

**902 KAR 20:320. Level I and Level II psychiatric residential treatment facility operation and services.**

RELATES TO: KRS 17.165, 17.500, 200.503, 216B.105, 216B.450-216B.457, 309.080, 309.130, 311.571, 311.840 – 311.862, 311.858, 314.011, 314.042, 319.050, 319.056, 319.064, 319C.010, 320.240, 335.100, 335.300, 335.080, 335.500, 439.3401, 645.020, 42 C.F.R. 441.156, 42 C.F.R. 483.350-483.376

STATUTORY AUTHORITY: KRS 216B.042, 216B.455, 216B.457

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042 requires the Kentucky Cabinet for Health and Family Services to promulgate administrative regulations to govern health facilities and services. KRS 216B.455 and 216B.457 require the cabinet to promulgate administrative regulations establishing requirements for psychiatric residential treatment facilities. This administrative regulation provides minimum licensure requirements regarding the operation of and services provided in Level I or Level II psychiatric residential treatment facilities, including those facilities which elect to provide outpatient behavioral health services.

Section 1. Definitions. (1) "BAMT" or "Blood Assay for Mycobacterium tuberculosis" means a diagnostic blood test that:

- (a) Assesses for the presence of infection with *M. tuberculosis*; and
- (b) Reports results as positive, negative, indeterminate, or borderline.

(2) "BAMT conversion" means a change in test result, on serial testing, from negative to positive.

(3) "Behavioral health professional" means:

(a) A psychiatrist licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc;

(b) A physician licensed in Kentucky to practice medicine or osteopathy in accordance with KRS 311.571;

(c) A psychologist licensed and practicing in accordance with KRS 319.050;

(d) A certified psychologist with autonomous functioning or licensed psychological practitioner practicing in accordance with KRS 319.056;

(e) A clinical social worker licensed and practicing in accordance with KRS 335.100;

(f) An advanced practice registered nurse licensed and practicing in accordance with KRS 314.042;

(g) A physician assistant licensed under KRS 311.840 to 311.862;

(h) A marriage and family therapist licensed and practicing in accordance with KRS 335.300;

(i) A professional clinical counselor licensed and practicing in accordance with KRS 335.500; or

(j) A licensed professional art therapist as defined by KRS 309.130(2).

(4) "Behavioral health professional under clinical supervision" means a:

(a) Psychologist certified and practicing in accordance with KRS 319.056;

(b) Licensed psychological associate licensed and practicing in accordance with KRS 319.064;

(c) Marriage and family therapist associate as defined by KRS 335.300(3);

(d) Social worker certified and practicing in accordance with KRS 335.080;

(e) Licensed professional counselor associate as defined by KRS 335.500(4); or

(f) Licensed professional art therapist associate as defined by KRS 309.130(3).

- (5) "Certified alcohol and drug counselor" is defined by KRS 309.080(2).
- (6) "Chemical restraint" means the use of a drug that:
- (a) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;
  - (b) Has the temporary effect of restricting the resident's freedom of movement; and
  - (c) Is not a standard treatment for the resident's medical or psychiatric condition.
- (7) "Child with a severe emotional disability" is defined by KRS 200.503(3).
- (8) "Community support associate" means a paraprofessional who meets the application, training, and supervision requirements of 908 KAR 2:250.
- (9) "Direct-care staff" means residential or child-care workers who directly supervise residents.
- (10) "Directly observed therapy" or "DOT" means an adherence-enhancing strategy:
- (a) In which a healthcare worker or other trained person watches a patient swallow each dose of medication; and
  - (b) Which is the standard care for all patients with TB disease and is a preferred option for patients treated for latent TB infection (LTBI).
- (11) "DOPT" means Directly Observed Preventive Therapy, which is the DOT for treatment of LTBI.
- (12) "Emergency safety intervention" is defined by 42 C.F.R. 483.352 and is the use of restraint or seclusion as an immediate response to an emergency safety situation.
- (13) "Emergency safety situation" is defined by 42 C.F.R. 483.352 and is an unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.
- (14) "Freestanding" is defined by KRS 216B.450(3).
- (15) "Governing body" means the individual, agency, partnership, or corporation in which the ultimate responsibility and authority for the conduct of the facility is vested.
- (16) "Home-like" is defined by KRS 216B.450(4).
- (17) "Induration" means a firm area in the skin which develops as a reaction to injected tuberculin antigen if a person has tuberculosis infection and which is measured in accordance with Section 18(1) of this administrative regulation.
- (18) "Latent TB infection" or "LTBI" means infection with M. tuberculosis without symptoms or signs of disease manifested.
- (19) "Licensed assistant behavior analyst" is defined by KRS 319C.010(7).
- (20) "Licensed behavior analyst" is defined by KRS 319C.010(6).
- (21) "Licensed clinical alcohol and drug counselor" is defined by KRS 309.080(4).
- (22) "Licensed clinical alcohol and drug counselor associate" is defined by KRS 309.080(5).
- (23) "Licensure agency" means the Cabinet for Health and Family Services, Office of Inspector General.
- (24) "Living unit" means:
- (a) The area within a single building that is supplied by a Level I facility for daily living and therapeutic interaction of no more than nine (9) residents; or
  - (b) The area within a Level II facility that is designated for daily living and therapeutic interaction of no more than twelve (12) residents.
- (25) "Mechanical restraint" means any device attached or adjacent to a resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.
- (26) "Mental health associate" means:
- (a) 1. An individual with a minimum of a bachelor's degree in a mental health related field;
  - 2. A registered nurse; or

3. A licensed practical nurse with at least one (1) year's experience in a psychiatric inpatient or residential treatment setting for children; or

(b) An individual with:

1. A high school diploma or an equivalence certificate; and

2. At least two (2) years work experience in a psychiatric inpatient or residential treatment setting for children.

(27) "Mental health professional" is defined by KRS 645.020(7).

(28) "Peer support specialist" means a paraprofessional who meets the application, training, examination, and supervision requirements of 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240.

(29) "Personal restraint" means the application of physical force without the use of any device for the purpose of restraining the free movement of a resident's body and does not include briefly holding without undue force a resident in order to calm or comfort him or her or holding a resident's hand to safely escort him or her from one (1) area to another.

(30) "Psychiatric residential treatment facility" or "PRTF" is defined in KRS 216B.450(5) as a Level I facility or a Level II facility.

(31) "Qualified mental health personnel" is defined by KRS 215B.450(6).

(32) "Qualified mental health professional" is defined by KRS 216B.450(7).

(33) "Seclusion" means the involuntary confinement of a resident alone in a room or in an area from which the resident is physically prevented from leaving.

(34) "Serious injury" means any significant impairment of the physical condition of the resident as determined by qualified medical personnel and that may:

(a) Include:

1. Burns;

2. Lacerations;

3. Bone fractures;

4. Substantial hematoma; or

5. Injuries to internal organs; and

(b) Be self-inflicted or inflicted by someone else.

(35) "Serious occurrence" means a resident's death, a serious injury to the resident, or a resident's suicide attempt.

(36) "Time out" means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

(37) "Tuberculin skin test" or "TST" means a diagnostic aid for finding M. tuberculosis infection that:

(a) Is performed by using the intradermal (Mantoux) technique using five (5) tuberculin units of purified protein derivative (PPD); and

(b) Has its results read forty-eight (48) to seventy-two (72) hours after injection and recorded in millimeters of induration.

(38) "Tuberculosis (TB) disease" means a condition caused by infection with a member of the M. tuberculosis complex that meets the descriptions established in Section 18(2) of this administrative regulation.

(39) "TST conversion" means a change in the result of a test for M. tuberculosis infection in which the condition is interpreted as having progressed from uninfected to infected in accordance with Section 18(3) of this administrative regulation.

(40) "Two-step TST" or "two-step testing" means a series of two (2) TSTs administered seven (7) to twenty-one (21) days apart and used for the baseline skin testing of persons who will receive serial TSTs, including healthcare workers and residents of psychiatric residential

treatment facilities to reduce the likelihood of mistaking a boosted reaction for a new infection.

(41) "Unusual treatment" means any procedure not readily accepted as a standard method of treatment by the relevant profession.

Section 2. Licensure Application and Fee. (1) An applicant for licensure as a Level I or Level II PRTF shall complete and submit to the Office of Inspector General an Application for License to Operate a Health Facility or Service, as required by 902 KAR 20:008, Section 2(1)(f).

(2) If an entity seeks to operate both a Level I and a Level II PRTF and is granted licensure to operate both levels, a separate license shall be issued for each level.

(3) The initial and annual fee for licensure as a Level I PRTF shall be \$270.

(4)(a) The initial and annual fee for licensure as a Level II PRTF that has nine (9) beds or less shall be \$270.

(b)1. The initial and annual fee for licensure as a Level II PRTF that has nine (9) beds to fifty (50) beds shall be \$270; and

2. A fee of ten (10) dollars shall be added to the minimum fee of \$270 for each bed beyond the ninth bed.

(5) If a Level I or Level II PRTF provides outpatient behavioral health services as described in Section 14(1) of this administrative regulation:

(a) The outpatient behavioral health services shall be provided:

1. On a separate floor, in a separate wing, or in a separate building from the PRTF; or
2. At an extension off the campus of the PRTF;

(b) The PRTF shall pay a fee in the amount of \$250 per outpatient behavioral health services extension, submitted to the Office of Inspector General at the time of:

1. Initial licensure, if applicable;
2. The addition of a new outpatient behavioral health services extension to the PRTF's license; and
3. Renewal;

(c) Each off-campus extension or on-campus program of outpatient behavioral health services provided shall:

1. Be listed on the PRTF's license;
2. Have a program director who may serve as the same program director described in Section 6(2) of this administrative regulation; and
3. Employ directly or by contract a sufficient number of personnel to provide outpatient behavioral health services; and

(d) An off-campus extension or a separate building on the campus of the PRTF where outpatient behavioral health services are provided shall comply with the physical environment requirements of Section 14(6) of this administrative regulation and be approved by the State Fire Marshal's office prior to:

1. Initial licensure;
2. The addition of the extension or on-campus program of outpatient behavioral health services in a separate building; or
3. A change of location.

Section 3. Location. (1)(a) A Level I psychiatric residential treatment facility shall be located in a freestanding structure.

(b) A Level II PRTF may be located:

1. In a separate part of a psychiatric hospital;
2. In a separate part of an acute care hospital;
3. In a completely detached building; or

4. On the campus of a Level I PRTF if the Level II beds are located on a separate floor, in a separate wing, or in a separate building from the Level I PRTF.

(c) A licensed Level II PRTF shall not be licensed for more than fifty (50) beds.

(2) In accordance with KRS 216B.455(5), multiple Level I PRTFs may be located on a common campus if each PRTF is freestanding.

(3)(a)1. If a Level I psychiatric residential treatment facility is located on grounds shared by another licensed facility other than a PRTF, the residents of the Level I or PRTF and the licensed facility with which it shares grounds shall not have any joint activities, except for organized education activities, organized recreational activities, or group therapy for children with similar treatment needs.

2. If a Level II PRTF is located on grounds shared by a Level I PRTF or a licensed private child-caring facility, the requirements in this subparagraph shall apply.

a. The residents of the Level II PRTF and the Level I PRTF or private child-caring facility with which it shares grounds shall not have any joint activities, except for organized education activities on campus, organized recreational activities, or group therapy for children with similar treatment needs in which dedicated Level II PRTF unit staff shall be present during the activity to ensure sufficient supervision.

b. Joint activities shall be documented in the resident's comprehensive treatment plan of care.

c. The maximum age range for joint activities shall be no more than five (5) years for residents age six (6) to twenty-one (21), and no more than three (3) years for residents in Level II facilities age four (4) to five (5).

(b) Direct-care staff of the licensed facility with which the Level I or Level II PRTF shares grounds may provide relief, replacement, or substitute staff coverage to the PRTF.

(c) For continuity of care, at least fifty (50) percent of direct care staff of the Level I or Level II PRTF shall be consistently and primarily assigned to the living unit.

Section 4. Licensure. (1) A Level I or Level II psychiatric residential treatment facility shall comply with all the conditions for licensure established in 902 KAR 20:008.

(2) A Level I or Level II psychiatric residential treatment facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in a facility.

(3) Pursuant to KRS 216B.455(3) and 216B.457(5) which require compliance with KRS 216B.105, a person shall not operate a PRTF without first obtaining a license issued by the Office of Inspector General.

(4) Pursuant to KRS 216B.455(4) and 216B.457(6), a PRTF shall be accredited by the Joint Commission, Council on Accreditation of Services for Families and Children, or any other accrediting body with comparable standards.

Section 5. Governing Body for a Level I or Level II PRTF. A PRTF shall have a governing body with overall authority and responsibility for the facility's operation. (1)(a) The governing body shall be a legally constituted entity in the Commonwealth of Kentucky by means of a charter, articles of incorporation, partnership agreement, franchise agreement, or legislative or executive act.

(b) A Level I and a Level II PRTF that are part of the same multifacility system, or a Level II PRTF operated by a psychiatric hospital, may share the same governing body.

(2) A facility that is part of a multifacility system or is operated by a government agency shall have a written description of the system's administrative structure and lines of authority.

(3) The authority and responsibility of any person designated to function as the governing body shall be specified in writing.

(4) If a business relationship exists between a governing body member and the organization, there shall be a conflict-of-interest policy that governs the member's participation in decisions influenced by the business interest.

(5) The responsibilities of the governing body shall be stated in writing and shall describe the process for the following:

(a) Adopting policies and procedures;

(b) Providing sufficient funds, staff, equipment, supplies, and facilities to assure that the facility is capable of providing appropriate and adequate services to residents;

(c) Overseeing the system of financial management and accountability;

(d) Adopting a program to monitor and evaluate the quality of all care provided and to appropriately address identified problems in care; and

(e) Electing, appointing, or employing the clinical and administrative leadership personnel of the facility, and defining the qualifications, authority, responsibility, and function of those positions.

