must document the grievance along with the investigation findings and resulting action taken by the license holder. Information regarding the grievance must be kept on file at the facility for five years.

R2960V.05 ADMISSION, CONTINUED STAY, AND DISCHARGE.

Subpart 1. **Admission Criteria.** The license holder must develop and maintain admission criteria for the program that meets the requirements under this section. The requirements do not prohibit the license holder from restricting admissions or transferring residents who present an imminent danger to themselves or others.

A. The license holder must:
   (1) Identify what information the license holder requires to make a determination concerning an admission referral; and
   (2) Consider the program's staffing patterns and competencies of staff when making a determination concerning whether the program is able to meet the needs of a person seeking admission.

B. Resident must meet the eligibility criteria outlined in Minnesota Statute, section 256B.0941, subdivision 1.

Facility must have a provider agreement with Minnesota Health Care Program provider enrollment to provide PRTF benefit to Medicaid-eligible individuals under the age of 21 (residents who reach age 21 at the time they are receiving services until they no longer require services or until they reach age 22, whichever occurs first.)

Subpart 2. **Continued Stay Criteria** When a continued stay at the facility is needed, it is the responsibility of the resident's multidisciplinary treatment team and the clinical director to establish that the requirements for a continued stay have been met.

All of the following criteria are necessary for continuing treatment at this level of care and recertification of continued stay:

A. The child/adolescent's condition continues to meet admission criteria at this level of care;
B. The resident does not require a more intensive level of care, and a less intensive level of care would not be appropriate;
C. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
D. If treatment progress is not evident, then there is documentation of adjustments to the individual plan of care a minimum of every 30 days to address such lack of progress;
E. Submit documentation to the medical review agent every 30 days indicating resident continues to meet medical necessity.
F. Care is rendered in a clinically appropriate manner and focused on the resident's functional outcomes.

Subpart 3. **Discharge Criteria**. All discharge planning that occurs throughout a resident's care must reflect best practices, and comply with the Olmstead plan and person-centered practices. The following criteria must be met for a resident discharge:

A. The child or adolescent can be safely treated at an alternative level of care;
B. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place;
C. In addition to A and B above, any one or more of criteria 1 through 5 must be met:
    (1) The resident's documented treatment plan goals and objectives have been substantially met or a safe, continuing care program can be arranged and deployed at;
    (2) The resident no longer meets admission criteria, or meets criteria for a less or more intensive level of care;
    (3) The resident, or family member, guardian, or custodian are competent but non-participatory in treatment or in following the program rules and regulations and there is non-participation to such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address nonparticipation issues;
    (4) Consent for treatment is withdrawn, and it is determined that the resident, parent, or guardian has the capacity to make an informed decision and the resident does not meet criteria for an emergency hold per Minnesota Statute, section 253B.05, subdivision 1.
    (5) The resident is not making progress toward treatment goals despite persistent efforts to engage him or her, and there is no reasonable expectation of progress at this level of care; nor is the level of care required to maintain the current level of function.

R2960V.06 TREATMENT PROGRAMMING.

Subpart 1. **Active treatment**. Psychiatric residential treatment services must involve active treatment seven days a week.

A. Active treatment is:
    (1) The implementation of services immediately upon admission outlined in a plan of care;
    (2) The continuous and intentional interaction between the resident and staff;
    (3) Designed to meet the mental health needs of the resident that necessitated the admission to the PRTF;
    (4) Supervised by a licensed mental health professional who is responsible for the care of the resident; and
    (5) Determining length of stay based on the resident's needs and not on the program structure.
B. Facilities providing active treatment will:
    (1) Provide a safe, nurturing, non-hostile and therapeutic milieu to residents;
    (2) Document the delivery and response to treatment;
    (3) Provide a flexible schedule to facilitate family involvement in treatment;
    (4) Include, at an appropriate time, post-discharge plans and coordination of services with transition discharge plans and related community services to ensure continuity of care with the resident's family, school, and community upon discharge.
C. Treatment services include the following:
    (1) Active treatment seven days per week, which may include individual, family, or group therapy as identified in the individual plan of care;
    (2) Individual therapy, provided a minimum of twice per week;
    (3) Family engagement activities, provided a minimum of once per week;

(4) Consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners;
(5) Coordination of educational services between local and resident school districts and the facility;
(6) Nursing 24 hours and seven days a week; and
(7) Direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Subpart. 2. **Individualized Program**. Each resident shall be prescribed an individualized program that does the following:

A. Includes obtaining all medically necessary services the resident needs while a resident of the facility;
B. Addresses their specific needs and maximizes functioning in activities of daily living, education, and vocational preparation;
C. Is designed to improve the person's mental health resiliency and recovery;
D. Builds upon the strengths and preferences of the resident and their family identified in the plan of care;
E. Includes family involvement with a focus towards the resident and family's presenting problem(s) with assistance given to identify resources and discover solutions;
F. Is culturally and spiritually responsive as defined by the resident and family;
G. Consists of multiple and various treatment offerings that are trauma informed and person centered and provided immediately upon admission and continuing during the day, evening, and weekends;
H. All PRTF service staff in regular contact with the resident are aware and understand each resident's needs, goals and services identified on the plan of care; and
I. Staff engage residents in continuous and intentional interaction designed to meet the resident's needs regardless of the setting or activity during all waking hours including day, evening, and weekends.

R2960.07 REQUIRED SERVICE COMPONENTS AND DOCUMENTATION.

Treatment Team.

A. The team must include, as a minimum, either
(1) A Board-eligible or Board-certified psychiatrist;
(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.
B. The team must also include one of the following:
(1) A psychiatric social worker.
(2) A registered nurse.
(3) An occupational therapist.

(4) A psychologist.

Subpart 1. **Individual plan of care.** License holder must comply with the following:

A. Within 24 hours, an immediate needs assessment and preliminary plan of care must be completed including the following:
   (1) An assessment of needs related his/her health and safety, including specific measures to minimize risks;
   (2) Minimally one primary treatment goal/objectives/interventions; and
   (3) The resident's treatment schedule.