(6) The governing body shall meet as a whole at least quarterly and keep records that demonstrate the ongoing discharge of its responsibilities.

(7) If a facility is a component of a larger organization, the facility staff, subject to the overall authority of the governing body, shall be given the necessary authority to plan, organize, and operate the program.

Section 6. Level I or Level II PRTF Program Director. (1) A program director shall be responsible for the administrative management of the facility.

(2) A program director:

(a) Shall be qualified by training and experience to direct a treatment program for children and adolescents with emotional problems;

(b) Shall have at least minimum qualifications of a master's degree or bachelor's degree in the human services field including:

1. Social work;

2. Sociology;

3. Psychology;

4. Guidance and counseling;

5. Education;

6. Religion;

7. Business administration;

8. Criminal justice;

9. Public administration;

10. Child care administration;

11. Christian education;

12. Divinity;

13. Pastoral counseling;

14. Nursing; or

15. Another human service field related to working with families and children;

(c)1. With a master's degree shall have two (2) years of prior supervisory experience in a human services program; or

2. With a bachelor's degree shall have four (4) years of prior supervisory experience in a human services program; and

(d)1. Shall have three (3) professional references, two (2) personal references, and a crimi-

nal record check performed every two (2) years through the Administrative Office of the Courts or the Kentucky State Police;

2. Shall not have a criminal conviction, or plea of guilty, pursuant to KRS 17.165 or a Class A felony; and

3. Shall be subject to the provisions of KRS 216B.457(12), which requires submission to a check of the central registry, and requires an employee to be removed from contact with a child under the conditions described in KRS 216B.457(12).

(3) A program director shall be responsible to the governing body in accordance with the by-laws, rules or policies for the following, unless the PRTF is part of a health care system under common ownership and governance in which the duties are assigned to, or are the responsibility of, the program director's supervisor or other staff:

(a) Overseeing the overall operation of the facility, including the control, utilization, and conservation of its physical and financial assets and the recruitment and direction of staff;

(b) Assuring that sufficient, qualified, and appropriately supervised staff are on duty to meet the needs of the residents at all times;

(c) Approving purchases and payroll;

(d) Assuring that treatment planning, medical supervision, and quality assurance occur as specified in this administrative regulation;

(e) Advising the governing body of all significant matters bearing on the facility's licensure and operations;

(f) Preparing reports or items necessary to assist the governing body in formulating policies and procedures to assure that the facility is capable of providing appropriate and adequate services to residents;

(g) Maintaining a written manual that defines policies and procedures and is revised and updated at the time changes in policies and procedures occur; and

(h) Assuring that all written facility policies, plans, and procedures are followed.

Section 7. Administration and Operation of a Level I or Level II PRTF. (1) A Level I or Level II PRTF shall have written documentation of the following:

(a) An organizational chart that includes position titles and the name of the person occupying the position, and that shows the chain of command;

(b) A service philosophy with clearly defined assumptions and values;

(c) Estimates of the clinical needs of the children and adolescents served by the facility;

(d) The services provided by the facility in response to needs;

(e) The population served, including age groups and other relevant characteristics of the resident population;

(f) The intake or admission process, including how the initial contact is made with the resident and the family or significant others;

(g) The assessment and evaluation procedures provided by the facility;

(h) The methods used to deliver services to meet the identified clinical needs of the residents served;

(i) The methods used to deliver services to meet the basic needs of residents in a manner as consistent with normal daily living as possible;

(j) The methods used to create a home-like environment for all residents, including opportunities for family-style meals in which:

1. Residents dine together;

2. Residents may assist with preparation of certain dishes or help set the table; and

3. Food may be placed in serving dishes on the table;

(k) The methods, means and linkages by which the facility involves residents in community

activities, organizations, and events;

(l) The treatment planning process and the periodic review of therapy;

(m) The discharge and aftercare planning processes;

(n) The facility's therapeutic programs;

(o) How professional services are provided by qualified, experienced personnel;

(p) How mental health professionals in Level I facilities and qualified mental health professionals in Level II facilities and direct-care staff in Level I or Level II facilities who have been assigned specific treatment responsibilities are qualified by training or experience and have demonstrated competence and; or are supervised by a mental health professional or qualified mental health professional who is qualified by experience to supervise the treatment;

(q) How the facility is linked to regional interagency councils, psychiatric hospitals, community mental health centers, Department for Community Based Services offices and facilities, and school systems in the facility's service area;

(r) The means by which the facility provides, or makes arrangements for the provision of:

1. Emergency services and crisis stabilization;

2. Discharge and aftercare planning that promotes continuity of care; and

3. Education and vocational services;

(s) Services the facility provides to improve stability of care and reduce re-hospitalization including:

1. How psychiatric and nursing coverage is provided to assure the continuous ability to manage and administer medications in crisis situations except for those that may only be administered by a physician; and

2. How direct-care staffing with supervision is provided to manage behavior problems in accordance with the residents' treatment plans, including an array of interventions that are alternatives to seclusion and restraint, and the staff training necessary to implement them; and

(t) If provided, a description of each outpatient behavioral health service provided pursuant to Section 14(1) of this administrative regulation.

(2) The documentation shall be:

(a) Made available to each mental health professional in a Level I PRTF or qualified mental health professional in a Level II PRTF and to the program director; and

(b) Reviewed and revised as necessary, in accordance with the changing needs of the residents and the community and with the overall objectives and goals of the facility. Revisions in the documentation shall incorporate, as appropriate, relevant findings from the facility's quality assurance and utilization review programs.

(3) Professional staff for a Level I or Level II PRTF.

(a) A Level I PRTF shall:

1. Employ a sufficient number of mental health professionals to meet the treatment needs of residents and the goals and objectives of the facility; and

2. Meet the requirements of this subparagraph with regard to professional staffing.

a.(i) A board-eligible or board-certified child psychiatrist or board-certified adult psychiatrist shall be employed or contracted to meet the treatment needs of the residents and the functions which shall be performed by a psychiatrist specified within this administrative regulation.

(ii) If a facility has residents ages twelve (12) and under, the licensed psychiatrist shall be board-eligible or board-certified in child psychiatry.

(iii) The psychiatrist shall be present in the facility to provide professional services to the facility's residents at least weekly. The services provided shall include a review of each resident's progress and a meeting with the resident if clinically indicated.

b. A Level I PRTF shall employ at least one (1) full-time mental health professional.

c. A mental health professional in a Level I PRTF shall be available to assist on-site in



emergencies on at least an on-call basis at all times.

d. A psychiatrist shall be available on at least an on-call basis at all times.

(b) A Level II PRTF shall:

1. Employ or contract with a sufficient number of qualified mental health professionals to meet the treatment needs of residents and the goals and objectives of the facility;

2. Ensure that at least one (1) qualified mental health professional shall be available to assist on-site in emergencies on at least an on-call basis at all times; and

3. Meet the requirements established in KRS 216B.457(9) with regard to professional staff.

a. In accordance with KRS 216B.457(9)(c), the professional services provided by the licensed psychiatrist shall include meeting with each resident at least one (1) time each week unless the resident is not at the facility due to a field trip, medical appointment, or other circumstance in which the resident is not at the facility.

b. A licensed psychiatrist shall be available on at least an on-call basis at all times.

(c) Clinical director.

1. The administration of the facility shall designate one (1) full-time:

a. Mental health professional as the clinical director for a Level I PRTF; or

b. Qualified mental health professional as the clinical director for a Level II PRTF.

2. In addition to the requirements related to his or her profession, the clinical director shall have at least two (2) years of clinical experience in a mental health setting that serves children or adolescents with emotional problems.

3. The administration of the facility shall define the authority and duties of the clinical director.

4. An individual may serve as both the clinical director and the program director if the qualifications of both positions are met.

5. The clinical director shall be responsible for:

a. The maintenance of the facility's therapeutic milieu; and

b. Assuring that treatment plans developed in accordance with Section 12(3) of this administrative regulation are implemented.

6.a. A full-time mental health professional may be designated as clinical director for more than one (1) Level I PRTF if the Level I PRTFs are located on a common campus or in the same county.

b. A full-time qualified mental health professional designated as the clinical director of a Level II PRTF may service as the clinical director of more than one (1) PRTF if the PRTFs are located on a common campus or in the same county.

c. A full-time qualified mental health professional employed by a psychiatric hospital may serve as the clinical director of a Level II PRTF located on the same campus as the hospital or in the same county.

(4) Direct-care staff for a Level I PRTF.

(a) A Level I PRTF shall employ adequate direct-care staff to ensure the adequate provision of regular and emergency supervision of all residents twenty-four (24) hours a day.

(b) Level I Direct-care staff shall:

1. Have at least a high school diploma or equivalency; and

2. Complete a forty (40) hour training curriculum meeting the requirements of subsection (6)(c) of this section within one (1) month of employment.

(c) In order to assure that the residents are adequately supervised and are cared for in a safe and therapeutic manner, the direct-care staffing plan for a Level I PRTF shall meet the requirements established in this paragraph.

1. At least one (1) direct-care staff member who is a mental health associate shall be assigned direct-care responsibilities for a PRTF at all times during normal waking hours when

residents are not in school.

2. At least one (1) direct-care staff member shall be assigned to direct-care responsibilities for each three (3) residents during normal waking hours when residents are not in school.

3.a. At least one (1) direct-care staff member shall be assigned direct-care responsibilities, be awake, and be continuously available on each living unit during all hours the residents are asleep.

b. A minimum of one (1) additional direct-care staff member who is a mental health associate shall be immediately available on the grounds of the PRTF to assist with emergencies or problems which might arise.

4. If a mental health professional is directly involved in an activity with a group of residents, he or she may meet the requirement for a direct-care staff member.

5. The direct-care staff member who is supervising residents shall know the whereabouts of each resident at all times.

(d) Written policies and procedures approved by the Level I PRTF's governing body shall:

1. Provide for the supervision of the direct-care staff; and
2. Describe the responsibilities of direct-care staff in relation to professional staff.

(5) Direct-care staff for a Level II PRTF.

(a) A Level II PRTF shall employ adequate direct-care staff to ensure the adequate provision of regular and emergency supervision of all residents twenty-four (24) hours a day.

(b) Level II direct-care staff shall:

1. Have at least a high school diploma or equivalence certificate; and
2. Complete a forty (40) hour training curriculum meeting the requirements of subsection

(6)(c) of this section within one (1) month of employment.

(c) In order to assure that the residents are adequately supervised and are cared for in a safe and therapeutic manner, a Level II PRTF shall prepare a written staffing plan pursuant to KRS 216B.457(10)(a) that is tailored to meet the needs of the specific population of children and youth that will be admitted to the facility based on the facility's admission criteria.

(d) A Level II facility shall submit, follow, and revise a written staffing plan as required by KRS 216B.457(10)(a).

(6) Staff development.

(a) Level I or Level II PRTF staff development programs shall be provided and documented for administrative, professional, direct-care, and support staff.

(b) Level I or Level II PRTF professional and direct-care staff shall meet the continuing education requirements of their profession or, if there is not a continuing education requirement for that profession, be provided with forty (40) hours per year of in-service training

(c) Each Level I or Level II PRTF staff member working directly with residents shall receive annual training in the following areas:

1. Child and adolescent growth and development;
2. Emergency and safety procedures;
3. Behavior management, including de-escalation training;
4. Detection and reporting of child abuse or neglect;
5. Physical management procedures and techniques;
6. Infection control procedures; and
7. Training specific to the specialized nature of the facility.

(d) A Level I or Level II PRTF shall develop and implement a plan for staff to obtain training in first aid and cardiopulmonary resuscitation.

(7) Employment practices in a Level I or Level II PRTF.

(a) A Level I or Level II PRTF shall have employment and personnel policies and procedures designed, established, and maintained to promote the objectives of the facility, to ensure

that an adequate number of qualified personnel under appropriate supervision is provided during all hours of operation, and to support quality of care and functions of the facility.

(b) The Level I or Level II PRTF's personnel policies and procedures shall be written, systematically reviewed, and approved on an annual basis by the governing body, and dated to indicate the time of last review.

(c) The Level I or Level II PRTF's personnel policies and procedures shall provide for the recruitment, selection, promotion, and termination of staff.

(d) The Level I or Level II PRTF shall maintain job descriptions that:

1. Specify the qualifications, duties, and supervisory relationship of the position;
2. Accurately reflect the actual job situation; and
3. Are revised if a change is made in the required qualifications, duties, supervision, or any other major job-related factor.

(e) The Level I or Level II PRTF shall provide a personnel orientation to all new employees.

(f)1. The Level I or Level II PRTF's personnel policies and procedures shall be available and apply to all employees and shall be discussed with all new employees.

2. The Level I or Level II PRTF's facility administration shall establish a mechanism for notifying employees of changes in the personnel policies and procedures.

(g) The Level I or Level II PRTF's personnel policies and procedures shall describe methods and procedures for supervising all personnel, including volunteers.

(h)1. The Level I or Level II PRTF's personnel policies and procedures shall require:

a.(i) A criminal records check through the Administrative Office of the Courts or the Kentucky State Police for all new staff and volunteers to assure that only persons whose presence does not jeopardize the health, safety, and welfare of residents are employed and used;

(ii) A subsequent criminal records check on each employee or volunteer, in accordance with KRS 216B.457(11);

(iii) Removal from contact with a child within the residential treatment center if the employee or volunteer has committed or been charged with a crime listed in KRS 216B.457(12)(a), or is the subject of a cabinet investigation, pursuant to KRS 216B.457(12)(b); and

(iv) A prohibition against working with a child until the conditions of KRS 216B.457(12)(c) are met; and

b.(i) A check of the central registry, established under 922 KAR 1:470; and

(ii) A prohibition on employment or volunteer activities for any person listed on the registry, in accordance with KRS 216B.457(12)(d).

2. If an employee or volunteer is removed from contact with a child, a PRTF may take other action, in accordance with KRS 216B.457(12)(e).

(i) The Level I or Level II PRTF's personnel policies and procedures shall provide for reporting and cooperating in the investigation of suspected cases of child abuse and neglect by facility personnel.

(j) A Level I or Level II PRTF's personnel record shall be kept on each staff member and shall contain the following items:

1. Name and address;
2. Verification of all training and experience and of licensure, certification, registration, or renewals;
3. Verification of submission to the background checks required by paragraph (h) of this subsection;
4. Performance appraisals;
5. Employee incident reports; and
6. Record of health exams related to employment, including compliance with the tuberculosis testing requirements of Section 25 of this administrative regulation.

(k) The Level I or Level II PRTF's personnel policies and procedures shall assure the confidentiality of personnel records and specify who has access to various types of personnel information.

(l) Performance appraisals shall relate job description and job performance and shall be written.

Section 8. Resident Rights. (1) A Level I or Level II PRTF shall support and protect the basic human, civil, and constitutional rights of the individual resident.

(2) Written policy and procedure approved by the Level I or Level II PRTF's governing body shall provide a description of the resident's rights and the means by which these rights are protected and exercised.

(3) At the point of admission, a Level I or Level II PRTF shall provide the resident and parent, guardian, or custodian with a clearly written and readable statement of rights and responsibilities. The statement shall be read to the resident or parent, guardian, or custodian if either cannot read and shall cover, at a minimum:

(a) Each resident's right to access treatment, regardless of race, religion, or ethnicity;

(b) Each resident's right to recognition and respect of his or her personal dignity in the provision of all treatment and care;

(c) Each resident's right to be provided treatment and care in the least restrictive environment possible;

(d) Each resident's right to an individualized treatment plan;

(e) Each resident's and family's right to participate in planning for treatment;

(f) The nature of care, procedures, and treatment that the resident shall receive;

(g) The right to informed consent related to the risks, side effects, and benefits of all medications and treatment procedures used;

(h) The right, to the extent permitted by law, to refuse the specific medications or treatment procedures and the responsibility of the facility if the resident refuses treatment, to seek appropriate legal alternatives or orders of involuntary treatment, or, in accordance with professional standards, to terminate the relationship with the resident upon reasonable notice; and

(i) The right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

(4) The rights of residents in a Level I or Level II PRTF shall be written in language which is understandable to the resident, his or her parents, custodians, or guardians and shall be posted in appropriate areas of the facility.

(5) The policy and procedure concerning Level I or Level II PRTF resident rights shall assure and protect the resident's personal privacy within the constraints of his or her treatment plan. These rights to privacy shall at least include:

(a) Visitation by the resident's family or significant others in a suitable private area of the facility;

(b) Sending and receiving mail without hindrance or censorship; and

(c) Telephone communications with the resident's family or significant others at a reasonable frequency.

(6) If any rights to privacy are limited, the resident and his or her parent, guardian, or custodian shall receive a full explanation from the Level I or Level II PRTF. Limitations shall be documented in the resident's record and their therapeutic effectiveness shall be evaluated and documented by professional staff every seven (7) days.

(7) The right to initiate a complaint or grievance procedure and the means for requesting a hearing or review of a complaint shall be specified in a written policy approved by the Level I or Level II PRTF's governing body and made available to residents, parents, guardians, and cus-

todians responsible for the resident. The procedure shall indicate:

- (a) To whom the grievance is to be addressed; and
- (b) Steps to be followed for filing a complaint, grievance, or appeal.

(8) The resident and his or her parent, guardian, or custodian shall be informed of the current and future use and disposition of products of special observation and audio-visual techniques such as one (1) way vision mirrors, tape recorders, videotapes, monitors, or photographs.

(9) The policy and procedure regarding resident's rights shall ensure the resident's right to confidentiality of all information recorded in his or her record maintained by the Level I or Level II facility. The facility shall ensure the initial and continuing training of all staff in the principles of confidentiality and privacy.

(10)(a) A Level I or Level II resident shall be allowed to work for the facility only under the following conditions:

- 1. The work is part of the individual treatment plan;
- 2. The work is performed voluntarily;
- 3. The patient receives wages commensurate with the economic value of the work; and
- 4. The work project complies with applicable law and administrative regulation.

(b) The performance of tasks related to the responsibilities of family-like living, such as laundry and housekeeping, shall not be considered work for the facility and need not be compensated or voluntary.

(11) A Level I or Level II PRTF's written policy developed in consultation with professional and direct care staff and approved by the governing body shall provide for the measures utilized by the facility to discipline residents. These measures shall be fully explained to each resident and the resident's parent, guardian, or custodian.

(12) A Level I or Level II PRTF shall prohibit all cruel and unusual disciplinary measures including the following:

- (a) Corporal punishment;
- (b) Forced physical exercise;
- (c) Forced fixed body positions;
- (d) Group punishment for individual actions;
- (e) Verbal abuse, ridicule, or humiliation;
- (f) Denial of three (3) balanced nutritional meals per day;
- (g) Denial of clothing, shelter, bedding, or personal hygiene needs;
- (h) Denial of access to educational services;
- (i) Denial of visitation, mail, or phone privileges for punishment;
- (j) Exclusion of the resident from entry to his or her assigned living unit; and
- (k) Restraint or seclusion as a punishment or employed for the convenience of staff.

(13) Written policy shall prohibit Level I or Level II PRTF residents from administering disciplinary measures upon one another and shall prohibit persons other than professional or direct-care staff from administering disciplinary measures to residents.

(14)(a) Written rules of Level I or Level II PRTF resident conduct shall be developed in consultation with the professional and direct-care staff and be approved by the governing body.

(b) Residents shall participate in the development of the rules to a reasonable and appropriate extent.

(c) These rules shall be based on generally acceptable behavior for the resident population served.

(15) The application of disciplinary measures in a Level I or Level II PRTF shall relate to the violation of established rules.

Section 9. Resident Records. (1) A Level I or Level II PRTF shall:

(a) Have written policies concerning resident and, if provided, outpatient client records approved by the governing body; and

(b) Maintain a written record on each resident or, if applicable, outpatient client to be directly accessible to staff members caring for the resident or outpatient client.

(2) The Level I or Level II PRTF resident record shall contain at a minimum:

(a) Basic identifying information;

(b) Appropriate court orders or consent of appropriate family members or guardians for admission, evaluation, and treatment;

(c) A provisional or admitting diagnosis which includes a physical diagnosis, if applicable, as well as a psychiatric diagnosis;

(d) The report by the parent, guardian, or custodian of the patient's immunization status;

(e) A psychosocial assessment of the resident and his or her family, including:

1. An evaluation of the effect of the family on the resident's condition and the effect of the resident's condition on the family; and

2. A summary of the resident's psychosocial needs;

(f) An evaluation of the resident's growth and development, including physical, emotional, cognitive, educational, and social development; and needs for play and daily activities;

(g) The resident's legal custody status, if applicable;

(h) The family's, guardian's, or custodian's expectations for, and involvement in, the assessment, treatment, and continuing care of the resident;

(i) Physical health assessment, including evaluations of the following:

1. Motor development and functioning;

2. Sensorimotor functioning;

3. Speech, hearing, and language functioning;

4. Visual functioning;

5. Immunization status; and

6. The results of the tuberculosis testing required by Sections 20 and 21 of this administrative regulation; and

(j) In a Level II PRTF that opts to provide bedrooms with sleeping accommodations for two (2) residents, documentation of placement in a single occupancy bedroom if recommended by the multidisciplinary team. The basis for the team's recommendation for a single occupancy bedroom shall be maintained in the record.

(3) The Level I or Level II PRTF resident record shall also include:

(a) Physician's notes which shall include an entry made at least weekly by the staff psychiatrist regarding the condition of the resident;

(b) Professional progress notes, which shall:

1. Be completed following each professional service:

a. Daily; or

b. If the service is provided daily to groups of residents, through a weekly summary;

2. Be signed and dated by the:

a. Mental health professional who provided the service in a Level I PRTF; or

b. Qualified mental health professional who provided the service in a Level II PRTF;

(c) Direct-care progress notes which shall:

1. Record implementation of all treatment and any unusual or significant events which occur for the resident;

2. Be completed at least by the end of each direct-care shift and summarized weekly; and

3. Be signed and dated by the direct-care staff making the entry;

(d) Special clinical justifications for the use of unusual treatment procedures, including

emergency safety interventions, and reports;

(e) Discharge summary;

(f) If a patient dies, a summation statement in the form of a discharge summary, including events leading to the death, signed by the attending physician; and

(g) Documentation that any serious occurrence involving the resident was reported to the Department for Medicaid Services and to Kentucky Protection and Advocacy, and that any resident death was reported to the Centers for Medicare and Medicaid Services (CMS) regional office, as required by Sections 10(4) and 10(5) of this administrative regulation.

(4) An outpatient client record shall be maintained for each client receiving outpatient behavioral health services under Section 14(1) of this administrative regulation.

(a) Each entry shall be dated, signed, and indexed according to the outpatient service received.

(b) Each outpatient client record shall contain:

1. An identification sheet, including the client's name, address, age, gender, marital status, expected source of payment, and referral source;

2. Name, address, and telephone number of the client and client's parent or guardian;

3. Intake interview;

4. The signed and dated consent for treatment from the client's parent or guardian;

5. The report of the behavioral health assessment and other assessments as appropriate, which may include psychological testing;

6. The plan of care as described in Section 14(5) of this administrative regulation;

7. Examination, diagnosis, and progress notes by the physician, nurse, or other behavioral health professionals or treatment staff that relate to the implementation of plan of care objectives;

8. A record of all contacts with other providers, family members, community partners, or other contacts;

9. A record of medical treatment and administration of medication, if administered;

10. An original or original copy of all physician medication and treatment orders, if applicable; and

11. Documentation of orientation to the program and program rules.

(5) A Level I or Level II PRTF shall maintain confidentiality of resident and, if applicable, outpatient client records. Resident or outpatient client information shall be released only on written consent of the resident, outpatient client, or his or her parent, guardian, or custodian or as otherwise authorized by law. The written consent shall contain the following information:

(a) The name of the person, agency, or organization to which the information is to be disclosed;

(b) The specific information to be disclosed;

(c) The purpose of disclosure; and

(d) The date the consent was signed and the signature of the individual witnessing the consent.

**Section 10. Quality Assurance.** (1) A Level I or Level II PRTF shall have an organized quality assurance program designed to enhance resident treatment and care, including outpatient services if provided, through the ongoing objective assessment of important aspects of care and the correction of identified problems.

(2) A Level I or Level II PRTF shall prepare a written quality assurance plan designed to ensure that there is an ongoing quality assurance program that includes effective mechanisms for reviewing and evaluating resident care, including outpatient services if provided, and that provides for appropriate response to findings.

(3) A Level I or Level II PRTF shall record all incidents or accidents that present a direct or immediate threat to the health, safety or security of any resident or staff member. Examples of incidents to be recorded include the following: physical violence, fighting, absence without leave, use or possession of drugs or alcohol, or inappropriate sexual behavior. The record shall be kept on file and retained at the facility and shall be made available for inspection by the licensure agency.

(4)(a) A Level I or Level II PRTF shall report any serious occurrence involving a resident to the Department for Medicaid Services and to Kentucky Protection and Advocacy by no later than close of business the next business day after the serious occurrence.

(b) The report shall include:

1. The name of the resident involved in the serious occurrence;
2. A description of the occurrence; and
3. The name, street address, and telephone number of the facility.

(5) A Level I or Level II PRTF shall report the death of any resident to the 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.

Section 11. Admission Criteria. (1) A Level I or Level II PRTF shall have written admission criteria that are:

- (a) Approved by the governing body; and
- (b) Consistent with the facility's goals and objectives.

(2) Admission criteria shall be made available to referral sources and to parents, guardians, or custodians and shall include:

- (a) Types of admission (crisis stabilization, long-term treatment);
- (b) Age and sex of accepted residents;
- (c) Criteria that preclude admission in a Level I or Level II PRTF;
- (d) Clinical needs and problems typically addressed by the facility's programs and services;
- (e) Criteria for discharge;
- (f) Any preplacement requirements of the resident, his or her parents, guardians, custodians, or the placing agency; and

(g) Residency requirements. In a Level II PRTF that opts to provide bedrooms with sleeping accommodations for two (2) residents, the facility shall:

1. Place each newly admitted resident in a single occupancy bedroom until completion of the comprehensive treatment plan of care, which shall be completed within ten (10) calendar days of admission pursuant to Section 12(4)(c) of this administrative regulation;

2. Maintain a resident in a single occupancy bedroom if recommended in the comprehensive treatment plan of care; and

3. Provide notification and general information to each Level II resident's parent, guardian, or custodian about the installation of the electronic surveillance system required by 902 KAR 20:330, Section 6(3)(d), if the resident is placed in a bedroom shared with another resident.

(3) Pursuant to 42 C.F.R. 483.356, at admission, a facility shall:

(a) Inform both the incoming resident and the resident's parent or legal guardian of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;

(b) Communicate its restraint and seclusion policy in a language that the resident or his or her parent or legal guardian understands (including American Sign Language, if appropriate) and if necessary, the facility shall provide interpreters or translators;

(c) Obtain an acknowledgment, in writing, from the resident's parent or legal guardian that he or she has been informed of the facility's policy on the use of restraint or seclusion during



an emergency safety situation. Staff shall file this acknowledgment in the resident's record; and

(d) Provide a copy of the facility policy to the resident's parent or legal guardian. The facility's policy shall provide contact information, including the phone number and mailing address for Kentucky Protection and Advocacy.

(4) Age limits.

(a) Residents admitted to a Level I PRTF shall have obtained age six (6), but not attained age eighteen (18).

(b) Residents in a Level I PRTF may remain in care until age twenty-one (21) if admitted by their 18th birthday.