B. Implemented no later than 10 days after admission to the facility the license holder must develop a more formalized individualized plan of care that must comply with the following:
   (1) The plan of care is individualized and appropriate to the resident's changing condition;
   (2) The multidisciplinary treatment team will meet to review/revise each resident and plan of care as often as necessary to provide optimum treatment but at least once during the first 10 days following admission and every 30 days thereafter with consideration of all applicable and appropriate treatment modalities;
   (3) Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement;
   (4) Specific treatment modalities and/or strategy interventions will be employed to reach each objective with identification of the staff who are responsible to deliver the interventions and frequency of the interventions;
   (5) For individuals who display issues related to inappropriate chemical use, but who do not have a sufficient chemical use history to refer to treatment the license holder must provide education about chemical health to the resident. The education must provide the individual with opportunities to examine the problems associated with inappropriate chemical use.
   (6) For individuals that display behaviors that may require the use of restraint or seclusion, an individual support plan must be developed. The support plan will be developed with the individuals' involvement that identifies target behaviors, triggers, coping skills, precursors and a plan to assist the individual during crisis.
   (7) The date it was completed or updated.
   (8) The resident and legal guardian's signature to acknowledge his/her participation in the development and revisions of the plan of care. If the resident and/or legal guardian refuses to participate in the development of their plan of care or subsequent revisions, the refusal must be documented in the resident's individual file.
   (9) The signature(s) and title(s) of the multidisciplinary team who completed or update the plan of care and the signature of the mental health professional who approved the plan of care.

A. Plan of Care must be based on a diagnostic evaluation that includes:
   (1) An assessment of the medical, psychological, social, behavioral and developmental aspects of the resident's situation and reflects the need for psychiatric residential treatment;
   (2) Includes strengths and preferences and address any other needs which may have been identified, including the assessment of trauma and family resources; and

(3) Identification of the clinical problems that are to be the focus of treatment;

B. Must be developed by an inter-disciplinary team of physicians and other personnel who provide services to residents, and implemented no later than 14 days after admission and reviewed every 30 days.

C. Development and review of plan of care includes resident, parent(s), legal guardians, or others in whose care he/she will be released after discharge;

D. Plan of care must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

E. Post discharge plans and coordination of residential services with partial discharge plans and related community services to ensure continuity of care with the resident's family, school, and community upon discharge.

Subpart 2. **Therapeutic and Hospital Leave Days.** The license holder must document therapeutic and hospital leave days in the resident record. Therapeutic leave day(s) must be included in the individual plan of care that lists out the objective for the leave day. The therapeutic leave visit may not exceed three days per visit without prior authorization.

Subpart 3. **Discharge Planning.**

A. Discharge planning for the resident shall begin upon admission to the PRTF. This process should include the community based provider where the youth will be discharging to if determined, the treatment team and other facility staff, and the resident and their legal guardian when possible.

B. Prior to discharge, the license holder shall prepare an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care. The aftercare plan shall include the following:

(1) Medical needs including allergies;
(2) Medication, dosage, clinical rationale, and name of prescriber;
(3) Discharge diagnosis and treatment summary;
(4) Prevention plan to address symptoms of harm to self or others;
(5) Any other essential recommendations;
(6) Appointments with after discharge service providers indicating date, time, and place;
(7) Contact information for internal providers;
(8) Education contact number from the PRTF education provider

C. License holder shall submit documents related to the resident's care in their facility to any mental health provider who will be providing aftercare.

Includes discharge planning upon admission and based on the resident's needs and achievement of goals and objectives identified in an individualized, measurable and goal-directed treatment plan;

Subpart 4**. No eject policy.** A license holder must have a written no eject policy. Before administratively discharging a resident who has not reached the resident's treatment plan goals the license holder must confer with other interested persons to review the issues involved in the decision. During this review process, which must not exceed five working days, the license holder must determine whether the license holder, treatment team, interested persons, if any, and the resident can develop additional strategies to resolve the issues leading to the discharge and to permit the resident an opportunity to continue to receive services from the license holder. If the review indicates that the decision to discharge is warranted, the reasons for it and the alternatives considered or attempted must

be documented. A resident may be temporarily removed from the facility during the five-day review period. This subpart does not apply to a resident removed by the parent, guardian or payer.

R2960V.08 HEALTH CARE SERVICES AND MEDICATION.

Subpart 1. **Health care services description.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the license holder.

Subpart 2. **Health Services Monitoring and Supervision.** The following nursing services must be provided by the license holder. The individual responsible for these services must be a registered nurse. The nurse shall be responsible for the development of policies, procedures, and forms to assure (A) through (L) are met. The nurse is also responsible to assure that staff are trained and supervised related to (A) through (L).

A. Provides for a health screening of each resident within 72 hours of admission;
B. Provides a system for on-going monitoring and addressing the health needs of residents;
C. Addresses any special needs of the resident population served by the program; and
D. Addresses the needs of residents with co-occurring disorders.
E. Guidelines regarding when to inform the registered nurse of residents' health concerns and in what circumstances and how to attain medical care for residents;
F. Referrals to and coordination with community psychiatric and medical services occur in a timely manner;
G. Medical and health documentation is accurate, thorough, and maintained appropriately. The documentation must include recording significant medical or health related information, including but not limited to results of assessments for medication compliance and results of assessments of medication side effects;
H. Ongoing consultation and advice concerning the health and medical care of residents is provided to staff;
I. Routinely assessing and documenting residents for medication side effects and drug interactions;
J. Ensuring medication management treatment and goal(s) are reflected on the treatment plan; and
K. Medications are administered safely and accurately. This must include establishing methods for the following:
    (1) When and how staff are to inform the registered nurse or physician of problems or issues with residents' medication administration by staff or observation of self-administration of medications, including the failure to administer, refusal of medication, adverse reactions to medications and errors in administering medications;
    (2) Access to information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;
    (3) Procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic. A provision that delegations of administration

of medication are limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;

(4) A provision that clients may carry emergency medication such as Epi-pen as instructed by their physician;

(5) A provision for medication to be self-administered when a client is scheduled not to be at the facility or the parent may only administer medication to the child while not at the facility;

(6) Requirements for recording the client's use of medication, including staff signatures with date and time;

(7) Training of staff who are responsible for administering medications, including direct observation of staff who are being trained to administer medications to evaluate their competency before independently administering medications.

(8) A license holder must meet the requirements in items (a) and (b) if medication is administered by a staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse:

a) Document that the staff member has successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. Completion of the course must be documented in writing and placed in the staff member's personnel file; or

b) Be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder. Completion of the course must be documented in writing and placed in the staff member's personnel records.

L. Effective and prompt response by staff to medical emergencies, including those related to intoxication and withdrawal.

Subpart 3. **Medication Reconciliation:** The license holder must conduct medication reconciliation on admission, transfer to another unit and at discharge. The license holder will develop clear policies and procedures for each step in the reconciliation process. The process must comprise the following four steps:

A. Develop a list of current medications that includes dose and frequency along with other drug interactions, allergies from the residents last residence or hospitalization;

B. Compare prescriptions or admission orders to current medication list, identifying discrepancies, and reconciling differences;

C. Notify prescriber of discrepancies so the prescriber can make clinical decisions based on the comparison;

D. Obtain new orders if required; and

E. Communicate and document the current medications on the medication administration record and with the resident and resident's legal representative.

Subpart 4. **Medication Administration:** The license holder must complete the following:

A. The license holder must obtain written or verbal authorization from the resident or the resident's legal representative to administer medication. This authorization shall remain in effect unless it is withdrawn in writing and may be withdrawn at any time. If the resident or the resident's legal representative refuses to authorize the license holder to administer medication, the medication must not be administered. The refusal to authorize medication

administration must be reported to the prescriber as expediently as possible. After reporting the refusal to the prescriber, the license holder must follow any directives or orders given by the prescriber. A refusal may not be overridden without a court order. Refusal to authorize administration of a specific psychotropic medication is not grounds for sole service termination and does not constitute an emergency.

B. The license holder must ensure the following information is documented in the resident's medication administration record or resident file:
   (1) The information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes the resident's name, description of the medication to be provided, and the frequency and other information needed to safely and correctly administer the medication or treatment to ensure effectiveness;
   (2) Notation of any occurrence of a dose of medication not being administered as prescribed, whether by error by the staff or the resident or by refusal by the resident, or of adverse reactions, and when and to whom the report was made; and
   (3) Notation of when a medication is started, administered, changed, or discontinued.
C. The license holder must keep records for a resident who receives prescription drugs at the facility and note: the quantity initially received from the pharmacy, amount of medication given, dosage, and time when the medication was taken. The license holder must document a resident's refusal to take prescription medication.
D. Prescription medicine belonging to a resident must be given to the resident's parent or legal guardian or a resident who is 18 years of age or older upon the resident's release or must be disposed of according to a pharmacy-approved plan when medications have been determined by the physician to be harmful to release medications. The license holder must note the disposition of the resident's medicine in the resident's file.
E. Standing orders must be individualized to the resident and shall specify the circumstances under which the drug is to be administered, the drug, dosage, route, frequency of administration, and duration.

Subpart 5. **Control of drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

A. A requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;
B. A system which accounts for all scheduled drugs each shift;
C. A procedure for recording the client's use of medication, including the signature of the administrator of the medication with the time and date;
D. A procedure for destruction of discontinued, outdated, or deteriorated medications;
E. A statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and
F. A statement that no legend drug supply for one client will be given to another client.

Subpart 6. **Conditions for use of psychotropic medications.**

A. Psychotropic medication must not be administered as punishment, for staff convenience, as a substitute for a behavioral or therapeutic program, or in quantities that interfere with learning or other goals of the individual treatment plan.
B. When psychotropic medications are administered to a resident in a PRTF, the prescribing practitioner must document the following:
   (1) A description in observable and measurable terms of the symptoms and behaviors that the psychotropic medication is to alleviate; and
   (2) Data collection methods the license holder must use to monitor and measure changes in symptoms and behaviors that are to be alleviated by the psychotropic medication.
C. Ongoing the prescribing practitioner must conduct and document a psychotropic medication review at least weekly for the first month and every month thereafter. The LH must consider and document items (1) to (3) in the resident file.
   (1) Targeted symptoms and behaviors of concern;
   (2) Data collected since the last review; and
   (3) Side effects observed and actions taken.

Subpart 7. **Informed Consent**. The license holder must obtain informed consent before any nonemergency administration of psychotropic medication. To the extent possible, the resident must be informed and involved in the decision making.

A. Informed consent is required either orally or in writing before the nonemergency administration of psychotropic medication, except that for antipsychotic or neuroleptic medication, informed consent must be in writing. If oral informed consent is obtained for a non-antipsychotic medication, subitems (1) to (4) must be followed and documented:
   (1) An explanation why written informed consent could not be initially obtained;
   (2) Documentation that the oral consent was witnessed and the name of the witness;
   (3) Oral and written communication of all items required in R2960V.07, subpart 9; and
   (4) An explanation that written informed consent material is immediately being sent by the license holder to the resident's parent or legal representative, that the oral consent expires in one month, and that the medication must be discontinued one month from the date of the telephone consent if written consent is not received.
B. Informed consent for any psychotropic medication must be renewed in writing at least yearly.
C. Informed consent must be obtained from an individual authorized to give consent. An individual authorized to give consent is specified in subitems (1) to (3).
   (1) If applicable, minors age 16 or older see Minnesota Statute 253B.04.
   (2) If the resident has a legal representative or conservator authorized by a court to give consent for the resident, consent is required from the legal representative or conservator.
   (3) If subitem (1) does not apply, consent is required from at least one of the resident's parents. If the parents are divorced or legally separated, the consent of a parent with legal custody is required, unless the separation or marriage dissolution decree otherwise delegates' authority to give consent for the resident.
   (4) If the commissioner of human services is the resident's legal representative, consent is required from the county representative designated to act as legal representative on behalf of the commissioner of human services.
D. Informed consent is not necessary in an emergency situation where the physician determines that the psychotropic medication is needed to prevent serious and immediate physical harm

to the individual or others. In the event of the emergency use of psychotropic medication, the license holder must:

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

(2) Document the specific behaviors constituting the emergency, the circumstances of the emergency behaviors, the alternatives considered and attempted, and the results of the use of the emergency psychotropic medication; and

(3) Arrange for an interdisciplinary team review of the individual treatment plan within seven days of the emergency to determine what actions, if any, are required in light of the emergency. If a psychotropic medication continues to be required, the license holder must seek a court order according to Minnesota Statutes, section 253B.092, subdivision 3.

E. Informed consent must be obtained by the license holder within 30 days to continue the use of psychotropic medication for a resident admitted with prescribed psychotropic medication.

Subpart. 8. **Information communicated in obtaining consent.** The information in this subpart must be provided both orally and in writing in nontechnical language to the resident's parent, the resident's legal representative, and, to the extent possible, the resident. The information must include:

A. The diagnosis and behaviors for which the psychotropic medication is prescribed;

B. The expected benefits of the medication.

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

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

E. The more frequent and less frequent or rare but serious risks and side effects of the psychotropic medication, including how the risks and possible side effects must be managed;

F. An explanation that consent may be refused or withdrawn at any time and that the consent is time-limited and automatically expires within 30 days for oral consent and yearly for written consent;

G. The names, addresses, and telephone numbers of appropriate professionals to contact if questions or concerns arise.

H. Signature of resident and legal representative acknowledging the following:

(1) Prescribing practitioner has talked about the medication with resident and the resident's legal representative and answered questions; and

(2) The resident and resident's legal representative has agreed to the medication and dosage; and

Subpart 9. **Refusal of routine administration of psychotropic medication.** If the authorized person refuses consent for a routine administration of psychotropic medication, the conditions in items A to C apply.