(c) Pursuant to KRS 216B.450(5)(b), a Level II PRTF may provide inpatient psychiatric residential treatment and habilitation to persons who are age four (4) to twenty-one (21) years.

(d)1. Admission criteria related to age at admission shall be determined by the age grouping of children currently in residence and shall reflect a range no greater than five (5) years in a living unit for residents six (6) years of age and older.

2. If a Level II PRTF admits residents who are four (4) or five (5) years of age, the age range shall not be more than three (3) years in the living unit.

(5) Children and adolescents who are a danger to self or others for whom the facility is unable to develop a risk-management plan shall not be admitted to a Level I PRTF.

(6)(a) Except for paragraph (b) of this subsection, a Level II PRTF shall not refuse to admit a patient who meets the medical necessity criteria and facility criteria for Level II facility services pursuant to KRS 216B.457(2).

(b) A Level II PRTF shall refuse to admit a patient if the admission exceeds the facility's licensed bed capacity.

## Section 12. Resident Management. (1) Intake.

(a) A Level I or Level II PRTF shall have written policies and procedures approved by the facility administration for the intake process which addresses at a minimum the following:

1. Referral, records, and statistical data to be kept regarding applicants for residence;
2. Criteria for determining the eligibility of individuals for admission;
3. Methods used in the intake process which shall be based on the services provided by the facility and the needs of residents; and
4. Procurement of appropriate consent forms. This may include the release of educational and medical records.

(b) The intake process shall be designed to provide at least the following information:

1. Identification of agencies who have been involved in the treatment of the resident in the community and the anticipated extent of involvement of those agencies during and after the resident's stay in the facility;
2. Legal, custody and visitation orders; and
3. Proposed discharge plan and anticipated length of stay.

(c) The intake process shall include an orientation for the parent, guardian, or custodian as appropriate and the resident which includes the following:

1. The rights and responsibilities of residents, including the rules governing resident conduct and the types of infractions that can result in disciplinary action or discharge from the facility;
2. Rights, responsibilities, and expectations of the parent, guardian, or custodian; and
3. Preparation of the staff and residents of the facility for the new resident.

(d) Upon admission each resident of school age shall have been certified or be referred for assessment as a child with a disability pursuant to 20 U.S.C. 1400.

(2) Assessment.

(a) A complete evaluation and assessment shall be performed for each resident which in-

cludes at least physical, emotional, behavioral, social, recreational, educational, legal, vocational, and nutritional needs.

(b) An initial health screening for illness, injury, and communicable disease or other immediate needs shall be conducted within twenty-four (24) hours after admission by a nurse.

(c) A physician, nurse practitioner, or physician's assistant shall conduct a physical examination of each resident within fourteen (14) days after admission. Communication to schedule the physical examination of each resident shall be initiated within twenty-four (24) hours after admission. The physical examination shall include at least evaluations of the following:

1. Motor development and functioning;
2. Sensorimotor functioning;
3. Speech, hearing, and language functioning;
4. Visual functioning; and

5. Immunization status. If a resident's immunization is not complete as required by 902 KAR 2:060, the facility shall be responsible for its completion and shall begin to complete any immunizations which are outside of the set periodicity schedule within thirty (30) days of admission or the physical examination, whichever is later.

(d) If the resident has had a complete physical examination by a qualified physician, nurse practitioner, or physician's assistant within the previous three (3) months which includes the requirements of paragraph (c) of this subsection and if the facility obtains complete copies of the record, the physician, nurse practitioner, or physician's assistant may determine after reviewing the records and assessing the resident's physical health that a complete physical examination is not required. If that determination is made, the examination performed in the previous three (3) months shall be used to meet the requirement for a physical examination in paragraph (c) of this subsection.

(e) Facilities shall have all the necessary diagnostic tools and personnel available or have written agreements with another organization to provide physical health assessments, including electroencephalographic equipment, a qualified technician trained in dealing with children and adolescents, and a properly qualified physician to interpret electroencephalographic tracing of children and adolescents.

(f) An emotional and behavioral assessment of each resident that includes an examination by a psychiatrist shall be completed and entered in the resident's record. The emotional and behavioral assessment shall include the following:

1. A history of previous emotional, behavioral, and substance abuse problems and treatment;
2. The resident's current emotional and behavioral functioning, risk factors, protective factors and needs;
3. A direct psychiatric evaluation;
4. If indicated, psychological assessments, including intellectual, projective, and personality testing;
5. If indicated, other functional evaluations of language, self-care, and social-affective and visual-motor functioning; and
6. An evaluation of the developmental age factors of the resident.

(g) The facility shall have an assessment procedure for the early detection of mental health problems that are life threatening, are indicative of severe cognitive disorganization or deterioration, or may seriously affect the treatment or rehabilitation process.

(h) A social assessment of each resident shall be undertaken and include:

1. Environment and home;
2. Religion;
3. Childhood history;

4. Financial status;
5. The social, peer-group, and environmental setting from which the resident comes; and
6. The resident's family circumstances, including the constellation of the family group; the current living situation; and social, ethnic, cultural, emotional, and health factors, including drug and alcohol use.

(i) The social assessment shall include a determination of the need for participation of family members or significant others in the resident's treatment.

(j) An activities assessment of each resident shall include information relating to the individual's current skills, talents, aptitudes, and interest.

(k) An assessment shall be performed to evaluate the resident's potential for involvement in community activity, organizations, and events.

(l) For adolescents age fourteen (14) and older, a vocational assessment of the resident shall be done which includes the following:

1. Vocational history;
2. Education history, including academic and vocational training; and
3. A preliminary discussion, between the resident and the staff member doing the assessment, concerning the resident's past experiences with an attitude toward work, present motivations or areas of interest, and possibilities for future education, training, and employment.

(m) If appropriate, a legal assessment of the resident shall be undertaken and shall include the following:

1. A legal history; and
2. A preliminary discussion to determine the extent to which the legal situation will influence his or her progress in treatment and the urgency of the legal situation.

(3) Level I treatment plans.

(a)1. Within seventy-two (72) hours following admission, a mental health professional shall develop an initial treatment plan that is based at least on an assessment of the resident's presenting problems, physical health, and emotional and behavioral status.

2. Appropriate therapeutic efforts shall begin before a master treatment plan is finalized.

(b)1. A comprehensive treatment plan of care shall be developed by a multidisciplinary team conference in conformity with 42 C.F.R. 441.156 within ten (10) days of admission for any resident remaining in treatment. It shall:

a. Be based on the comprehensive assessment of the resident's needs completed pursuant to subsection (2) of this section;

b. Include a substantiated diagnosis and the short-term and long-range treatment needs; and

c. Address the specific treatment modalities required to meet the resident's needs.

2. The comprehensive treatment plan of care shall:

a. Contain specific and measurable goals for the resident to achieve;

b. Describe the services, activities, and programs to be provided to the resident, and shall specify staff members assigned to work with the resident and the time or frequency for each treatment procedure; and

c. Specify criteria to be met for termination of treatment; and

d. Include any referrals necessary for services not provided directly by the facility.

3. The resident shall participate to the maximum extent feasible in the development of his or her comprehensive treatment plan of care, and the participation shall be documented in the resident's record.

4.a. A specific plan for involving the resident's family or significant others shall be included in the comprehensive treatment plan of care.

b. The parent, guardian, or custodian shall be given the opportunity to participate in the mul-

tidisciplinary treatment plan conference if feasible and shall be given a copy of the resident's comprehensive treatment plan of care.

c. The comprehensive treatment plan of care shall identify the mental health professional who is responsible for coordinating and facilitating the family's involvement throughout treatment.

5. The comprehensive treatment plan of care shall be reviewed and updated through multidisciplinary team conferences as clinically indicated and at least thirty (30) days following the first ten (10) days of treatment. The comprehensive treatment plan of care shall be reviewed every thirty (30) days thereafter and updated every sixty (60) days or earlier if clinically indicated.

6. Following one (1) year of continuous treatment, the review and update may be conducted at three (3) month intervals.

(c) The comprehensive treatment plan of care and each review and update shall be signed by the participants in the multidisciplinary team conference that developed it.

(4) Level II PRTF treatment plans.

(a) A Level II PRTF shall develop and implement an initial treatment plan of care for each resident as required by KRS 216B.457(13).

(b) Appropriate therapeutic efforts shall begin before a comprehensive treatment plan of care is finalized.

(c)1. A comprehensive treatment plan of care shall be developed by a multidisciplinary team conference in conformity with 42 C.F.R. 441.156 and KRS 216B.457(14).

2. In a Level II PRTF that opts to provide bedrooms with sleeping accommodations for two (2) residents, the comprehensive treatment plan of care shall document whether the facility's multidisciplinary team recommends placement of the resident in a private bedroom or in a double occupancy bedroom with another resident.

3. The comprehensive treatment plan of care shall:

- a. Contain specific and measurable goals for the resident to achieve;
- b. Describe the services, activities, and programs to be provided to the resident; and
- c. Specify staff members assigned to work with the resident and the time or frequency for each treatment procedure.

4. The resident shall participate to the maximum extent feasible in the development of his or her comprehensive treatment plan of care, and the participation shall be documented in the resident's record.

5.a. A specific plan for involving the resident's family or significant others shall be included in the comprehensive treatment plan of care.

b. The parent, guardian, or custodian shall be given the opportunity to participate in the multidisciplinary treatment plan conference if feasible and shall be given a copy of the resident's comprehensive treatment plan of care.

c. The comprehensive treatment plan of care shall identify the mental health professional who is responsible for coordinating and facilitating the family's involvement throughout treatment.

(d) The comprehensive treatment plan of care shall be reviewed and documented as required by KRS 216B.457(15).

(5) Level I and Level II PRTF progress notes.

(a) Progress notes shall be entered in the resident's records, be used as a basis for reviewing the treatment plan, signed and dated by the individual making the entry and shall include the following:

1. Documentation of implementation of the treatment plan;
2. Chronological documentation of all treatment provided to the resident and documentation

of the resident's clinical course; and

3. Descriptions of each change in each of the resident's conditions.

(b) All entries involving subjective interpretation of the resident's progress shall be supplemented with a description of the actual behavior observed.

(c) Efforts shall be made to secure written progress reports for residents receiving services from outside sources and, if available, to include them in the resident record.

(d) The resident's progress and current status in meeting the goals and objectives of his or her treatment plan shall be regularly recorded in the resident record.

(6) Discharge planning. A Level I or Level II PRTF shall have written policies and procedures for discharge of residents.

(a)1. Discharge planning shall begin at admission and be documented in the resident's record.

2. At least ninety (90) days prior to the planned discharge of a resident from the facility, or within ten (10) days after admission if the anticipated length of stay is under ninety (90) days, the multidisciplinary team shall formulate a discharge and aftercare plan.

3. This plan shall be maintained in the resident's record and reviewed and updated with the comprehensive treatment plan of care.

(b) All discharge recommendations shall be determined through a conference, including the appropriate facility staff, the resident, the resident's parents, guardian, or custodian and, if indicated, the representative of the agency to whom the resident may be referred for any aftercare service, and the affected local school districts. All aftercare plans shall delineate those parties responsible for the provision of aftercare services.

(c) If the aftercare plan involves placement of the resident in another licensed program following discharge, facility staff shall share resident information with representatives of the aftercare program provider if authorized by written consent of the parent, guardian, or custodian.

(d) A Level I facility deciding to release a resident on an unplanned basis shall:

1. Have reached the decision to release at a multidisciplinary team conference chaired by the clinical director that determined, in writing, that services available through the facility cannot meet the needs of the resident;

2. Provide at least ninety-six (96) hours notice to the resident's parent, guardian, or custodian and the agency which will be providing aftercare services. If authorized by written consent of the parent, guardian, or custodian, the facility shall provide to the receiving agency copies of the resident's records and discharge summary; and

3. Consult with the receiving agency in situations involving placement for the purpose of ensuring that the placement reasonably meets the needs of the resident.

(e) Within fourteen (14) days of a resident's discharge from the facility, the facility shall compile and complete a written discharge summary for inclusion in the resident's record. The discharge summary shall include:

1. Name, address, phone number, and relationship of the person to whom the resident was released;

2. Description of circumstances leading to admission of the resident to the facility;

3. Significant problems of the resident;

4. Clinical course of the resident's treatment;

5. Assessment of remaining needs of the resident and alternative services recommended to meet those needs;

6. Special clinical management requirements including psychotropic drugs;

7. Brief descriptive overview of the aftercare plan designed for the resident; and

8. Circumstances leading to the unplanned or emergency discharge of the resident, if applicable.

Section 13. Services. A Level I or Level II PRTF shall provide the following services in a manner which takes into account and addresses the social life; emotional, cognitive, and physical growth and development; and the educational needs of the resident. Services shall include the opportunity for the resident to participate in community activities, organizations and events and shall provide a normalized environment for the resident. (1) Level I or Level II mental health services.

(a) Mental health assessments and evaluations shall be provided as required in Section 12 of this administrative regulation.

(b) The mental health services available through the Level I or Level II PRTF shall include the services listed in this paragraph provided by staff of the Level I or Level II PRTF:

1. Case coordination services to assure the full integration of all services provided to each resident. Case coordination activities shall include monitoring the resident's daily functioning to assure the continuity of service in accordance with the resident's treatment plan and ensuring that all staff responsible for the care and delivery of services actively participate in the development and implementation of the resident's treatment plan;

2. Planned on-site therapies including individual, family, and group therapies as indicated by the comprehensive treatment plan of care.

a. These therapies shall include psychotherapy, interventions, or face-to-face contacts, which may be made verbally or using assistive communication, between staff and the resident to enhance the resident's psychological and social functioning as well as to facilitate the resident's integration into a family unit.

b. Contacts that are incidental to other activities shall be excluded from this service;

3. Task and skill training to enhance a resident's age appropriate skills necessary to facilitate the resident's ability to care for himself or herself, and to function effectively in community settings. Task and skill training activities shall include homemaking, housekeeping, personal hygiene, budgeting, shopping, and the use of community resources.