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

B. A court order must be obtained to override the refusal.
C. Refusal to consent to use of a specific psychotropic medication is not grounds for discharge of a resident. A decision to discharge a resident must be reached only after the alternatives to the specific psychotropic medication have been attempted and only after an administrative review of the proposed discharge has occurred. If the refusal to consent to the routine administration of a psychotropic medication results in an emergency situation, then the requirements of subpart 8, item D, must be met when psychotropic medication will be administered to a resident.

Subpart 10. **Monitoring side effects.** The license holder must monitor for side effects if a resident is prescribed a psychotropic medication. The license holder, under the direction of a prescribing psychiatric practitioner, must document and monitor for side effects within 24 hours of admission. The nurse will determine and document frequency of side effect monitoring within the resident's file based on the results and the medications prescribed. The license holder must monitor for side effects when a new psychotropic medication is ordered for a resident or when a psychotropic medication has been discontinued as determined by the prescribing psychiatric practitioner. In addition to appropriate physical or laboratory assessments as determined by the medically licensed person, standardized checklists or rating scales, or scales developed for a specific drug or drug class, must be used as monitoring tools. The license holder must provide the assessments to the prescribing psychiatric practitioner for review.

The applicant or license holder must have written procedures for obtaining medical interventions when needed for a client, that are approved in writing by a physician licensed under Minnesota Statutes, chapter 147, or as a clinical nurse specialist with child/adolescent specialty or a an Advanced Practice Registered nurse in Family and Individual, unless the following:

A. The license holder does not provide medical services under the Psychiatric Residential Treatment Facility; and
B. Emergency medical interventions are referred to 911;
C. The license holder must have affiliations or written transfer arrangements that describe care will be available 24 hours a day, 7 days a week, including emergent care with one or more hospitals to receive residents in the case of an emergency;
D. The license holder will determine and document the medical and other information needed for an exchange of care.

R2960V.08 EDUCATION.

Subpart 1. **Educational services.** The license holder must ensure that educational services are provided to residents according to items A to E, except where not applicable; due to the age of the resident or the resident's short stay in the facility.

A. The license holder must facilitate the resident's admission to an accredited public school or, if the resident is home-schooled or educated at a private school or school operated by the license holder, the school must meet applicable laws and rules. If the educational services are provided on the grounds of the facility, the license holder must:
(1) Arrange for educational programs that provide for instruction on a year-round basis, if required by law;

(2) Get the approval of the education services from the Department of Education; and
(3) Cooperate with the school district.

B. The license holder must facilitate the resident's school attendance and homework activities.

C. The license holder must inquire at least every 90 days to determine whether the resident is receiving the education required by law and the resident's individual education plan that is necessary for the resident to make progress in the appropriate grade level. The license holder must report the resident's educational problems to the case manager or placing agency.

D. Prior to discharge, the PRTF education provider shall submit necessary information to the community education provider to ensure continuity of education services

R2960V.09 PROGRAM RULES.

Subpart 1. **Program rules and due process system for residents**.
The license holder must communicate verbally and in writing to a resident who is capable of understanding the program rules and the details for the due process system used in the facility. The rules must address the following topics:

A. Which behaviors are considered acceptable and unacceptable and the reasons why;

B. The consequences that will be applied utilizing positive support strategies and evidence based practices; and

C. The circumstances, if any, that will result in time-out or the use of restraints or seclusion.

Application of Time Out

A. A resident in time out must never be physically prevented from leaving the time out area.

B. Time out may take place away from the area of activity or from other residents, such as in the resident's room, or in the area of activity of other residents.

C. Staff must continually monitor the resident while he or she is in time out.

D. Staff must document the following:

(1) The factors or circumstances which caused the need for the use of time-out;
(2) Time of initiation;
(3) Progression of behaviors and the ability to de-escalate during the time out episode;
(4) End time of timeout; and
(5) The resident's disposition at the end of timeout.

R2960.10 SECLUSION AND RESTRAINT.

Subpart 1. **Standards for the Use of Restraint or Seclusion.**

A. Consideration of individual dignity and privacy will be of highest priority;

B. Staff may initiate the use of restraint and seclusion only when necessary to protect the individual or others from imminent risk of harm;

C. Before staff uses restraint or seclusion with an individual, staff must complete the training required regarding the use of restraint and seclusion at the facility, to include the different restraint holds and must successfully demonstrate the techniques;

D. Upon admission, the Medical Practitioner must document any medical or physical contraindications for the use of restraint or seclusion with the individual;

E. At the initiation of the restraint or seclusion the individual will be made aware of the reason for the restraint or seclusion and the release criteria to discontinue the intervention;
F. Preserving the safety and dignity of the individual served when restraint or seclusion is used.

Protection of Rights
At admission, the facility must:

A. Inform and provide a copy of the facility policy on the use of restraint or seclusion to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s);
B. Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;
C. Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation,
D. Staff must file acknowledgement in resident's file; and
E. The license holder must inform residents how to contact the appropriate state-appointed ombudsman, Minnesota Disability Law Project, and Minnesota Department of Health.
F. The facility muse establish a policy for the use of restraint and seclusion. The policy must address emergency safety intervention (ESI) which is the immediate response to an emergency safety situation (ESS).
G. Restraint or seclusion must not result in harm or injury to the resident and must be used only for (ESS) – prone restraints are prohibited.
H. Must be performed in a manner that is safe and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse);
I. Restraint and seclusion, including drugs or medications used as restraint, must not be used to enforce facility rules, coercion, discipline, for the convenience of staff or programming, or retaliation; and
J. The intervention will be utilized for the shortest period of time to meet safety concern.

Orders for the use of restraint or seclusion:

A. Each use of restraint and seclusion must be assessed and authorized by a physician or licensed mental health professional. If the resident's treatment team physician is available, only he or she can order restraint or seclusion.
B. A physician or other licensed mental health professional must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
C. If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or the licensed mental health professional must verify the verbal order within 48 hours in a signed written form in the resident's record. The physician or licensed mental health professional must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.
D. Each order for restraint or seclusion must:

a. Be limited to no longer than the duration of the emergency safety situation; and
b. Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents' ages 9 to 17; or 1 hour for residents under age 9;
c. If the ESS continues beyond the time limit of the order for the use of seclusion or restraint, a registered nurse or other licensed staff (LPN), must immediately contact the ordering physician or licensed mental health professional to receive further instruction. If seclusion or restraint is extended it requires a new order.