(2) Level I or Level II physical health services.

(a) The physical health services available through the Level I or Level II PRTF facility shall include the following services provided either directly by the facility or written agreement:

1. Assessments and evaluations as required in Section 12 of this administrative regulation;

2. Diagnosis, treatment, and consultation for acute or chronic illnesses occurring during the resident's stay at the facility or for problems identified during an evaluation;

3. Preventive health care services to include periodic assessments in accordance with the periodicity schedule established by the American Academy of Pediatrics;

4. A dental examination within six (6) months of admission, periodic assessments in accordance with the periodicity schedule established by the American Dental Association, and treatment as needed;

5. Health and sex education; and

6. An ongoing immunization program.

(b) If physical health services are provided by written agreement with a provider of services other than the facility, the written agreement shall, at a minimum, address:

1. Referral of residents;

2. Qualifications of staff providing services;

3. Exchange of clinical information; and

4. Financial arrangements.

(c) A Level I or Level II PRTF shall not admit a resident who has a communicable disease or acute illness requiring treatment in an acute care inpatient setting.

(3) Level I or Level II dietary services.

(a) A Level I or Level II PRTF shall have written policies and procedures approved by the governing body for the provision of dietetic services for staff and residents which may be provided directly by the facility staff or through written contractual agreement.

(b) Adequate staff, space, equipment, and supplies shall be provided for safe sanitary operation of the dietetic service, the safe and sanitary handling and distribution of food, the care and cleaning of equipment and kitchen area, and the washing of dishes.

(c) The nutritional aspects of resident's care shall be planned, reviewed, and periodically evaluated by a licensed dietician pursuant to KRS 310.021 and employed by the facility as a staff member or consultant.

(d) The food shall be served to residents and staff in a common eating place and:

1. Shall account for the special food needs and tastes of residents;
2. Shall not be withheld as punishment; and
3. Shall provide for special dietary need of residents such as those relating to problems, such as diabetes and allergies.

(e) Residents shall participate in the preparation and serving of food as appropriate.

(f) At least three (3) meals per day shall be served with not more than a fifteen (15) hour span between the substantial evening meal and breakfast. The facility shall arrange for and make provision for between-meal and unscheduled snacks.

(g) Except for school lunches and meals at restaurants, all members of a living unit shall be provided their meals together as a therapeutic function of the living unit.

(4) Level I or Level II emergency services.

(a) A Level I or Level II PRTF shall provide for the prompt notification of the resident's parents, guardian, or custodian in case of serious illness, injury, surgery, emergency safety intervention, elopement, or death.

(b)1. All staff shall be knowledgeable of a written plan and procedure for meeting potential disasters and emergencies such as fires or severe weather.

2. The plan shall be posted.

3. Staff shall be trained in properly reporting a fire, extinguishing a small fire, and in evacuation from the building.

4. Fire drills shall be practiced monthly, with a written record kept of all practiced fire drills, detailing the date, time, and residents who participated.

(c) The facility shall have written procedures to be followed by staff if a psychiatric, medical, or dental emergency of a resident occurs that specifies:

1. Notification of designated member of the facility's chain of command;

2. Designation of staff person who shall decide to refer resident to outside treatment resources;

3. Notification of resident's parent, guardian, or custodian;

4. Transportation to be used;

5. Staff member to accompany resident;

6. Necessary consent and referral forms to accompany resident; and

7. Name, location, and telephone of designated treatment resources.

(d) The facility shall have designated treatment resources who shall have agreed to accept a resident for emergency treatment. At a minimum the resources shall include:

1. Licensed physician and an alternate designee;

2. Licensed dentist and an alternate designee;

3. Licensed hospital; and

4. Licensed hospital with an accredited psychiatric unit.

(5) Level I or Level II pharmacy services. A Level I or Level II PRTF shall have written policies and procedures approved by the governing body for proper management of pharmaceuti-

icals that are consistent with the requirements established in this subsection.

(a)1. Medications shall be administered by a registered nurse, physician, or dentist, except if administered by a licensed practical nurse, certified medication aide, or direct care staff under the supervision of a registered nurse.

2. Direct care staff who administer medications shall have successfully completed a medicine administration course approved by the Kentucky Board of Nursing.

(b)1. Medications shall not be given without a written order signed by a physician, dentist, advanced practice registered nurse as authorized in KRS 314.011(8) and 314.042(8), therapeutically-certified optometrist as authorized in KRS 320.240(14), or physician assistant as authorized by KRS 311.858.

2. Telephone orders for medications shall be given only to licensed nurses or a pharmacist and signed by a physician, dentist, advanced practice registered nurse, therapeutically-certified optometrist, or physician assistant within seventy-two (72) hours from the time the order is given.

(c) Medications shall be prescribed only if clinically indicated. The facility shall ensure that medication is not administered solely for the purpose of program management or control, and that medication is not prescribed for the purposes of experimentation or research.

(d) All medications shall require "stop orders".

(e) All prescriptions shall be reevaluated by the prescriber prior to its renewal.

(f) There shall be a systematic method for prescribing, ordering, receipting, storing, dispensing, administering, distributing and accounting for all medications.

(g) The facility shall provide maximum security storage of and accountability for all legend medications, syringes, and needles.

(h) Self-administration of medication shall be permitted only if specifically ordered by the responsible prescriber and supervised by a member of the professional staff or a mental health associate. Drugs to be self-administered shall be stored in a secured area and be made available to the resident at the time of administration.

(i) Residents permitted to self-administer drugs shall be counseled regarding the indications for which the drugs are to be used, the primary side effects, and the physical dosage forms which are to be administered.

(j) Drugs brought into the facility by residents shall not be administered unless they have been identified and unless written orders to administer these specific drugs are given by the responsible physician. Otherwise these drugs shall be packaged, sealed, and stored, and, if approved by the responsible physician, returned to the resident, parent, guardian, or custodian at the time of discharge.

(6) Level I or Level II education and vocational services.

(a) Educational and vocational services available through a PRTF shall include the minimum requirements of Kentucky Revised Statutes and federal laws and regulations regarding regular education, vocational education, and special education as appropriate to meet the needs of the residents.

1. Educational services shall be provided by:

a. The facility;

b. The local school district in which the facility is located; or

c. A nonpublic school program which is specially accredited and approved by the Kentucky Department of Education to provide special education services to students with disabilities.

2. If the educational services are provided by the facility, the school program shall be specially accredited and approved by the Kentucky Department of Education to provide special education services to students with disabilities.

3. Educational services provided by a local school district shall be provided within the facility



or within the local school district.

4. The facility's multidisciplinary team shall make a recommendation concerning the delivery site of educational services provided by a local school district that is based on least restrictive environment determinations for individual residents.

5. Education services approved by the Department of Education shall be available either on the same site or in close physical proximity to the PRTF.

(b) If the education services are not provided directly by the facility, there shall be a written plan for the provision of education services. The education provider shall be a state education department-approved program. The written plan shall, at a minimum, address:

1. Qualifications of staff providing educational services;
2. Participation of educational and vocational staff in the plan for the provision of educational services;
3. Access by staff of the facility to educational and vocational programs and records; and
4. Financial and service arrangements.

(c) The facility shall ensure that residents have opportunities to be educated in the least restrictive environment consistent with the treatment needs of the resident as determined by the multidisciplinary team and reflected in the resident's comprehensive treatment plan of care.

(d) The facility shall ensure that education services are developed and implemented with input from the child's education staff in conjunction with the comprehensive treatment plan of care and meet the requirements established in this paragraph.

1. Each resident's comprehensive treatment plan of care shall include formal academic goals for remediation and continuing education.

2.a. Each resident who is eligible for special education services shall have treatment activities developed by the multidisciplinary team, which shall be incorporated, as applicable, into the individualized education plan developed by the local school district.

b. The multidisciplinary team shall develop treatment activities which extend into the classroom as appropriate.

c. The program director or designee shall request an invitation to attend all individualized education plan or Admissions and Release Committee meetings.

d. If allowed, the program director or designee shall attend all individualized education plan or Admissions and Release Committee meetings.

3. To avoid unnecessary duplication and make maximum use of resources, the services provided by the education and treatment components for children with disabilities pursuant to 20 U.S.C. 1400 shall be developed with the opportunity for input from both school personnel and the PRTF.

(f)1. The facility shall provide or arrange for vocational services for residents, as is age appropriate and is in accordance with the comprehensive treatment plan of care.

2. The services shall be planned, implemented and supervised by a vocational counselor or appropriate therapist who shall be a full- or part-time employee of the facility or a consultant.

(g) Residents may be permitted to accumulate earnings in a bank account established with the resident by the facility.

(7) Level I or Level II PRTF activity services.

(a) A daily schedule of planned recreational activities shall be prepared for the approval of the clinical director prior to implementation of the schedule.

1. The schedule shall be for normal waking hours that residents are not in school, or in active treatment.

2. The schedule shall include a full range of activities which may include physical recreation, team sports, art, and music; attendance at recreational and cultural events in the community if appropriate; and individualized, directed activities like reading and crafts.

3. Nondirected leisure time shall be limited to two (2) one-half (1/2) hour periods on school days and three (3) one-half (1/2) hour periods on nonschool days.

4. The activity schedule shall identify the professional or direct-care staff who will lead and support each activity.

5. Changes made to the schedule as the schedule is implemented shall be indicated on a copy of each daily schedule maintained as a permanent record by the clinical director.

(b) Appropriate time, space, and equipment shall be provided by the facility for leisure activity and free play.

(c) The facility shall provide the means of observing holidays and personal milestones in keeping with the cultural and religious background of the residents.

(8) Speech, language, and hearing services. A Level I or Level II PRTF shall provide or arrange for speech, language, and hearing services to meet the identified needs of residents. These services shall be provided by the facility or through written agreement with a qualified speech-language and hearing clinician. The written agreement shall, at a minimum, address:

- (a) Referral of residents;
- (b) Qualifications of staff providing services;
- (c) Exchange of clinical information; and
- (d) Financial arrangements.

Section 14. Provision of Outpatient Behavioral Health Services, Requirements for Case Managers, Plan of Care, and Physical Environment Requirements. (1) A Level I or Level II PRTF may provide one (1) or more of the following outpatient behavioral health services:

(a) Screening which shall be provided to a client age twenty-one (21) or younger by a behavioral health professional, behavioral health professional under clinical supervision, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice to determine the:

1. Likelihood that an individual has a mental health, substance use, or co-occurring disorder; and

2. Need for an assessment;

(b) Assessment which shall:

1. Be provided to a client age twenty-one (21) or younger by a behavioral health professional, behavioral health professional under clinical supervision, licensed behavior analyst, licensed assistant behavior analyst working under the supervision of a licensed behavior analyst, a certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice who gathers information and engages in a process with the client, thereby enabling the professional to:

a. Establish the presence or absence of a mental health, substance use, or co-occurring disorder;

b. Determine the client's readiness for change;

c. Identify the client's strengths or problem areas which may affect the treatment and recovery processes; and

d. Engage the client in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinical disorder or service need;

3. Include working with the client to develop a plan of care if a clinical disorder or service need is assessed; and

4. Not include psychological or psychiatric evaluations or assessments;

(c) Psychological testing which shall:

1. Be performed by a licensed psychologist, licensed psychological associate, or licensed psychological practitioner for a client age twenty-one (21) or younger; and
2. Include a psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities, and interpretation and written report of testing results;
- (d) Crisis intervention which:
  1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to the client or another individual;
  2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities;
  3. Shall be provided to a client age twenty-one (21) or younger:
    - a. On-site in the facility where the licensee provides outpatient behavioral health services;
    - b. As an immediate relief to the presenting problem or threat; and
    - c. In a face-to-face, one (1) on one (1) encounter;
  4. May include verbal de-escalation, risk assessment, or cognitive therapy;
  5. Shall be provided by one (1) or more of the following practicing within his or her scope of practice:
    - a. Behavioral health professional;
    - b. Behavioral health professional under clinical supervision;
    - c. Certified alcohol and drug counselor;
    - d. Licensed clinical alcohol and drug counselor; or
    - e. Licensed clinical alcohol and drug counselor associate;
  6. Shall be followed by a referral to noncrisis services, if applicable; and
  7. May include:
    - a. Further service prevention planning, including:
      - (i) Lethal means reduction for suicide risk; or
      - (ii) Substance use disorder relapse prevention; or
    - b. Verbal de-escalation, risk assessment, or cognitive therapy;
- (e) Mobile crisis services which shall:
  1. Be provided to a client age twenty-one (21) or younger;
  2. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the year;
  3. Be provided for a duration of less than twenty-four (24) hours;
  4. Not be an overnight service;
  5. Be a multi-disciplinary team based intervention that ensures access to acute mental health and substance use services and supports to:
    - a. Reduce symptoms or harm; or
    - b. Safely transition an individual in an acute crisis to the appropriate, least restrictive level of care;
  6. Involve all services and supports necessary to provide:
    - a. Integrated crisis prevention;
    - b. Assessment and disposition;
    - c. Intervention;
    - d. Continuity of care recommendations; and
    - e. Follow-up services;
  7. Be provided face-to-face in a home or community setting by one (1) or more of the following practicing within his or her scope of practice:
    - a. Behavioral health professional;
    - b. Behavioral health professional under clinical supervision;
    - c. Certified alcohol and drug counselor;
    - d. Licensed clinical alcohol and drug counselor; or

- e. Licensed clinical alcohol and drug counselor associate; and
- 8. Ensure access to a board certified or board-eligible psychiatrist for consultation twenty-four (24) hours a day, seven (7) days a week, every day of the year;
- (f) Day treatment which shall:
  - 1. Be a nonresidential, intensive treatment program designed for children who:
    - a. Have a substance use disorder, mental health disorder, or co-occurring disorder;
    - b. Are under twenty-one (21) years of age; and
    - c. Are at high risk of out-of-home placement due to a behavioral health issue;
  - 2. Consist of an organized, behavioral health program of treatment and rehabilitative services for substance use disorder, mental health disorder, or a co-occurring disorder;
  - 3. Have unified policies and procedures that address the facility's philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning;
  - 4. Include the following:
    - a. Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;
    - b. Behavior management and social skill training;
    - c. Independent living skills that correlate to the age and developmental stage of the client; and
    - d. Services designed to explore and link with community resources before discharge and to assist the client and family with transition to community services after discharge;
  - 5. Be provided as follows:
    - a. In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);
    - b. On school days and during scheduled breaks;
    - c. In coordination with the child's individual educational plan or Section 504 plan if the child has an individual educational plan or Section 504 plan;
    - d. By personnel that includes a behavioral health professional, a behavioral health professional under clinical supervision, a certified alcohol and drug counselor, a licensed clinical alcohol and drug counselor, a licensed clinical alcohol and drug counselor associate, or a peer support specialist practicing within his or her scope of practice; and
    - e. According to a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider; and
  - 6. Not include a therapeutic clinical service that is included in a child's individualized education plan;
- (g) Peer support which:
  - 1. Shall be provided by a peer support specialist;
  - 2. Shall be structured and scheduled nonclinical therapeutic activity with a client or group of clients;
  - 3. Shall promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills;
  - 4. Shall be identified in the client's plan of care; and
  - 5. If provided by a family peer support specialist who meets the requirements of 908 KAR 2:230, may be provided to an individual over the age of twenty-one (21) as follows:
    - a. The individual shall be a family member of a client age twenty-one (21) or younger who receives outpatient behavioral health services from the Level I or Level II PRTF; and
    - b. The family peer support services shall focus on the needs and treatment of the client as identified in the client's plan of care;
- (h) Intensive outpatient program services which shall:

1. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy;
2. Be provided to a client age twenty-one (21) or younger and may continue without disruption after the client reaches age twenty-two (22) if the service is continued for therapeutic benefit as identified in the client's plan of care;
3. Be provided at least three (3) hours per day at least three (3) days per week;
4. Include the following:
  - a. Individual outpatient therapy;
  - b. Group outpatient therapy;
  - c. Family outpatient therapy unless contraindicated;
  - d. Crisis intervention; or
  - e. Psycho-education during which the client or client's family member shall be:
    - (i) Provided with knowledge regarding the client's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and
    - (ii) Taught how to cope with the client's diagnosis or condition in a successful manner;
5. Include a treatment plan which shall:
  - a. Be individualized; and
  - b. Focus on stabilization and transition to a lesser level of care;
6. Be provided by a behavioral health professional, behavioral health professional under clinical supervision, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice;
7. Include access to a board-certified or board-eligible psychiatrist for consultation;
8. Include access to a psychiatrist, other physician, or advanced practice registered nurse for medication prescribing and monitoring; and
9. Be provided in a setting with a minimum client-to-staff ratio of ten (10) clients to one (1) staff person;
  - (i) Individual outpatient therapy which shall:
    1. Be provided to promote the:
      - a. Health and wellbeing of the client; or
      - b. Recovery from a substance related disorder;
    2. Be provided to a client age twenty-one (21) or younger and may continue without disruption after the client reaches age twenty-two (22) if the service is continued for therapeutic benefit as identified in the client's plan of care;
    3. Consist of:
      - a. A face-to-face encounter with the client; and
      - b. A behavioral health therapeutic intervention provided in accordance with the client's plan of care;
    4. Be aimed at:
      - a. Reducing adverse symptoms;
      - b. Reducing or eliminating the presenting problem of the client; and
      - c. Improving functioning;
    5. Not exceed three (3) hours per day; and
    6. Be provided by a behavioral health professional, a behavioral health professional under clinical supervision, licensed behavior analyst, licensed assistant behavior analyst working under the supervision of a licensed behavior analyst, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice;

(j) Group outpatient therapy which shall:

1. Be provided to promote the:
  - a. Health and wellbeing of the client; or
  - b. Recovery from a substance related disorder;
2. Be provided to a client age twenty-one (21) or younger and may continue without disruption after the client reaches age twenty-two (22) if the service is continued for therapeutic benefit as identified in the client's plan of care;
3. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the client's plan of care;
4. Excluding multi-family group therapy, be provided in a group setting of nonrelated individuals, not to exceed twelve (12) individuals in size. For group outpatient therapy, a nonrelated individual means any individual who is not a spouse, significant other, parent or person with custodial control, child, sibling, stepparent, stepchild, step-brother, step-sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild;
5. Focus on the psychological needs of the client as evidenced in the client's plan of care;
6. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;
7. Not include physical exercise, a recreational activity, an educational activity, or a social activity;
8. Not exceed three (3) hours per day per client unless additional time is medically necessary in accordance with 907 KAR 3:130;
9. Ensure that the group has a deliberate focus and defined course of treatment;
10. Ensure that the subject of group outpatient therapy shall be related to each client participating in the group; and
11. Be provided by a behavioral health professional, behavioral health professional under clinical supervision, licensed behavior analyst, licensed assistant behavior analyst working under the supervision of a licensed behavior analyst, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice who shall maintain individual notes regarding each client within the group in the client's record;

(k) Family outpatient therapy which shall:

1. Consist of a face-to-face behavioral health therapeutic intervention provided through scheduled therapeutic visits between the therapist, at least one (1) member of the client's family, and the client unless the client's presence is not required in his or her plan of care;
2. Focus on the needs and treatment of a client age twenty-one (21) or younger and may continue without disruption after the client reaches age twenty-two (22) if the service is continued for therapeutic benefit as identified in the client's plan of care;
3. Address issues interfering with the relational functioning of the family;
4. Seek to improve interpersonal relationships within the client's home environment;
5. Be provided to promote the health and wellbeing of the client or recovery from a substance use disorder;
6. Not exceed three (3) hours per day per client unless additional time is medically necessary in accordance with 907 KAR 3:130; and
7. Be provided by a behavioral health professional, behavioral health professional under clinical supervision, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice;

(l) Collateral outpatient therapy which shall consist of a face-to-face behavioral health con-

sultation:

1. With a parent, caregiver, or person who has custodial control of a client under the age of twenty-one (21), household member, legal representative, school personnel, or treating professional;

2. Provided by a behavioral health professional, behavioral health professional under clinical supervision, licensed behavior analyst, licensed assistant behavior analyst working under the supervision of a licensed behavior analyst, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice; and

3. Provided upon the written consent of a parent, caregiver, or person who has custodial control of a client under the age of twenty-one (21). Documentation of written consent shall be signed and maintained in the client's record;

(m) Service planning which shall be provided to a client age twenty-one (21) or younger by a behavioral health professional, behavioral health professional under clinical supervision, licensed behavior analyst, licensed assistant behavior analyst working under the supervision of a licensed behavior analyst to:

1. Assist a client in creating an individualized plan for services needed for maximum reduction of the effects of a mental health disorder;

2. Restore a client's functional level to the client's best possible functional level; and

3. Develop a service plan which:

a. Shall be directed by the client; and

b. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan;

(n) Screening, brief intervention, and referral to treatment for substance use disorders which shall:

1. Be an evidence-based early intervention approach for an individual with non-dependent substance use prior to the need for more extensive or specialized treatment;

2. Consist of:

a. Using a standardized screening tool to assess the individual for risky substance use behavior;

b. Engaging a client who demonstrates risky substance use behavior in a short conversation, providing feedback and advice;

c. Referring the client to therapy or other services that address substance use if the client is determined to need additional services; and

3. Be provided by a behavioral health professional, behavioral health professional under clinical supervision, certified alcohol and drug counselor, licensed clinical alcohol and drug counselor, or licensed clinical alcohol and drug counselor associate practicing within his or her scope of practice to a client age twenty-one (21) or younger;

(o) Assertive community treatment for mental health disorders which shall:

1. Be provided to a client age twenty-one (21) or younger and may continue without disruption after the client reaches age twenty-two (22) if the service is continued for therapeutic benefit as identified in the client's plan of care;

2. Include assessment, treatment planning, case management, psychiatric services, medication prescribing and monitoring, individual and group therapy, peer support, mobile crisis services, mental health consultation, family support, and basic living skills;

3. Be provided by a multidisciplinary team of at least four (4) professionals, including a psychiatrist, nurse, case manager, peer support specialist, and any other behavioral health pro-

fessional or behavioral health professional under clinical supervision; and

4. Have adequate staffing to ensure that no caseload size exceeds ten (10) participants per team;

(p) Comprehensive community support services which shall:

1. Be provided to a client age twenty-one (21) or younger and may continue without disruption after the client reaches age twenty-two (22) if the service is continued for therapeutic benefit as identified in the client's plan of care;

2. Consist of activities needed to allow an individual with a mental health disorder to live with maximum independence in the community through the use of skills training as identified in the client's treatment plan;

3. Consist of using a variety of psychiatric rehabilitation techniques to:

- a. Improve daily living skills;
- b. Improve self-monitoring of symptoms and side effects;
- c. Improve emotional regulation skills;
- d. Improve crisis coping skills; and
- e. Develop and enhance interpersonal skills; and

4. Be provided by a;

- a. Behavioral health professional;
- b. Behavioral health professional under clinical supervision;
- c. Community support associate;
- d. Licensed behavior analyst; or
- e. Licensed assistant behavior analyst working under the supervision of a licensed behavior analyst;

(q) Therapeutic rehabilitation program for a child with a severe emotional disability which shall be provided to a client under twenty-one (21) years of age and shall:

1. Include services designed to maximize the reduction of the emotional disability and restoration of the client's functional level to the individual's best possible functioning;

2. Establish the client's own rehabilitative goals within the person-center plan of care;

3. Be delivered using a variety of psychiatric rehabilitation techniques focused on:

- a. Improving daily living skills;
- b. Self-monitoring of symptoms and side effects;
- c. Emotional regulation skills;
- d. Crisis coping skills; and
- e. Interpersonal skills; and

4. Be provided individually or in a group by a:

- a. Behavioral health professional;
- b. Behavioral health professional under clinical supervision; or
- c. Peer support specialist; or

(r) Targeted case management services which shall:

1. Include services to one (1) or more of the following target groups:

- a. A client under age twenty-one (21) with substance use disorder;
- b. A client under age twenty-one (21) with co-occurring mental health or substance use disorder and chronic or complex physical health issues; or
- c. A child with a severe emotional disability as defined by KRS 200.503(3);

2. Be provided by a case manager as described in subsection (2), (3), or (4) of this section; and

3. Include the following assistance:

a. Comprehensive assessment and reassessment of client needs to determine the need for medical, educational, social, or other services. The reassessment shall be conducted annually



or more often if needed based on changes in the client's condition;

b. Development of a specific care plan which shall be based on information collected during the assessment and revised if needed upon reassessment;

c. Referral and related activities, which may include:

(i) Scheduling appointments for the client to help the individual obtain needed services; or

(ii) Activities that help link the client with medical, social, educational providers, or other programs and services which address identified needs and achieve goals specified in the care plan;

d. Monitoring which shall be face-to-face and occur no less than once every three (3) months to determine that:

(i) Services are furnished according to the client's care plan;

(ii) Services in the care plan are adequate; and

(iii) Changes in the needs or status of the client are reflected in the care plan; and

e. Contacts with the client, family members, service providers, or others are conducted as frequently as needed to help the client:

(i) Access services;

(ii) Identify needs and supports to assist the client in obtaining services; and

(iii) Identify changes in the client's needs.

(2) A case manager who provides targeted case management services to clients with a substance use disorder shall:

(a) Be a certified alcohol and drug counselor, meet the grandfather requirements of 907 KAR 15:040, Section 4(1)(a)3, or have a bachelor's degree in a human services field, including:

1. Psychology;

2. Sociology;

3. Social work;

4. Family studies;

5. Human services;

6. Counseling;

7. Nursing;

8. Behavioral analysis;

9. Public health;

10. Special education;

11. Gerontology;

12. Recreational therapy;

13. Education;

14. Occupational therapy;

15. Physical therapy;

16. Speech-language pathology;

17. Rehabilitation counseling; or

18. Faith-based education;

(b)1. Have a minimum of one (1) year of full-time employment working directly with adolescents in a human service setting after completion of a bachelor's degree as described in paragraph (a) of this subsection; or

2. Have a master's degree in a human services field as described in paragraph (a) of this subsection;

(c)1. Have successfully completed case management training in accordance with 908 KAR 2:260; and

2. Successfully complete continuing education requirements in accordance with 908 KAR

2:260; and

(d) Be supervised by a behavioral health professional who:

1. Has completed case management training in accordance with 908 KAR 2:260; and
2. Has supervisory contact at least two (2) times per month with at least one (1) of the contacts on an individual, in person basis.

(3) A case manager who provides targeted case management services to clients with a mental health or substance use disorder and chronic or complex physical health issues shall:

(a) Meet the requirements of subsection (2)(a) of this section;

(b)1. After completion of a bachelor's degree, have a minimum of five (5) years of experience providing service coordination or referring clients with complex behavioral health needs and co-occurring disorders or multi-agency involvement to community based services; or

2. After completion of a master's degree in a human services field as described in subsection (2)(a) of this section, have a minimum of two (2) years of experience providing service coordination or referring clients with complex behavioral health needs and co-occurring disorders or multi-agency involvement to community based services;

(c)1. Have successfully completed case management training in accordance with 908 KAR 2:260; and

2. Successfully complete continuing education requirements in accordance with 908 KAR 2:260; and

(d) For a bachelor's level case manager, be supervised by a behavioral health professional who:

1. Has completed case management training in accordance with 908 KAR 2:260; and

2. Has supervisory contact at least three (3) times per month with at least two (2) of the contacts on an individual, in person basis.