E. Each order for restraint or seclusion must include:
a. The name of the ordering physician or licensed mental health professional permitted by the state and the facility to order restraint or seclusion;
b. The date and time the order was obtained; and
c. The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.
d. If behaviors continue after the end of one order timeframe a separate order is required.

F. Restraint and seclusion must not be used simultaneously.
a. If restraint is necessary as a means of safely transporting the resident to seclusion, a separate order is not required. However, the initial order for the seclusion must include the physical transport restraint and be consistent with the requirements for restraint/seclusion orders.

G. Within 1 hour of the initiation of the emergency safety intervention a physician or a registered nurse trained in the use of emergency safety interventions and the facility to assess the physical and psychological well-being of residents, must conduct a face-to-face assessment of the physical and psychological well-being of the resident, including but not limited to:
a. The resident's physical and psychological status;
b. The residents behavior;
c. The appropriateness of the intervention measures; and
d. Any complications resulting from the intervention.

H. The use of restraint or seclusion must end when the threat of harm ends;
I. The individual will be continuously observed during the use of restraint or seclusion.

Subpart 2. **Documentation**

A. Prior events that may have been a contributing factor to the incident;
B. What supportive and less restrictive interventions were attempted and why these interventions failed or were found to be inappropriate; and
C. The types of interventions utilized including the type of physical holding used.

The license holder must document all uses of restraint or seclusion. The documentation must include:

A. A detailed description of the incident that demonstrated imminent risk of harm which led to the ESI of restraint or seclusion;
B. The restraint and seclusion order for each type of intervention utilized, the time-limit and the release criteria;
C. The staff persons who implemented the emergency use of restraint and seclusion must document its use immediately after the intervention ends;

D. The documentation of the restraint and/or seclusion must be completed by the end of the shift in which the intervention occurs;
E. Any injuries that occurred as a result of the intervention both to resident and staff;
F. The time the emergency safety intervention actually began and ended for each type of intervention;
G. The name of staff involved in the emergency intervention;
H. The ongoing observation (video monitoring does not meet this requirement) of the resident documented at 5 minute intervals, documenting any individual's behavioral changes or changes to physical status during the use of restraint or seclusion;
I. A physician or registered nurse must evaluate face to face the resident's well-being immediately after the restraint is removed or resident is removed from seclusion.
J. Notification of parent(s) or legal representative if the resident is a minor, including the date and time of the notification and the name of the staff person providing the notification;
K. The time and results of the 1-hour assessment;
L. If treatment team physician did not order the emergency safety intervention, the consulting physician must consult with treatment team physician as soon as possible and must comply with the following:
a. Date and time the treatment team physician was consulted; and
b. Documentation is located in resident file.
M. The facility must maintain a record of each ESS, the interventions used, and their outcomes.

Subpart 3: **Debriefing**

A. Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, the names of staff who were excused from the debriefing, and any changes to the resident's treatment plan or additional staff training that result from the debriefings.
B. The license holder will provide the resident with the opportunity to have a legal representative or advocate participate in the debriefing. License holder must document the resident's response and rationale if license holder is not able to accommodate participation upon resident's request.
C. Precipitating factors and alternative techniques that might have prevented the use of restraints and/or seclusion must be incorporated into the individual's support plan to prevent future use.
D. Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Debriefing:
A. The license holder must conduct a face-to-face debriefing with the resident within 24 hours after the use of restraint or seclusion.
B. The debriefing must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident.
C. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility.
D. The discussion must be in language that is understood by the resident's parent(s) or legal guardian(s).

E. The debriefing must attempt to re-establish a therapeutic alliance with the individual; the emergency situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; alternative techniques that might have prevented the use of the restraint or seclusion; the procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

Subpart 4. **Administrative review.** The license holder must complete an administrative review of the use of a restrictive procedure within three working days after the use of the restrictive procedure. The administrative review must be conducted by someone other than the person who decided to impose the restrictive procedure, or that person's immediate supervisor. The resident or the resident's representative must have an opportunity to present evidence and argument to the reviewer about why the procedure was unwarranted.

The record of the administrative review of the use of a restrictive procedure must state whether:

A. The required documentation was recorded;
B. The restrictive procedure was used in accordance with the treatment plan;
C. The rule standards governing the use of restrictive procedures were met; and
D. The staff who implemented the restrictive procedure were properly trained.

Subpart 5. **Review of patterns of use of restraint and seclusion procedures.** At least quarterly, the license holder must review the patterns of the use of restraint and seclusion procedures. The review must be done by the license holder or the facility's advisory committee. The review must consider:

A. Any patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a procedure, individuals involved, or other factors associated with the use of restraint and seclusion procedures;
B. Any injuries resulting from the use of restraint and seclusion procedures;
C. actions needed to correct deficiencies in the program's implementation of restraint and seclusion procedures;
D. An assessment of opportunities missed to avoid the use of restraint and seclusion procedures; and
E. Proposed actions to be taken to minimize the use of restraint and seclusion.

R2960V.11 REPORTING OF CRITICAL INCIDENTS.

Subpart 1 **Critical incident and maltreatment reports.** The license holder must report critical incidents and the maltreatment of a resident according to items A to D.

A. The license holder must report critical incidents of a serious nature that involve or endanger the life or safety of the resident or others to the commissioner of human services or corrections within ten days of the occurrence on forms approved by the commissioner of human services or corrections. The license holder must maintain records of all critical incidents on file in the facility.
B. The license holder must meet the reporting requirements of Minnesota Statutes, sections 626.556 and 626.557, if applicable, and other reporting requirements based on the age of the resident.
C. The license holder must develop policies and procedures to follow if maltreatment is suspected.
D. The license holder must review policies and procedures about maltreatment at least annually and revise the policies if the maltreatment laws change or if the license holder's review of incident

reports or quality assurance reports indicates that a change in maltreatment policy or procedure is warranted.

Reporting of serious occurrences.

Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in section of this part, and a resident's suicide attempt.

A. Staff must report any serious occurrence involving a resident to the Minnesota Department of Health (State Medicaid agency) and the federal protection and advocacy system, the Minnesota Disability Law Center (MDLC) no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence and, the name, street address, and telephone number of the facility.