(4) A case manager who provides targeted case management services to children with a severe emotional disability or clients with a severe mental illness shall:

(a) Meet the requirements of subsection (2)(a) of this section;

(b)1. Have a minimum of one (1) year of full-time employment working directly with individuals with behavioral health needs after completion of a bachelor's degree in a behavioral science field as described in subsection (2)(a) of this section; or

2. Have a master's degree in a human services field as described in subsection (2)(a) of this section;

(c)1. Have successfully completed case management training in accordance with 908 KAR 2:260; and

2. Successfully complete continuing education requirements in accordance with 908 KAR 2:260; and

(d) Be supervised by a behavioral health professional who:

1. Has completed case management training in accordance with 908 KAR 2:260; and

2. Has supervisory contact at least two (2) times per month with at least one (1) of the contacts on an individual in person basis.

(5) Plan of care.

(a) Each client receiving outpatient behavioral health services from a Level I or Level II PRTF shall have an individual plan of care signed by a behavioral health professional.

(b) A plan of care shall:

1. Describe the services to be provided to the client, including the frequency of services;

2. Contain measurable goals for the client to achieve, including the expected date of achievement for each goal;

3. Describe the client's functional abilities and limitations or diagnosis listed in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental

Disorders;

4. Specify each staff member assigned to work with the client;
5. Identify methods of involving the client's family or significant others if indicated;
6. Specify criteria to be met for termination of treatment;
7. Include any referrals necessary for services not provided directly by the chemical dependency treatment program; and
8. State the date scheduled for review of the plan.

(c) The client shall participate to the maximum extent feasible in the development of his or her plan of care, and the participation shall be documented in the client's record.

(d)1. The initial plan of care shall be developed through multidisciplinary team conferences at least thirty (30) days following the first ten (10) days of treatment.

2. The plan of care for individuals receiving intensive outpatient program services shall be reviewed every thirty (30) days thereafter and updated every sixty (60) days or earlier if clinically indicated.

3. Except for intensive outpatient program services, the plan of care for individuals receiving any other outpatient behavioral health service described in subsection (1) of this section shall be reviewed and updated every six (6) months or earlier if clinically indicated.

4. The plan of care and each review and update shall be signed by the participants in the multidisciplinary team conference that developed it.

(6) Physical environment of an off-campus extension or separate building on the campus of the Level I or Level II PRTF where outpatient behavioral health services are provided.

(a) Accessibility. The off-campus extension or separate building on the campus of the PRTF shall meet requirements for making buildings and facilities accessible to and usable by individuals with physical disabilities pursuant to KRS 198B.260 and 815 KAR 7:120.

(b) Physical location and overall environment.

1. The program shall:

- a. Comply with building codes, ordinances, and administrative regulations which are enforced by city, county, or state jurisdictions;
- b. Display a sign that can be viewed by the public that contains the facility name, hours of operation, and a street address;
- c. Have a publicly listed telephone number and a dedicated phone number to send and receive faxes with a fax machine that shall be operational twenty-four (24) hours per day;
- d. Have a reception and waiting area;
- e. Provide a restroom; and
- f. Have an administrative area.

2. The condition of the physical location and the overall environment shall be maintained in such a manner that the safety and well-being of clients, personnel, and visitors are assured.

(c) Prior to occupancy, the facility shall have final approval from appropriate agencies.

Section 15. Use of Emergency Safety Interventions in a Level I or Level II PRTF. (1) Pursuant to 42 C.F.R. 483.356(a)(3), restraint or seclusion shall not result in harm or injury to the resident and shall be used only:

- (a) To ensure the safety of the resident or others during an emergency safety situation; and
- (b) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.

(2)(a) The use of mechanical restraint shall be prohibited in a Level I or Level II PRTF.

(b) Residents of a Level I or Level II PRTF shall not be held in a prone position during restraint. A Level I or Level II PRTF may use a supine hold:

1. As a last resort if other less restrictive interventions have proven to be ineffective; and

2. Only by staff who are trained to identify risks associated with positional, compression, or restraint asphyxiation, and who monitor to ensure that the resident's breathing is not impaired.

(3) Emergency safety interventions shall not be used as a means of coercion, punishment, convenience, or retaliation.

(4) Orders for restraint or seclusion shall be:

(a) By a physician or other licensed practitioner acting within his or her scope of practice who is trained in the use of emergency safety interventions;

(b) Carried out by trained staff;

(c) If the resident's treatment team physician is available, given only by that physician; and

(d) The least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(5) A Level I or Level II PRTF shall have a written plan approved by the governing body for the use of emergency safety interventions which at a minimum shall meet the following requirements:

(a) Any use of an emergency safety intervention shall require clinical justification;

(b) A rationale and the clinical indications for the use of an emergency safety intervention shall be clearly stated in the resident's record for each occurrence. The rationale shall address the inadequacy of less restrictive intervention techniques;

(c) The plan shall specify the length of time for which a specific approval remains effective;

(d) The plan shall specify the length of time the emergency safety intervention may be utilized; and

(e) The plan shall specify when continued or repeated emergency safety interventions shall trigger multidisciplinary team review.

(6) If an emergency safety situation requires restraint or seclusion and a practitioner authorized to order restraint or seclusion is not available in a Level I or Level II PRTF, a verbal order for restraint and seclusion may be obtained and carried out under the following conditions:

(a) The verbal order shall be given by a licensed practitioner, as authorized by the facility, who is acting within his or her scope of practice and is trained in the use of emergency safety interventions;

(b) The verbal order shall be received by a licensed practitioner, as authorized by the facility, who is acting within his or her scope of practice;

(c) The physician or ordering practitioner shall be immediately available, at least by telephone, for consultation during the time that restraint or seclusion is being carried out; and

(d) The verbal order shall be countersigned by the physician or ordering practitioner within seven (7) days of the date that the order was given, and included in the resident's record.

(7) An order for restraint or seclusion shall not exceed the shortest of:

(a) The duration of the emergency safety situation;

(b) Four (4) hours for a resident eighteen (18) to twenty-one (21) years of age;

(c) Two (2) hours for a resident nine (9) to seventeen (17) years of age;

(d) One (1) hour for a resident seven (7) to eight (8) years of age; or

(e) Thirty (30) minutes for a child four (4) to six (6) years of age.

(8) If an emergency safety situation exists beyond the time limit for the use of restraint or seclusion, a new order for restraint or seclusion shall be obtained.

(9) A resident that is placed in restraint or seclusion shall receive a face-to-face evaluation to determine physical and psychological well being. The evaluation shall:

(a) Be conducted by a licensed practitioner who is acting within his or her scope of practice and is trained in the use of emergency safety interventions;

(b) Include the resident's physical and psychological status, resident's behavior, appropriateness of the intervention measures, and any complications resulting from the intervention;

and

(c) Be conducted within one (1) hour of restraint or seclusion being initiated.

(10) Each order for restraint or seclusion shall include:

(a) The name of the ordering physician or other licensed practitioner, acting within his or her scope of practice and trained in the use of emergency safety interventions;

(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 authorized its use.

(11)(a) Staff shall document the emergency safety intervention in the resident's record.

(b) The documentation shall be completed by the end of the shift in which the intervention occurs.

(c) If the intervention does not end during the shift in which it began, documentation shall be completed during the shift in which it ends. Documentation shall include:

1. Each order for restraint or seclusion as described in subsection (10) of this section;

2. The time the emergency safety intervention actually began and ended;

3. The time and results of the evaluation required by subsection (9) of this section;

4. The emergency safety situation that required the resident to be restrained or put in seclusion; or

5. The name of staff involved in the emergency safety intervention.

(12) Staff who implement emergency safety interventions shall:

(a) Have documented training in the proper use of the procedure used;

(b) Be certified in physical management by a nationally-recognized training program in which certification is obtained through skills-based testing; and

(c) Receive annual training and recertification in crisis intervention and behavior management.

(13) Staff authorized by a Level I or Level II PRTF shall:

(a) Be constantly, physically present with a resident being restrained;

(b) Monitor the physical and psychological well being of a resident being restrained, and monitor the safe use of restraint throughout the duration of the emergency safety intervention; and

(c) Document observations of, and actions taken for, a resident being restrained.

(14) Within one (1) hour of initiation of restraint or seclusion, a physician or licensed practitioner acting within his or her scope of practice and trained in the use of emergency safety interventions shall conduct a face-to-face evaluation of the resident's physical and psychological well-being.

(15) Staff shall provide constant visual attention to a resident who is in seclusion, through physical presence or a window.

(16) Staff authorized by a Level I or Level II PRTF shall:

(a) Monitor the physical and psychological well being of the resident;

(b) Ensure that a resident in seclusion is provided:

1. Regular meals;

2. Hydration;

3. Bathing; and

4. Use of the toilet; and

(c) Document observations of, and actions taken for, a resident in restraint every fifteen (15) minutes.

(17) A procedure shall not be used at any time in a manner that causes harm or pain to a resident.

(18)(a) A Level I or Level II PRTF shall notify the parent, guardian, or custodian of the resi-

dent who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility shall document in the resident's record that the parent, guardian, or custodian has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

(19)(a) Within twenty-four (24) hours after use of restraint or seclusion, staff involved in an emergency safety intervention and the resident shall have a face-to-face discussion.

(b) The discussion shall include all staff involved in the intervention except if the presence of a particular staff person may jeopardize the well-being of the resident. The discussion may include other staff and the resident's parent, guardian, or custodian.

(20) Within twenty-four (24) hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes a review and discussion of:

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

(b) Alternative techniques that might have prevented the use of the restraint or seclusion;

(c) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

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

(21) Application of time out.

(a) A resident in time out shall not 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.

(c) Staff shall monitor the resident while he or she is in time out.

(22) A Level I or Level II PRTF shall not use extraordinary risk procedures, including experimental treatment modalities, psychosurgery, aversive conditioning, electroconvulsive therapies, behavior modification procedures that use painful stimuli, unusual medications, or investigational and experimental drugs.

(23) Unusual treatment shall require the informed consent of the resident and parent, guardian, or custodian prior to the provision of unusual treatment as follows:

(a) The proposed unusual treatment shall be reviewed and interpreted by the child's psychiatrist addressing:

1. The rationale for use;

2. Methods to be used;

3. Specified time to be used;

4. Who will provide the treatment; and

5. The methods that will be used to evaluate the efficacy of the treatment.

(b) The potential risks, side effects, and benefits of the proposed unusual treatment shall be explained, verbally and in writing, to the resident and the parent, guardian, or custodian prior to their granting approval for the unusual treatment. The approval shall be given in writing prior to implementation of the treatment.

(24) The clinical director or designee shall review all uses of unusual treatment procedures, including emergency safety interventions, on a daily basis. The daily review shall include an evaluation for the possibility of unusual or unwarranted patterns of use.

Section 16. Housekeeping Services. (1) A Level I or Level II PRTF shall have policies and procedures for and services which maintain a clean, safe, and hygienic environment for residents and facility personnel. Policies and procedures shall include guidelines for at least the following:

- (a) The use, cleaning, and care of equipment;
  - (b) Assessing the proper use of housekeeping and cleaning supplies;
  - (c) Evaluating the effectiveness of cleaning; and
  - (d) The role of the facility staff in maintaining a clean environment.
- (2) A laundry service shall be provided by a Level I or Level II PRTF or through contractual agreement.
- (3) Pest control shall be provided by a Level I or Level II PRTF or through contractual agreement.

Section 17. Infection Control. (1) Because infections acquired in a Level I or Level II PRTF or brought into a Level I or Level II PRTF from the community are potential hazards for all persons having contact with the facility, there shall be an infection control program developed to prevent, identify, and control infections.

(2) Written policies and procedures pertaining to the operation of the infection control program shall be established, reviewed at least annually, and revised as necessary.

(3) A practical system shall be developed for reporting, evaluating, and maintaining records of infections among residents and personnel.

(4) The system shall include assignment of responsibility for the ongoing collection and analysis of data, as well as for the implementation of required follow-up actions.

(5) Corrective actions shall be taken on the basis of records and reports of infections and infection potentials among residents and personnel and shall be documented.

(6) All new employees shall be instructed in the importance of infection control and personal hygiene and in their responsibility in the infection control program.

(7) A Level I or Level II PRTF shall document that in-service education in infection prevention and control is provided for all services and program components.

Section 18. Tuberculosis Testing Requirements. (1) Induration Measurements. The diameter of the firm area shall be measured transversely to the nearest millimeter to gauge the degree of reaction, and the result shall be recorded in millimeters.

(a) A reaction of ten (10) millimeters or more of induration shall be considered highly indicative of tuberculosis infection in a healthcare setting.

(b) A reaction of five (5) millimeters or more of induration may be significant in certain individuals, including HIV-infected persons, persons with immunosuppression, or recent contacts of persons with active TB disease.

(2) Tuberculosis (TB) disease.

(a) A person shall be diagnosed as having tuberculosis (TB) disease if the infection has progressed to causing clinical (manifesting signs or symptoms) or subclinical (early stage of disease in which signs or symptoms are not present, but other indications of disease activity are present, including radiographic abnormalities) illness.

1. Tuberculosis that is found in the lungs shall be called pulmonary TB and may be infectious.

2. Tuberculosis that occurs at a body site outside the lungs shall be called extra pulmonary disease and may be infectious in rare circumstances.

(b) If the only clinical finding is specific chest radiographic abnormalities, the condition shall be termed "inactive TB" and may be differentiated from active TB disease, which shall be accompanied by symptoms or other indications of disease activity, including the ability to culture reproducing TB organisms from respiratory secretions or specific chest radiographic finding.

(3)(a) A TST conversion shall have occurred if there is a greater than ten (10) millimeters increase in the size of the TST induration during a two (2) year period in:

1. A health care worker with a documented negative (<10 mm) baseline two (2) step TST result; or
2. A person who is not a health care worker with a negative (<10 mm) TST result within two (2) years.
  - (b) A TST conversion shall be presumptive evidence of new *M. tuberculosis* infection and poses an increased risk for progression to TB disease.

Section 19. Admission of Residents under Treatment for Pulmonary Tuberculosis Disease.

- (1) A Level I or Level II PRTF shall not admit a person under medical treatment for pulmonary tuberculosis disease unless the person is declared noninfectious by a licensed physician in conjunction with the local or state health department.
  - (2) Documentation of noninfectious status shall include:
    - (a) Documented TB disease treatment with multi-drug therapy for at least two (2) weeks;
    - (b) Documentation of clinical improvement on therapy;
    - (c) Three (3) consecutive sputum smears negative for acid-fast bacilli within the one (1) month period prior to admission; or
    - (d) Three (3) negative sputum cultures for TB.

Section 20. Tuberculin Skin Tests or BAMTs of Residents. (1) For residents entering a facility, a TST or BAMT shall not be required if one (1) of the following is documented:

- (a) A previously documented TST has shown ten (10) or more millimeters of induration;
- (b) A previously documented TST has shown five (5) or more millimeters of induration for a resident who has medical reasons (HIV-infected persons, immunosuppression, or recent contact with a person with active TB disease) for his or her TST result to be interpreted as positive;
- (c) A positive BAMT;
- (d) The resident is currently receiving or has completed treatment of LTBI with nine (9) months of isoniazid or four (4) months of rifampin, or has completed a course of multiple-drug therapy for active TB disease; or
- (e) The resident can document that he or she has had a TST or BAMT within three (3) months prior to admission and has previously been in a serial testing program at a medical facility.

(2)(a) If a resident does not meet the criteria of subsection (1) of this section, a TST or a BAMT shall be required upon admission to the Level I or Level II facility.

(b)1. A TST shall be required for residents less than five (5) years of age.

2. A TST result of five (5) or more millimeters of induration may be positive for those residents who have medical reasons (HIV-infected persons, immunosuppression, or recent contact with a person with active TB disease) for his or her TST result to be interpreted as positive.

3. For a resident without medical reasons as identified in subparagraph 2. of this paragraph whose initial TST shows less than ten (10) millimeters of induration, two-step TSTs shall be required for:

- a. A resident age fourteen (14) years and older; or
- b. A resident expected to stay longer than twelve (12) months unless the resident is able to document that he or she has had a TST within one (1) year prior to initial testing upon admission to the facility.

(3)(a) The TST result of each resident shall be documented through recording of the date and millimeters of induration of the most recent skin test in the medical record.

(b) The medical record shall be labeled in a conspicuous manner (e.g. Problem Summary or



Care Plan) with the notation "TST Positive" for each resident with a reaction of ten (10) or more millimeters of induration and for each resident with a reaction of five (5) or more millimeters of induration who has a medical reason (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for that TST result to be interpreted as positive.

(4)(a) If performed and the result is positive or negative, only one (1) BAMT result shall be required on admission.

(b) A second BAMT shall be performed if the BAMT result is borderline or indeterminate.

(c) If a resident has a positive BAMT, the medical record shall be labeled in a conspicuous manner (e.g. Problem Summary or Care Plan) with the notation "BAMT Positive."

Section 21. Medical Evaluations and Chest X-rays of Residents. (1) A resident shall receive a medical evaluation, which may include an HIV test, if the resident is found at the time of admission to have a:

(a) TST of ten (10) or more millimeters of induration;

(b) TST result of five (5) or more millimeters of induration if the resident has a medical reason (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for that TST result to be interpreted as positive; or

(c) Positive BAMT.

(d) A chest x-ray shall be performed unless a chest x-ray done within two (2) months prior to admission showed no evidence of tuberculosis disease.

(2)(a) A resident who meets the criteria listed in subsection (1) of this section and who has no clinical evidence of active TB disease upon evaluation by a licensed physician and a negative chest x-ray shall be offered treatment for LTBI unless there is a medical contraindication.

(b) A resident who refuses treatment for LTBI or who has a medical contraindication shall be monitored according to the requirements established in Section 22 of this administrative regulation.

(3) A resident with an abnormal chest x-ray, consistent with TB disease, shall be:

(a) Evaluated for active tuberculosis disease; and

(b) If the resident is diagnosed with active tuberculosis disease, transferred to a facility with an airborne infection isolation (All) room and started on multi-drug antituberculosis treatment that is administered by DOT.

Section 22. Monitoring of Residents with a Positive TST, a Positive BAMT, a TST Conversion, or a BAMT Conversion. (1) A resident shall be monitored for development of pulmonary symptoms, including cough, sputum production, or chest pain, if the resident has a:

(a) TST result with ten (10) or more millimeters of induration;

(b) TST result of five (5) or more millimeters of induration if the resident has a medical reason (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for that TST result to be interpreted as positive;

(c) Positive BAMT;

(d) TST conversion; or

(e) BAMT conversion.

(2) If pulmonary symptoms, including cough, sputum production, or chest pain, develop and persist for three (3) weeks or longer:

(a) The resident shall have a medical evaluation;

(b) A chest x-ray shall be taken; and

(c) Three (3) sputum samples shall be submitted to the Division of Laboratory Services, Department for Public Health, Frankfort, Kentucky, for tuberculosis culture and smear.

(3) A resident with suspected or active TB disease shall be transferred to a facility with an All room and started on multi-drug antituberculosis treatment that is administered by DOT.

Section 23. Monitoring of Residents with a Negative TST or a Negative BAMT who are Residents Longer than One (1) Year. (1) Annual testing shall be required on or before the anniversary of the resident's last TST or BAMT.

(2) A TST shall be required for residents less than five (5) years of age.

(3) If pulmonary symptoms develop and persist for three (3) weeks or more:

(a) The resident shall have a medical evaluation;

(b) The tuberculin skin test shall be repeated;

(c) Three (3) sputum samples shall be submitted to the Division of Laboratory Services, Department for Health Services, Frankfort, Kentucky for tuberculosis culture and smear; and

(d) A chest x-ray shall be taken.

(4) A resident with suspected or active TB disease shall be transferred to a facility with an All room and started on multi-drug antituberculosis treatment that is administered by DOT.

Section 24. Tuberculin Skin Tests or BAMTs for Staff. (1) The TST or BAMT status of all PRTF facility staff members who have direct contact with residents shall be documented in the employee's health record.

(2) A TST or BAMT shall be initiated on each new staff member who has direct contact with residents before or during the first week of employment, and the results shall be documented in the employee's health record within the first month of employment.

(3) A TST or BAMT shall not be required at the time of initial employment if the employee documents one of the following:

(a) A prior TST of ten (10) or more millimeters of induration;

(b) A prior TST of five (5) or more millimeters of induration if the employee has a medical reason (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for his or her TST result to be interpreted as positive;

(c) A positive BAMT;

(d) A TST conversion;

(e) A BAMT conversion; or

(f) The employee is currently receiving or has completed treatment for LTBI.

(4)(a) If performed and the result is positive or negative, one (1) BAMT test result shall be required on initial employment.

(b) A second BAMT shall be performed if the BAMT result is borderline or indeterminate.

(5) A TST result of five (5) or more millimeters of induration may be positive for a new employee who has a medical reason (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for his or her TST result to be interpreted as positive.

(6) A two-step TST shall be required for a new employee who does not have a medical reason as described in subsection (5) of this section and whose initial TST shows less than ten (10) millimeters of induration, unless the individual documents that he or she has had a TST within one (1) year prior to his or her current employment.

(7) A staff member who has never had a TST of ten (10) or more millimeters induration or a positive BAMT shall have a TST or BAMT annually on or before the anniversary of his or her last TST or BAMT.

Section 25. Medical Evaluations and Chest X-rays and Monitoring of Staff with a Positive TST, a Positive BAMT, a TST Conversion, or a BAMT Conversion. (1) At the time of initial em-

ployment testing or annual testing, a staff member who has direct contact with residents shall have a medical evaluation, which may include an HIV test, if the staff member is found to have a:

- (a) TST of ten (10) or more millimeters induration;
  - (b) TST result of five (5) or more millimeters of induration if the staff member has a medical reason (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for his or her TST result to be interpreted as positive;
  - (c) Positive BAMT;
  - (d) TST conversion; or
  - (e) BAMT conversion.
- (2) A chest x-ray shall be performed unless a chest x-ray within the previous two (2) months showed no evidence of tuberculosis disease.
- (3)(a) A staff member with a negative chest x-ray shall be offered treatment for LTBI unless there is a medical contraindication.
- (b) A staff member who refuses treatment for LTBI or who has a medical contraindication shall be monitored according to the requirements established in Section 28 of this administrative regulation.
- (4)(a) A staff member with an abnormal chest x-ray shall be evaluated for active tuberculosis disease, and three (3) sputum samples shall be submitted to the Division of Laboratory Services, Department for Public Health, Frankfort, Kentucky, for tuberculosis culture and smear.
- (b) A staff member shall remain off work until cleared as being noninfectious for TB by a licensed physician.
- (c) A staff member whose medical evaluation and laboratory tests are suspect for active tuberculosis disease shall be isolated (e.g. in an All room or in home isolation) and started on four (4) drug antituberculosis treatment that is administered by DOT.
- (5)(a) A staff member under treatment for pulmonary tuberculosis disease may return to work in the facility after being declared noninfectious by a licensed physician in conjunction with the local or state health department.
- (b) Documentation of noninfectious status shall include:
- 1. Documented TB disease treatment with multi-drug therapy for at least two (2) weeks;
  - 2. Documentation of clinical improvement on therapy;
  - 3. Three (3) consecutive sputum smears negative for acid-fast bacilli within the month prior to the employee's anticipated return to work; or
  - 4. Three (3) negative sputum cultures for TB.

Section 26. Responsibility for Screening and Monitoring Requirements. (1) The program director or clinical director of the facility shall be responsible for ensuring that all TSTs, BAMTs, chest x-rays and sputum samples submissions are done in accordance with Sections 18 through 28 of this administrative regulation.

(2) If a facility does not employ licensed professional staff with the technical training to carry out the screening and monitoring requirements, the program director or clinical director shall arrange for professional assistance from the local health department.

(3)(a) Dates of all TSTs or BAMTs and results, all chest x-ray reports and all sputum sample culture and smear results for residents shall be recorded as a permanent part of the resident's medical record and be summarized on the individual's transfer form if an interfacility transfer occurs.

(b) The TST or BAMT status of all staff members and any TB related chest x-ray reports shall be documented in the employee's health record.

Section 27. Reporting to Local Health Departments. The following shall be reported to the local health department having jurisdiction by the program director or clinical director of the facility immediately upon becoming known:

- (1) All residents and staff who have a TST of ten (10) millimeters or more induration;
- (2) A TST result of five (5) or more millimeters of induration for all residents or staff who have medical reasons (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for their TST result to be interpreted as positive;
- (3) A positive BAMT at the time of admission of a resident or employment of a staff member who has direct contact with residents;
- (4) TST conversions or BAMT conversions on serial testing or identified in a contact investigation;
- (5) Chest x-rays which are suspicious for TB disease;
- (6) Sputum smears positive for acid-fast bacilli;
- (7) Sputum cultures positive for *Mycobacterium tuberculosis*; or
- (8) The initiation of multi-drug antituberculosis treatment.

Section 28. Treatment for LTBI. (1) A resident or staff member with a TST conversion or a BAMT conversion shall be considered to be recently infected with *Mycobacterium tuberculosis*.

(2) Recently infected persons shall have a medical evaluation, which may include an HIV test, and shall include a chest x-ray.

(3)(a) Individuals who meet the criteria listed in subsection (1) of this section and have no signs or symptoms of tuberculosis disease by medical evaluation or chest x-ray shall be offered treatment for LTBI with isoniazid for nine (9) months or rifampin for four (4) months, in collaboration with the local health department, unless medically contraindicated as determined by a licensed physician.

(b) Medications shall be administered to residents upon the written order of a physician and shall be given by DOPT.

(4)(a) If a resident or staff member refuses treatment for LTBI or has a medical contraindication, the individual shall be advised of the clinical symptoms of active TB disease, and have an interval medical history for clinical symptoms of active TB disease every six (6) months during the two (2) years following conversion.

(b) A resident less than five (5) years of age who has a status change on admission to the facility or on annual testing shall be seen and monitored by a pediatrician.

(c) A resident or staff member who has a TST result of ten (10) millimeters or more induration or a positive BAMT at the time of admission of the resident or employment of the staff member shall be offered treatment for LTBI.

(d) A resident or staff member who has a TST result of five (5) or more millimeters of induration at the time of admission or employment and who has medical reasons (e.g. HIV-infected persons, immunosuppression, or recent contacts of persons with active TB disease) for his or her TST result to be interpreted as positive shall be offered treatment for LTBI.

(e) If a resident or staff member refuses treatment for LTBI detected on admission or employment or has a medical contraindication, the individual shall be educated about the clinical symptoms of active TB disease, and have an interval medical history for symptoms of active TB disease every six (6) months during the two (2) years following admission or employment. The education shall be documented in either the resident's medical record or the employee's health record.

(5) A resident who stays longer than one (1) year in the facility or staff member who documents completion of treatment for LTBI shall:

- (a) Be exempt from further requirements for TSTs or BAMTs; and
- (b) Receive education on the symptoms of active TB disease during his or her annual tuberculosis risk assessment and any other monitoring in accordance with Sections 21 or 26, or this section of this administrative regulation. (17 Ky.R. 2110; Am. 2452; eff. 3-12-1991; 19 Ky.R. 1202; 1613; 1772; eff. 1-27-1993; 21 Ky.R. 1572; 1889; eff. 2-10-1995; 23 Ky.R. 2309; 3053; eff. 2-19-97; 24 Ky.R. 1966; eff. 5-18-1998; 32 Ky.R. 517; 667; eff. 10-19-2005; 37 Ky.R. 1574; 2223; 2402; eff. 5-6-2011; 41 Ky.R. 2393; 42 Ky.R. 698; eff. 11-18-2015.)