B. In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

C. Staff must document in the resident's record that the serious occurrence was reported to Minnesota Department of Health and The Minnesota Disability Law Center (MDLC), including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

D. Reporting of deaths. In addition to the reporting requirements contained in paragraph (A) and (C) of this section, facilities must report and document notification of the death of any resident to the following:

(1) Centers for Medicare and Medicaid Services (CMS) regional office by no later than close of business the next business day after the resident's death; and

(2) DHS Licensing Central Intake and The Office of Ombudsman for Mental Health and Developmental Disabilities within 24 hours.

R2960V.12 CLINICAL SUPERVISION.

The license holder must assure that staff on all shifts exchange information necessary to carry out the resident plan of care, and respond to the residents' goals, and inform updates and revisions to the resident plan of care and individual abuse prevention plan if required.

A. The clinical supervisor must hold at least one clinical supervision meeting per calendar week and be physically present at the meeting. All treatment team members are expected to participate in a minimum of one team meeting during every calendar week they work. This includes part-time staff and staff who work on an intermittent basis. The license holder must maintain documentation of the weekly meetings, including the names of staff who attended; or

B. Staff who do not participate in the weekly meeting must participate in an ancillary meeting during each week in which they work. During the ancillary meeting the information that was shared at the most recent weekly team meeting must be verbally reviewed, including revisions to the residents' plan of care and other information that was exchanged. The ancillary meeting may be conducted by the clinical supervisor or a mental health practitioner that participated in the weekly meeting. The license holder must maintain documentation of the ancillary meetings, including the names of staff who attended.

R2960V.13 STAFF RATIOS.

Sufficient staff. The license holder must provide enough appropriately trained staff to ensure that a resident will have the treatment needs identified in the resident's individual plan of care met during the resident's stay in the facility.

The license holder must have nursing 24 hours a day, 7 days a week.

Awake hours. During normal waking hours, when residents are present, a facility certified to provide mental health treatment to residents must have a ratio of staff of at least one staff person to three residents within the living unit.

Sleeping hours. During normal sleeping hours, a license holder must provide at least one staff person for every four residents present within the living unit, with the ability to access other staff within the facility as needed. Staff persons must be awake.

Access to a licensed mental health professional. The license holder must have the capacity to promptly and appropriately respond to emergent needs of the residents and make any necessary staffing adjustments to assure the health and safety of residents. Within 30 minutes, treatment staff must have access in person or by telephone to a licensed mental health professional. The license holder must maintain a schedule of the licensed mental health professionals who will be available and a means to reach them. The schedule must be current and readily available to staff.

R2960V.14 STAFF MANAGEMENT.

Subpart 1. **Job descriptions.** The license holder shall have job descriptions for each position specifying the staff person's responsibilities, degree of authority to execute job responsibilities, standards of job performance, required qualifications, and to what extent the person may act independently.

Subpart. 2. **Job evaluation**. The license holder shall have a process to conduct work performance evaluations of all staff on a regular basis that includes a written annual review. The program must maintain documentation of these reviews.

Subpart 3. **Conditions of employment**. The license holder shall establish conditions of employment including those that constitute grounds for dismissal and suspension.

Subpart 4. **Good faith communication**. The license holder must not adversely affect a staff member's retention, promotion, job assignment, or pay related to good faith communication between a staff member and the department, the Department of Health, the Ombudsman for Mental Health and Developmental Disabilities, law enforcement, or local agencies for the investigation of complaints regarding a resident's rights, health, or safety. For purposes of this requirement, the scope of the department's jurisdiction is solely related to the policy and procedure requirements provided in this section and not related to issues concerning labor and management or disputes between staff and the license holder.

Subpart. 5. **Staff files**. The license holder must maintain organized records for each staff member that at a minimum include:

A. An application for employment or a resume;
B. Verification of the staffs' qualifications specific to the position including required credentials and other training or qualifications necessary to carry out their assigned job duties in accordance with the organizational credentialing requirements of the organizations Human Resources policy and procedure manual;
C. Documentation required under chapter 245C concerning background studies;
D. The date of hire;
E. A job description that identifies the date that specific job duties and responsibilities are effective, including the date the staff has direct contact;
F. Documentation of orientation;
G. An annual job performance evaluation;
H. An annual development and training plan; and
I. Records of training and education activities that were completed during employment.

Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Subpart. 6. **Organizational chart**. The license holder shall maintain a current organizational chart that is available upon request to staff, residents, and the public. The organizational chart must clearly identify the lines of authority.

Subpart. 7. **Volunteers**. If the license holder utilizes volunteers, the license holder must:

A. Not permit volunteers to provide treatment services.
B. Not regard volunteers as staff for the purpose of meeting licensing requirements for staffing or service delivery.
C. Develop job descriptions for volunteers. When volunteers are approved to have contact, the scope of that contact must be identified in the job description.
D. Provide orientation and training for volunteers.

Subpart 8. **Student Trainees.** If the license holder utilizes student trainees, the license holder must provide notification to the resident when student trainees provide treatment services. The treatment services must be overseen by a mental health practitioner/professional.

R2960V.15 STAFF TRAINING.

Subdivision 1. **Training Plan.** The license holder must develop a plan to assure that staff receive orientation and ongoing training. For staff that provide direct services, the license holder shall meet the requirements of this subdivision. The plan must include the requirements under paragraphs (a) through (d) below.

A. A formal process to evaluate the training needs of each staff person, such as through an annual performance evaluation.

B. How the program determines when additional training of a staff is needed and how and under what time lines the additional training will be provided.
C. A schedule of training opportunities for a 12 month period that is updated at least annually.
D. Orientation to the following topics must be provided prior to the staff providing direct contact services:
    (1) Resident rights as identified in section R2960V.04 and Minnesota Statute 253B.04;
    (2) Emergency procedures appropriate to the position, including but not limited to fires, inclement weather, missing persons, and residents' behavioral and medical emergencies;
    (3) Resiliency and recovery concepts and principles;
    (4) Gender based needs;
    (5) Resident confidentiality; and
    (6) Training related to the specific activities and job functions that the staff person will be responsible to carry out, including documentation of the delivery of services.
E. Orientation as required in sections 245A.65, subdivision 3 and 626.556, subdivision 2, 3, and 7 must be provided prior to providing direct contact services.
F. Orientation to the following topics must be provided within 30 calendar days of a staff first providing direct services.
    (1) Facility policies and procedures.
    (2) The treatment needs of residents, including psychiatric disorders and co- occurring disorders.
    (3) Best practice service delivery including:
        i. Trauma informed care;
        ii. Developmentally appropriate care;
        iii. The characteristics, and treatment of residents with special needs such as substance abuse, obsessive compulsive disorder, and eating disorders; and
        iv. Co-occurring disorders as defined by the population being served.
G. Annual training. Each staff person must complete training on the following topics annually.
    (1) Vulnerable adult and child maltreatment requirements in sections 245A.65, subdivision 3 and R2960V.11, subpart 1, subitem (c).
    (2) Resident rights as identified in section R2960V.04; and
    (3) Emergency procedures appropriate for the position, including but not limited to fires, inclement weather, missing persons, and residents' behavioral and medical emergencies.
    (4) Treatment services for residents with co-occurring disorders.
    (5) Additional training subjects. Staff who are not licensed mental health professionals or licensed independent practitioners must be provided additional annual training. The additional annual training must include a minimum of four of the following subjects.
        i. Resiliency and Recovery concepts and principles.
        ii. Documentation requirements related to resident services.
        iii. Psychiatric and substance use emergencies including prevention, crisis assessment and de-escalation techniques, and non-physical intervention techniques to address violent behavior.
        iv. Psychotropic medications and their side effects.
        v. Assessment and plan of care.

vi. Evidence based treatment of eating disorders, including family based therapy, cognitive behavioral therapy, and dialectical behavioral therapy
vii. The characteristics and treatment of residents with special needs, such as substance abuse, obsessive compulsive disorder, eating disorders, and physical health issues, including weight management, diabetes, smoking.
viii. Topics related to crisis intervention and stabilization of persons with serious mental illness.
ix. Prevention and control of infectious diseases, including human immunodeficiency virus (HIV) infection.
x. First aid and cardiopulmonary resuscitation (CPR) training.
xi. Healthy lifestyles, such as exercise nutrition, stress management, therapeutic recreation.
xii. Motivational interviewing.

(6) Additional training hours. Staff who are not licensed mental health professionals or licensed independent practitioners must receive additional hours of annual training based on their level of experience. The additional training must meet the following requirements.
i. Staff with less than 4000 hours of experience in the delivery of services to persons with mental illness must receive at least 24 hours of training annually; and,
ii. Staff with more than 4000 hours of experience in the delivery of services to persons with mental illness must receive 16 hours of training annually.

Training:

A. Staff must be trained and demonstrate competency before participating in an emergency safety intervention: Emergency Safety Situations must include the following:
iii. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
iv. De-escalation, mediation conflict resolution, active listing and verbal and observational methods to prevent behavioral emergencies;
v. Restraint and seclusion policy and procedures, including training exercises in which staff demonstrate competency in techniques to manage behavioral emergencies; and
vi. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

B. Semiannual training: Staff must demonstrate competency in Emergency Safety Situations that must include the following:
i. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
ii. De-escalation, mediation conflict resolution, active listing and verbal and observational methods to prevent behavioral emergencies;
iii. Restraint and seclusion policy and procedures, including training exercises in which staff demonstrate competency in techniques to manage behavioral emergencies; and

iv. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

C. First aid and cardiopulmonary resuscitation (CPR) training for all age categories by a current American Red Cross community, American Heart Association, or equivalent CPR certificate.

Subpart. 2. **Orientation and training for staff members not providing treatment services**. For staff that do not provide direct contact services, but who have contact with residents, the license holder shall meet the requirements of this subpart. The license holder shall also provide the necessary staff development and offer on-going training opportunities for staff who do not provide treatment services.

A. Orientation. The license holder shall have a plan for orienting new staff. The plan shall include the topics to be covered, who conducts the orientation, and the time frame for which it is to be completed. The topics must include:
   (1) Training related to the specific activities and job functions that the staff will be responsible to carry out;
   (2) Orientation as required in sections 245A.65, subdivision 3 and R2960V.11, subpart 1, subitem (c) must be provided within 72 hours of a staff hire.
   (3) Resident rights as identified in R2960V.04;
   (4) Emergency procedures appropriate for the position, including but not limited to fires, inclement weather, missing persons, and residents' behavioral and medical emergencies; and,

B. Annual training. Each staff person must complete training on the following topics annually.
   (1) Vulnerable adult and child maltreatment requirements in sections 245A.65, subdivision 3 and R2960V.11, subpart 1, subitem (c).
   (2) Resident rights as identified in R2960V.04; and,
   (3) Emergency procedures appropriate for the position, including but not limited to fires, inclement weather, missing persons, and residents' behavioral and medical emergencies.

Subpart. 3. **Documentation of orientation and training**. The license holder must document that orientation and training was provided. All training programs and materials used by the facility must be available to for review by regulatory agencies. The documentation must include the:

A. Dates of training;
B. Subjects covered;
C. Amount of time the training was provided;
D. Names and credentials of the people who certified the completion of the training;
E. Documentation of the employee competency evaluation, specifically medication administration and restraint/seclusion; and
F. Names of the staff and volunteers who attended.

R2960V.16 QUALITY ASSURANCE AND IMPROVEMENT.

Subpart 1. **Quality Assurance plan.** License holder must develop a written quality assurance and improvement plan that at a minimum includes the requirements of paragraphs (a) through (c) of this

section. The plan must also include processes to review the data or information related to each of the requirements of paragraphs (a) through (c) every three months.

A. Measuring resident outcomes, including:
    (1) Evaluating the outcome data to identify ways to improve the effectiveness of the services provided to residents and improve resident outcomes; and,
    (2) Attaining and evaluating feedback from residents, family members, staff and referring agencies concerning the services provided.
B. Restraint and seclusion data according to R2960V.10, subpart 7.
C. Reviewing critical incidents and other significant incidents, including:
    (1) Determining whether policies and procedures were followed;
    (2) Evaluating the staff's response to the critical and other significant incidents;
    (3) Assessing what could have prevented the critical and other significant incidents from occurring; and,
    (4) Modifying policies, procedures, training plans, or residents' ITPs in response to the findings of the review.
D. Self-monitoring of compliance, including:
    (1) Evaluating compliance with the requirements of this variance; and,
    (2) Demonstrating action to improve the program's compliance with the requirements.

Subpart 2. **Evaluating and updating the quality plan**. The quality assurance and improvement plan shall be reviewed, evaluated, and updated at least annually, by license holder. The review shall include documentation of the actions the license holder will take as a result of the information obtained from the monitoring activities outlined in the plan and establish goals for improved service delivery for the next year.

Subpart 3. **Community involvement.** Each facility must have a board of directors or advisory committee that represents the interests, concerns, and needs of the residents and community being served by the facility. The board of directors or advisory committee must meet at least annually. The license holder must meet at least annually with community leaders representing the area where the facility is located to advise the community leaders about the nature of the program, the types of residents served, the results of the services the program provided to residents, the number of residents served in the past 12 months, and the number of residents likely to be served in the next 12 months.

R2960.17 POLICIES AND PROCEDURES.

Subpart 1. **Intended use.** The license holder must have a statement of intended use for the facility, a description of the services to be offered, the program's service philosophy, the target population to be served, and program outcomes.

Subpart. 2. **Policies and procedures.** All license holders must develop and maintain a written manual of policies and procedures, plans and other documents required by this variance and that comply with Minnesota Statute, section 245A.04, subdivision 14. The license holder must at a minimum have policies and procedures or plans as identified in this section. All policies, procedures and plans must be consistent with the requirements of this variance and provide sufficient direction for staff and the license

holder to effectively carry out the policy, procedure, or plan. The policies and procedures and plans must include but are not limited to addressing paragraphs (a) through (m).

A. Policies and procedures related to reporting maltreatment of adults in accordance with Minnesota Statute 245A.65 and 626.557;
B. Policies and procedures related to reporting maltreatment of minors in accordance with Minnesota Statute 245A.66 and section 626.556;
C. Resident right requirements in accordance with section R2960V.04;
D. Admission. Continuing stay, and discharge requirements in accordance with section R2960V.05;
E. Individual plan of Care requirements in accordance with section R2960V.07, subpart 1;
F. Discharge planning and no eject policy in accordance with R2960V.07 subpart 3 and 4;
G. Health Care services requirements in accordance with section R2960V.08 subpart 2 through 10;
H. Program Rule in accordance with section R2960V.09;
I. Restraint and Seclusion procedures in accordance with section R2960V.10;
J. Critical incidents, including the program's definitions and procedures to address such situations in accordance with section R2960V.11;
K. Clinical supervision in accordance with section R2960V.12;
L. Orientation and training plan in accordance with section R2960V.15;
M. Quality assurance and improvement requirements identified in section R2960V.16; and
N. Documentation requirements in accordance with section R2960V.18.

R2960.18 RESIDENT FILE DOCUMENTATION and DATA PRIVACY.

Subpart 1. **Data privacy**. The license holder must comply with all Minnesota Government Data Practices Act, Minnesota Health Care Provider requirements, and the Health Insurance Portability and Accountability Act (HIPAA). In addition, the license holder must also comply with section 144.294, subdivision 3 concerning release of mental health records. The license holder's use of electronic record keeping or electronic signatures does not alter the license holder's obligations to comply with applicable state and federal law, and regulation.

Subpart 2**. Documentation standards**. Documentation in the resident's file must:
A. Be accurate and typed or legible if hand written;
B. Identify the resident on each page;
C. Identify the date of service;
D. Be signed and dated by the staff person completing the documentation, including the person's title; and
E. Be co-signed and dated by the mental health professional as required in this variance.

Subpart 3. **Daily documentation**. Each day the resident is present in the program (i.e., within a 24 hour period during a calendar day), the license holder must provide a summary in the resident's individual file that includes observations about the resident's behavior and symptoms, including any critical incidents for which the resident was involved.

Subpart 4**. Other documentation.** The license holder must document in the resident's individual file any information pertinent to providing services to the resident, if it is not otherwise documented as part of the ITP interventions. This includes but is not limited to:

A. Case coordination activities;
B. Medical and other appointments;
C. Critical incidents; and
D. Issues related to medications that are not otherwise documented in the resident's file.

R2960V.19 PHYSICAL PLANT AND CODE STANDARDS.

Subpart 1. **Housing requirements**. Must be licensed with the Minnesota Department of Health as a Supervised Living Facility, Class B.

Subpart 2. **Physical environment and equipment**. A facility must meet the requirements in items A to I.

A. Buildings, structures, or enclosures used by the facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings, must be kept in good repair.
B. Written policies and procedures must specify the facility's fire prevention protocols, including fire drills, and practices to ensure the safety of staff, residents, and visitors. The policies must include provisions for adequate fire protection service, inspection by local or state fire officials, and placement of fire hoses or extinguishers at appropriate locations throughout the facility.
C. The license holder must have a written maintenance plan that includes policies and procedures for detecting, reporting, and correcting building and equipment deterioration, safety hazards, and unsanitary conditions.
D. The license holder must have a written smoking policy for the facility that applies to staff and residents that complies with Minnesota Statutes, sections 144.411 to 144.417, and Public Law 103-227, title X, section 1043.
E. The license holder must ensure that food services, storage, housekeeping, laundry, and maintenance are operated on a consistent, healthy basis.
F. If food service is contracted to a food service vendor, the food service vendor must meet health code requirements.
G. If the license holder provides educational services on site, the classrooms must provide an atmosphere that is conducive to learning and meets the resident's special physical, sensory, and emotional needs.
H. The license holder must provide adaptive equipment and furnishings to meet the resident's special needs.
I. A facility must have first aid kits readily available for use by staff. The kits must be sufficient to meet the minor wound care needs of residents and staff.

Subpart 2. **Comfort, privacy, and dignity**. The physical environment must provide for the comfort, privacy, and dignity of residents.

Subpart. 3. **Code compliance**. A facility must comply with the applicable fire, health, zoning, and building codes and meet the physical plant and equipment requirements in items A to I.

A. A sleeping room must not be used to accommodate more than two residents. Multi-bed bedrooms must provide a minimum of 60 square feet per resident of useable floor space with three feet between beds placed side by side and one foot between beds placed end to end for

ambulatory residents. For non-ambulatory residents, the multi-bed bedrooms must provide 80 square feet per resident of useable floor space.

B. A resident must have adequate space for clothing and personal possessions, with appropriate furnishings to accommodate these items.
C. Facility grounds must provide adequate outdoor space for recreational activities.
D. There must be one shower or bathtub and sink with hot and cold water and one toilet for every eight residents.
E. The facility must have sufficient electric lighting in combination with natural lighting to provide reasonable light levels for the function of each given area.
F. The facility must have sufficient space provided for indoor quiet and group program activities.
G. The facility providing educational services on site must meet the physical plant and equipment requirements of the Department of Education for the provision of educational services.
H. A facility providing intake or admission services must have sufficient space to conduct intake functions in a private, confidential manner or provide the opportunity to conduct private meetings, including intake activities in a separate space.

Subpart 4. **Seclusion Room**. The room used for seclusion must be well lighted, well ventilated, clean, have an observation window which allows staff to directly monitor an individual in seclusion, fixtures that are tamper resistant, with electrical switches located immediately outside the door, and doors that open out.